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Martha Sajatovic
Editors

Encyclopedia of Immigrant Health

Springer

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Sana Loue and Martha Sajatovic (Eds.)

Encyclopedia of Immigrant Health

With 14 Figures and 14 Tables

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ISBN 978-1-4419-5655-2 e-ISBN 978-1-4419-5659-0
Print and electronic bundle under ISBN 978-1-4419-5660-6
DOI 10.1007/978-1-4419-5659-0
Springer New York Dordrecht Heidelberg London

Library of Congress Control Number: 2011939217

Printed on acid-free paper

Springer is part of Springer Science+Business Media (www.springer.com)

Introduction

The health care of immigrants and the health effects of migration on sending and receiving communities have been issues of concern worldwide. Given increasing globalization it is likely that migration and the health of immigrants will become even more important. These multifaceted and complex issues demand a multidisciplinary, multilevel perspective and immigrant health can no longer be considered a niche in health care that can be outside of the interest or expertise of health care systems and health care providers. The *Encyclopedia of Immigrant Health* represents our effort to provide a foundational reference work for health care providers, public health professionals, advocates, agency personnel, and policymakers as they increasingly are called upon to provide optimal support for immigrants and their families.

Contributors to these volumes approach their topics from diverse disciplinary, political, and cultural viewpoints and, wherever possible, approach their subject from a biopsychosocial perspective. Many, if not most, of the contributors have direct experience in one or more domains of immigrant health, including medicine, nursing, health-related research, law, human rights, public health, health education, economics, demography, psychology, sociology, social work, religion and theology, medical anthropology, and history.

The *Encyclopedia of Immigrant Health* comprises two major sections. Part I consists of overview chapters that provide the reader with an in-depth examination of various dimensions of immigrant health. Rausa and Lloyd focus on global patterns of migration as well as the various factors that motivate individuals to leave their countries of origin for another locale. Loue's chapter follows, with an examination of the interplay between immigration processes and health concerns, using U.S. immigration policy as an example.

The four chapters that follow focus on dimensions of health and health care that, while relevant to all populations, are particularly salient in the context of immigrant health. Regardless of where they are coming from and where they are going to, all immigrants bring with them their understandings of health, illness, disease, healing, and cure. Health care providers and researchers may find the chapters on alternative and complementary medicine, authored by Lovell, Daneshnia and Fries, and culture-specific diagnoses, authored by Smith, Mayes and Smith, particularly useful, with their examinations of conceptualizations of illness and approaches to healing that have been endorsed by various cultures, are often relied upon by immigrants in their new environments, and have in varying degrees been adopted by residents of their new host communities. Low and Low review the multitude of factors that can affect the health of immigrants and immigrant communities. Brugge and Siqueira examine health issues associated with occupational and environmental exposures, which represent a growing concern in view of the global increase in labor migration.

Significant methodological issues may arise in the context of immigrant health research. Murphy, Allen and Sin provide a review of the various study designs that can be utilized in conducting research related to immigrant health and the advantages and challenges associated with each such approach. Both immigrant health research and the provision of health care to immigrants often present significant ethical issues. Loue reviews the many aspects that must be considered in designing a study involving immigrants and their communities. Ioan reviews the ethical issues confronting health care providers in their efforts to provide quality care to their immigrant patients.

Part II consists of encyclopedic entries arranged in alphabetical order. These entries cover a broad range of topics, including specific diseases or disorders particularly relevant to immigrant groups, culture specific health concerns, international conventions and nongovernmental organizations. Each entry provides an overview of the current understandings of the subject and its relation to immigrant health. Other entries focus on specific countries that are particularly notable as sending or receiving countries for migration or individuals who are especially noteworthy for their effort to address issues related to immigrant health. All entries are followed by a listing of suggested readings that includes references and cross-references to other topics. In many cases, suggested web-based resources are also provided.

Immigrant health is an exciting and dynamic field that challenges the researcher, the clinician, and the policymaker with its complexity, breadth, and richness. As such, participation in this field in any capacity offers the professional immense opportunities to be of service to others beyond one's own community and, on a personal level, for the development of knowledge and understanding of diverse cultures and the enhancement of one's self-knowledge and sensitivity towards others.

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Part 1

Immigrant Health Overview Chapters

Immigration in the Global Context

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Introduction

Studies of human DNA indicate that migration has been a part of human existence for at least 100,000 years, when it is estimated that the first migrations of humans from Africa to Asia occurred (Stanyon et al., 2009). Migration has been part of the human story from the days of strictly hunting and gathering-based societies to the establishment of prolific urban areas that accommodate millions of human beings in small concentrated areas. Most human migration is in search of better opportunities reflecting the desire for an improved quality of life. In some cases, migration is the only means of survival, and yet in others, migration is forced, either by violence, political unrest, or natural disaster.

Some of the most significant historical movements of people include over 1.2 million Spaniards, Portuguese, and British subjects migrating to the Americas beginning in the 1490s, closely followed by up to 12 million African migrants forced to move as slaves across the Atlantic Ocean through the nineteenth century. From the 1840s to 1900, 3.6 million Chinese and Indians migrated as laborers to South-East Asia, Africa, and North America. Although differing cultural encounters have and still lead to conflicts, there are records of rather peaceful coexistence as far back as the eighteenth century BCE in ancient Babylon. Writings in the Old Testament and the Qur'an encourage people to treat others as themselves and provide safe havens to those from different lands and different faiths. Large movements of people have also played a critical role in transforming economies of scale, including spreading farming practices and providing large labor forces which fueled the British Industrial Revolution via rural to urban movements. In the nineteenth century, hunger and poverty were large drivers for the movement of people out of Europe. During this time, 14% of the Irish population left their homeland, in part due to the potato famine facilitated by the simultaneous and significant drop in the cost of passenger travel from Britain to New York (UNDP, 2009).

According to the International Organization for Migration's (IOM) *World Migration Report 2010*, the estimated total number of international migrants today is 214 million persons, or 3.1% of the global human population (the figures in this chapter are from the period 2008 to 2010 via census information gathered by the United Nations Department of Economic and Social Affairs (UN DESA), unless otherwise indicated). Migration used to be dominated by men, but it is estimated that now half of all migrants are women. Most of those migrants, 57%, live in developed countries, also referred to as high-income countries. The United States has the highest number of foreign-born individuals with current estimates as high as 42 million, followed by The Russian Federation with approximately 12 million immigrants. Germany has approximately 10.5 million foreign-born residents, followed by Saudi Arabia, Canada, France, the United Kingdom, Spain, India, and Ukraine, with numbers ranging from 7.5 million to 5 million, respectively. In terms of percentage of total population, however, Qatar has the highest percentage of non-native-born people residing within its borders, with 86.5% of its population foreign-born. Qatar is followed by the United Arab Emirates (70%), Kuwait (68.8%), Jordan (45.9%), the Occupied Palestinian Territories (43.6%), Singapore (40.7 %), Israel (40.4%), Hong Kong SAR (Special Administrative Region of China) (38.8%), Oman (28.4%), and Saudi Arabia (27.8%).

Although 57% of all migrants live in developed regions, they constitute only 10% of those populations (IOM, 2010). Given these figures, it would seem that most migrants move beyond the borders of their country of origin, but in fact, most migration occurs

Sana Loue & Martha Sajatovic (eds.), *Encyclopedia of Immigrant Health*, DOI 10.1007/978-1-4419-5659-0,

internally, that is, movement within a country's borders such as rural to urban movement or individuals forced to move from one area to another due to war, violence, or natural disaster. The comparison is striking: there are 740 million internal migrants in the world today, compared to 214 million migrants internationally. A closer look at general migration patterns reveals that almost half of all international migrants move within their region of origin, and close to 40% move to a neighboring country. The reasons for this are complex, but, in general, they can be attributed to the cost of moving. Moving costs are not only related to transportation but also to policy-based restrictions such as the cost of a passport, visa, or work permit, which for many migrants are prohibitive. Economics, however, are not the only determinant of where people migrate; statistics show that six out of ten migrants move to a country with the same major religion as their country of birth, and four out of ten move to a country that shares the dominant language (UNDP, 2009).

Several of the countries that are main destination areas for migrants are also in the top 10 countries of origin for those who emigrate: Germany, India, The Russian Federation, Ukraine, and the United Kingdom (IOM, 2010). However, internal migration in these countries is much greater than migration to other countries, as previously noted (UNDP, 2009). The term "migrant" is used in this chapter for all individuals who have left their place of origin; where relevant, specific migrant groups will be highlighted. General migration patterns within and between geographic regions will be reviewed first, followed by migration trends due to factors such as demand for specific types of labor, the impact of war and environmental changes on migration, and the migration during the ongoing global economic crisis.

Regional View of Migration

Africa

In 2010, Africa accounted for almost 9% of the total number of global migrants (19 million) – although this figure is considered an underestimate due to insufficient immigration data from the region. Almost 40% of internally displaced people, or refugees, in the world live in Africa. War and other conflicts, extreme poverty, and climate change are the most common reasons for internal displacement. In 2008, environmental disasters alone were responsible for the displacement of 700,000 people. Urban areas in Africa are growing rapidly and some estimates predict that by 2050, 1.2 billion Africans will be living in urban areas, with much of the growth due to internal migration, specifically rural to urban movement. This growth, however, is predicted to be temporary because urban areas in Africa have high costs of living, which could eventually push people to return to rural areas (IOM, 2010).

Emigration of Africans is high: in 2000, almost 23 million people left their country of origin, with most moving to a sub-Saharan country. In fact, migration within the region accounts for three quarters of all movement. The top destination for migrants in Africa is Kenya, which in 2010 hosted 818,000 migrants. After Kenya, the United Republic of Tanzania, Uganda, Ethiopia, Rwanda, and Mozambique were the top receiving countries in the region. East African migrants include many who have been forced to move due to conflicts and regional instability, an estimated ten million in 2008. The Democratic Republic of the Congo and Somalia together account for more than one million internally displaced individuals. North Africa hosts an estimated total of 1.8 million migrants, 753,000 of whom live in Sudan, 682,000 in Libya, 242,000 in Algeria, 53,000 in Morocco, and 34,000 in Tunisia. Traditionally, North African countries have been the source of immigrants, but they are now becoming either transit or destination countries for not only internal migrants, but external ones as well. Additionally, a growing number of migrants are moving to the southern African region as a result of better economic growth and because of economic and political crisis in bordering countries, such as Zimbabwe. The country of South Africa alone currently hosts 2.2 million migrants. The total estimated number of migrants to West Africa is 8.4 million people, two thirds of whom live in Cote d'Ivoire, Ghana, and Nigeria (IOM, 2010).

Americas

The Americas (North, Central, and South America, and the Caribbean) host the greatest number of international migrants, increasing from 47 million in 2000 to more than 57.5 million today. Twenty-seven percent of all migrants in the world live in the Americas. However, the majority of migration in the Americas is between countries in the region – with the main destination country being the United States. Seventy percent of Canadian and more than two thirds of Latin American and Caribbean emigrants live in the United States. Migrants make up 14.2% of the total US population, numbering about 50 million. The Mexico-US migration corridor is the largest in the world, with 30% of the United States' 50 million immigrants coming from Mexico. Following Mexico, the other primary countries of origin for migrants living in the United States are the Philippines, Germany, India, China, Vietnam, Canada, Cuba, El Salvador, and the United Kingdom. Asians currently make up 27% of the US migrant population with two million Chinese, 1.7 million Filipinos, and 1.6 million Indians. Of the 50 million international migrants currently living in the United States, as much as 30% are estimated to be "irregular migrants." Irregular migrants are individuals who have entered a country without proper immigration documents, commonly referred to as "undocumented immigrants." An estimated 40% of irregular migrants in the United States are women. Emigration from North America to other regions is relatively low; about 3.6 million individuals are currently living outside of the region, 60% of whom are from the United States.

Twenty-one percent of Canada's population is made up of immigrants, numbering about 7.2 million. In contrast to the United States, Canada's main source countries for immigrants are China, India, Italy, and the United Kingdom. Canada is also a source country of migrants living elsewhere: in 2005, about 1.3 million Canadians were living abroad, primarily in the United States, the United Kingdom, and Australia.

Latin America and the Caribbean are hosts to 7.5 million international migrants. Of note is the steady increase in the number of female migrants in the subregions since 1960, from 44.2% to 50.1% in 2010 (see section on ➋ "Women"). Argentina, the Bolivarian Republic of Venezuela, and Mexico (recently taking the third spot from Brazil) are the top three destination countries. Argentina and the Bolivarian Republic of Venezuela, together with Paraguay and Puerto Rico, have experienced a decrease in the number of immigrants in recent years. Ecuador on the other hand has seen an increase and is now ranked as seventh in destination countries in Latin America.

For both Latin America and the Caribbean, however, emigration from the region is greater than immigration to the subregions. Eleven million people left Latin America and the Caribbean between 2000 and 2010: 6.8 million Central Americans, three million South Americans, and 1.2 million Caribbeans. Emigrants from these areas make up 15% of international migrants globally. The country with the largest number of people emigrating is Mexico, with 10.1 billion, or 10% of its population currently living abroad, followed by Colombia, Puerto Rico, Cuba, El Salvador, Brazil, Jamaica, the Dominican Republic, Haiti, and Peru. As is the case for Mexican migrants, the United States is the main destination for Latin American migrants, followed by Argentina, Spain, the Bolivarian Republic of Venezuela, and Canada.

Migration to Latin America and Caribbean countries comes from neighboring countries. Argentina is a destination country for migrants from the Plurinational State of Bolivia, Chile, Paraguay, and Uruguay. The Bolivarian Republic of Venezuela is a destination for Colombian migrants, while Costa Rica is the primary destination for Nicaraguans. For those Latin American and Caribbean migrants who move to Europe, Spain is the main country of destination, accounting for 38% of Spain's immigrant population. Twenty percent of Brazilians however, migrate to Japan, ranking as the third largest migrant group in that country. It is interesting to note that most of the Brazilian migrants in Japan are of Japanese origin, and as such are able to benefit from special visa programs as well as better wages. Colombia, due to civil conflicts, ranks third in the world for internally displaced persons with an estimated 2.5 million or 6% of the current population (IOM, 2010).

Asia

As of 2010, Asia is host to 13%, or 25.7 million, of the international migrant population. With the exception of South-Central Asia, close to half of all migrants in Asia are women. The countries with the highest migration rates are Singapore, Macau, and China, while Sri Lanka, Lao People's Democratic Republic, Myanmar, the Philippines, and Pakistan all have negative rates of migration; that is, more people leave than enter the country. The majority (43%) of Asian migration occurs within the region: 37% is to countries that form the

Organization for Economic Co-operation and Development (OECD, currently made up of 34 countries, primarily those referred to as “developed” countries), and the remaining 20% migrate to other non-OECD countries outside the region. Although the United States is the main destination of Asian migrants (7.9 million in 2000), countries within the region are also primary destinations. For example, migrants from Bangladesh and Pakistan account for 6.1 million of India’s immigrants, even though Pakistan itself is host to 2.8 million intra-regional migrants. Hong Kong SAR hosts almost 2.5 million regional migrants, Iran 1.9 million, and Malaysia 1.7 million.

Irregular migration has become an increasing concern in Asia, with some estimates as high as 17 million people without proper immigration documentation. Refugee numbers are also on the rise, currently accounting for 3.9 million, or 14%, of all international migrants in the region. The region is host to 25% of the global refugee population. Natural disasters have increased internal migration within the Asian region. For example, the 2008 Sichuan earthquake displaced 15 million people in China. In fact, Asia accounts for 31 million, or 86% of all people displaced by natural disasters with 17 of the biggest disasters occurring in Asia in 2010 (IOM, 2010).

The number of immigrants in East Asia has also been growing, with the subregion now hosting approximately 6.5 million migrants, including the highest percentage of female international migrants in all of Asia (approximately 55%). The current top destination countries in the subregion are Hong Kong SAR with 2.7 million migrants (2.3 million from China), Japan with 2.2 million, and China, which topped the Republic of Korea (South Korea) in 2010, with 686,000. Prior to 2010, the Republic of Korea held the third spot with 568,000 migrants in 2000 compared to China’s 508,000. Emigration from East Asia is also significant, with around ten million people leaving the subregion, six million from China alone. The main countries of destination for East Asian immigrants are the United States, with about three million; Japan with 783,000; Canada, 775,000; and Australia, 300,000. Chinese students represent 25% of East Asian immigrants to Australia (IOM, 2010).

The countries of South-East Asia that currently have the largest number of migrants include Malaysia with almost 2.4 million (1.7 million of whom are from within the Asian region), Singapore with just over two million, and Thailand with 1.1 million. In Singapore, migrants make up almost 41% of the total population. While the Philippines is a destination country for migrants, ranking fourth with 435,000 migrants, it is a major exporter of human capital with 3.4 million of its citizens, half of whom are women, now living abroad. Of the total 10.2 million migrants in the subregion overall, 1.2 million are labor migrants working in Malaysia. The main country of destination for South-East Asian migrants is the United States (3.2 million); however, Saudi Arabia, with 700,000 immigrants, has become increasingly important as a labor migration destination for people from this subregion (IOM, 2010). Emigrants from Vietnam currently number two million, and Indonesia has been the source for 1.8 million emigrants. Recently, extreme weather conditions have played an important role in the number of migrants from South-East Asia. In 2007, massive floods displaced almost 421,000 people from Jakarta, Indonesia, and one million people were displaced in 2009 by tropical storms, primarily in the Philippines (IOM, 2010).

In South-Central Asia, there are about 14.3 million international migrants. After declining for several years, migration started to increase in 2005. The increase, however, is attributed mainly to Pakistan becoming, after India, the most important country of destination in the subregion, with 4.2 million migrants living within its borders in 2010. India’s share of international migrants has decreased over the past 10 years, from 6.4 million in 2000 to 5.4 million in 2010. The Islamic Republic of Iran hosts almost 2.2 million migrants, representing a slight increase since 2005 (two million), but an overall decrease since 2000 (2.8 million). India, along with having the highest number of migrants in the subregion, is also the largest source country of migrants, with an estimated 25 million people living abroad, 10% of whom live in the United States. Estimates for 2010 show that Bangladesh is also a major source country of immigrants in this Asian subregion, with 6.9 million emigrants; Pakistani emigrants number 3.4 million, followed by Afghanistan with 2.6 million, and Nepal with one million. It is estimated that close to half of these individuals remain in the region, and approximately 5.1 million move to countries of the Gulf Cooperation Council (GCC, made up of six countries: United Arab Emirates, The Kingdom of Bahrain, The Kingdom of Saudi Arabia, The Sultanate of Oman, Qatar, and Kuwait) in search of work. The United States and Canada together host 2.4 million South-Central Asians, and the United Kingdom is home to about 1.1 million. The demand for migrant labor from the region is significant in the Middle East, primarily in Saudi Arabia, Kuwait, the United Arab Emirates, Jordan, and Qatar. Notably, what is termed as the feminization of the migrant labor force has been a prominent feature of emigration from Sri Lanka, with women making up 54% of the estimated 200,000 Sri Lankans who leave the country each year (IOM, 2010).

Europe

Migrants currently make up 8.7% of the total European population, which hosts one of every three migrants in the world (72.6 million in 2010). Migration to Europe has increased consistently since 2005, with Western and Central Europe experiencing the highest net increase in migration in the countries of Cyprus, Luxemburg, Spain, Iceland, and Ireland. On the other hand, Eastern European and new European Union member states have seen a reduction in net migration. Albania, Georgia, the Republic of Moldova, Lithuania, and Tajikistan are still source countries of migrants, although the numbers have decreased since the 1990s. Since 2005, Southern Europe has had an annual immigration growth rate of 5.2%, with 3.4 million migrants currently living in the subregion.

The flow of migrants moving within the region is very high, with the majority of Western and Central European migrants moving within European Union (E.U.) member States. Eastern European migrants, on the other hand, migrate to former Soviet republics, including The Russian Federation and Western Europe. The Russian Federation currently has 12 million migrants residing within its borders and is a source country for an equal number of migrants living abroad. Second to The Russian Federation is Ukraine with an international migrant population of 5.9 million, the United Kingdom with 4.2 million, Germany with 4.1 million, and Kazakhstan with 3.6 million migrants. Female migrants in Eastern Europe comprise an estimated 57.3% of all migrants, compared to Western Europe where women make up 49% of the migrant population. A significant number of migrants live in urban centers in Europe: London, Paris, and Moscow each have one million foreign-born residents. In Amsterdam, Brussels, Frankfurt, and London, over 25% of the population are foreign-born (IOM, 2010).

When looking at all international migrants living in Europe (51 million), over 65% live in Western and Central Europe. The most important countries of destination are Germany with 10.5 million migrants, France with 6.7 million, the United Kingdom with 6.5 million, Spain with 6.4 million, and Italy with 4.5 million. In Western Europe alone, an increase of 5.6 million migrants has occurred since 2005, with Spain and Italy experiencing the highest increase. The increases are primarily due to declining populations, most prominently in Southern Europe, family reunification processes, and high rates of economic growth in countries like Ireland. An interesting note is that although Europe has had significant and sustained increases in the number of migrants, it also has large outflows of foreign-born populations. Some of this is due to movement between the European Union's older and newer member States. For example, European Union States with more open economies tend to be older E.U. members, and those countries attract large numbers of younger, educated migrants from the newer member States. The largest numbers of emigrants from Europe originate from Britain. In 2006, European emigration numbered 1.7 million, with most Europeans moving within the continent or to other OECD countries (IOM, 2010).

The International Organization for Migration also examines migration patterns in Eastern Europe and Central Asia combined. The individual countries in this subregion include Albania, Armenia, Azerbaijan, Belarus, Bosnia and Herzegovina, Georgia, Kazakhstan, Kosovo, Kyrgyzstan, Macedonia, Moldova, Montenegro, The Russian Federation, Serbia, Tajikistan, Turkmenistan, Ukraine, and Uzbekistan. In this subregion, the decline in both the number of migrants and refugees has lead to a decline in the total number of international migrants since 2005, even though, along with the Western Balkans and Central Europe, this subregion hosted 25.6 million migrants in 2010. The Russian Federation, Ukraine, and Kazakhstan are the top countries of destination, with 80% of international migrants living in these three countries. Notably, immigration to The Russian

Federation is led by ethnic Russian citizens from countries of the former Union of Soviet Socialist Republics (USSR). In fact, the vast majority, between 70% and 75%, already have Russian citizenship (IOM, 2010).

Middle East

About 13.5% of the total global migrant population lives in the Middle East, an estimated 26.6 million, and this region is growing as a destination by 3.8% annually. Migrants make up 11.9% of the total population, and although countries like Kuwait and the United Arab Emirates have seen some decrease in the number of immigrants, Qatar grew from 59 to 94 migrants per 1,000 population between 2005 and 2010. Israel and the GCC countries (United Arab Emirates, The Kingdom of Bahrain, The Kingdom of Saudi Arabia, The Sultanate of Oman, Qatar, and Kuwait) are the primary destination countries, with labor the main driver of movement to this region. The number of female migrants to the area has also grown; current numbers are 10.2 million women, about 38% of the total number of migrants in 2010. However, a closer look at the number of female migrants in individual countries shows that there are certain areas where women tend to migrate, for example, to Israel, where they make up close to 56% of the total number of migrants. In contrast, women account for just under 21% of the migrant population in Oman. Migrants to this region are attracted to urban centers, with the most popular migrant destination cities being Jeddah, Riyadh, Dubai, Tel Aviv, Muscat, Medina, and Jerusalem (IOM, 2010).

The Arab Mashreq, or Eastern Mediterranean region of the Middle East, has also experienced an increase in the number of migrants, with an estimated 8.7 million in the region in 2010. Countries that make up this region include Jordan, the Syrian Arab Republic, the Occupied Palestinian Territories, Lebanon, Yemen, Egypt, and Iraq. Egypt and Iraq have both experienced a decrease in the number of migrants during the last 7 and 10 years, respectively, with Iraq's number decreasing dramatically, from 147,000 to 83,000 during the height of the US invasion in 2003, while Egypt's declined modestly from 247,000 migrants in 2005 to 245,000 in 2010. However, the remaining countries in this region have experienced significant growth in the number of migrants. During the period of 2000–2010, the number of immigrants in Jordan grew from just over 1.9 million to more than 2.9 million and foreign-born residents make up almost 46% of the total population. The Syrian Arab Republic saw a growth of 924,000 to 2.2 million during the same period, with migrants representing 43.6% of the total population.

Forced migration was the primary reason for migration to this region; in fact, the vast majority of migrants to this region were refugees from Iraq and the Occupied Palestinian Territories. An estimated 1.6 million Iraqis, or 5.5% of the population, were displaced as a result of war with the United States. There was also growth in the number of African migrants and refugees from Somalia and Ethiopia crossing through the Gulf of Aden into Yemen, with some estimates showing a 50% increase, approximately 74,000 people, between 2008 and 2009. Climate change, specifically droughts in the region have also caused forced migration, with estimates between 40,000 and 60,000 families forced to move from drought-affected areas in the Syrian Arab Republic in recent years. Another important factor regarding the movement of people in this region is demographics. In 2010, 57% of the population was younger than 24 years of age, with unemployment rates ranging between 14% and 50%; it is likely this region will remain a significant source of young, mostly skilled migrants in the future (IOM, 2010).

The Gulf Cooperation Council (GCC) countries of the Middle East are major destinations for migrants of all labor skill levels. Estimations are that the six countries that make up the GCC had over 15.2 million migrants in 2010 – an increase of 19% since 2005. The GCC countries are primarily oil-rich countries where labor is in high demand, even more so since some are concentrating on developing and expanding more service and knowledge-based economies in an effort to diversify their revenue streams. Contractual foreign workers, mostly temporary, will remain a significant portion of the labor force, currently representing around 66% of the migrant population in Qatar, 70% in the United Arab Emirates, and almost 69% in Kuwait (IOM, 2010).

Immigrants account for 40% of the total current population of Israel, numbering approximately three million. Israel is unique in that it has passed specific legislation to bring people of Jewish ancestry to the country (the Law of Return enacted in 1950). Russian and Ethiopian Jews represent the largest flows of migrants in recent years. Other source countries are member States of the European Union, Thailand, the Philippines, India, China, and Nepal. As of 2008, the majority (55%) of work permits issued to migrants in Israel went to women (IOM, 2010).

Oceania

Six million international migrants live in the countries of Oceania (Australia, New Zealand, and the island states that make up Melanesia, Polynesia, and Micronesia), representing 16.8% of the regional population. This region has the highest proportion of migrants in its population – even though it only has about 3% of the total global number of migrants. More people enter than exit the region, and the close to 22% population growth in the last several years has been the result of new immigrants, especially to Australia and New Zealand. Both countries have promoted immigration over the last decade and, interestingly, British migrants make up the largest group of immigrants in both countries. The two countries also share immigrants, with Australia being home to 68% of New Zealand's emigrants and New Zealand hosting 13% of Australia's emigrants. The top two destination countries for Australian emigrants, however, are the United Kingdom and the United States, followed by New Zealand.

All indications are that both Australia and New Zealand will remain high-net immigrant receiving countries for some time to come. In recent years, the steady increase has been attributed to large numbers of overseas students, over 409,000 in 2008 (Chinese and Indian students account for the greatest portion), a strong Australian economy, and specific programs aimed at increasing migration to the area. After New Zealanders, the largest numbers of Australia's migrants come from India, China, and South Africa. Foreign-born workers currently make up about 25% of Australia's workforce. Australia also reports a growing number of irregular migrants, about 50,000 in 2008. Most enter the country as tourists, 10% of whom are travelers from the United States and China, which, together, account for the highest number of "overstayers." Emigration from Oceania accounts for about 1.5 million people globally, 37% of which comes from the Pacific Islands and 35% from New Zealand. About half of the regional migration is internal, and those leaving the region emigrate primarily to the United States and the United Kingdom. Of note, female migration to the region has been growing, reaching 51.2% in 2010 (IOM, 2010).

The subregion of Melanesia, Polynesia, and Micronesia also saw migrant numbers increase between 2000 and 2010, with a current count of 340,000. Of those, 151,000 are in Micronesia. Emigration from these countries is regional about 50% of the time, primarily to New Zealand, followed by Australia. The United States and Canada currently host 36% of Pacific Islander migrants. Much of the movement out of the Pacific Islands can be attributed to various factors, including: political and economic disparities in the region; freedom of movement among countries within the region; citizenship granted to Pacific Islanders by New Zealand and the United States; and active recruitment of migrants by the government of New Zealand. As a result, Micronesia and Polynesia have negative migration rates. For example, Polynesia has −8.5 migrants for every 1,000 people, and diaspora from some of the islands are larger than the resident populations. Skilled labor leaving the islands is a major concern; in fact, 52% of emigrants now living outside of these small countries have a post-secondary education. Eight nations in this tiny subregion have made the list of the top 30 countries with the highest skilled labor migration to OECD states: Palau, 80.9%; Tonga, 75.6%; Samoa, 73.4%; Nauru, 72%; Tuvalu, 65%; Fiji, 62.8%; Kiribati, 55.7%; and Marshall Islands, 42.8%. Women make up a large portion of emigrants from the islands, 63% of whom are skilled migrants (IOM, 2010).

Trends in Migration

According to the United Nations Development Programme (UNDP), migration is primarily shaped by government policies. Prior to the end of the nineteenth century, migration policies around the globe were fairly unrestrictive, with some countries openly encouraging migration. Despite periods of anti-immigrant sentiment, most governments acknowledged that migration was advantageous to both source and destination countries. By the end of the 1800s, however, entry restrictions began to emerge for various reasons, but primarily due to labor market pressures and popular sentiment. Countries like Australia and the United States created entry barriers which included race and nationality quotas. As countries curtailed migration, they actually expedited the liberalization of trade in goods and the movement of capital. To respond to labor shortages, some countries developed bilateral agreements like the US's Mexican Farm Labor Program, also known as the *Bracero* program in 1942. Over 4.6 million labor contracts were issued through the program during a 22-year period. At the same time, the United Kingdom and Australia developed a labor exchange program, but by 1964 and the 1970s, respectively, both the US-Mexico program and the United Kingdom-Australia labor exchange agreements had closed (UNDP, 2009).

Contemporary migration occurs primarily for the same reasons migration has traditionally occurred: the search for labor on the part of migrants and the need for labor on the part of individual countries and regions, family reunification, escape from war and other conflicts, and forced migration due to environmental changes and natural disasters. Regardless of how governments view migration, individuals will continue to seek opportunities in other countries through established or, when necessary, irregular immigration processes.

Labor Migration

Labor migration is often divided into two categories: skilled and low-skilled labor. Skilled labor consists of people who typically have higher education levels, often completing university and graduate school (tertiary education) and are considered professionals. Their careers are usually in medicine, law, higher education such as university professors, research and development professionals, information and communication technology experts, and business leaders. Low-skilled labor typically consists of agricultural workers, factory and processing plants workers, domestic and nursing home aides and hospital workers, janitorial and landscape services, food service and hotel workers, construction workers, child-care providers, and numerous other service-oriented jobs (Martin, 2001).

Skilled Labor

One of the advantages that skilled labor migrants have over low-skilled migrants is that destination countries usually make the migration and settlement path much easier because migrants with specialized skills, training, and experience are highly sought out by destination countries. Based on labor market tests and the demands of business and industry, countries develop and enact policies that facilitate skilled labor migrants to move to and settle in the host country. They may have an easier path to permanent residency as well because it is often offered to the skilled migrant by the host country as an incentive to move.

For example, in the United States, high-skilled workers are granted admission for up to 6 years, while low-skilled, usually seasonal, workers are granted admission for only 3 years (UNDP, 2009). First introduced in Canada, some countries looking for skilled labor have implemented a points-based system in which a minimum number of points via an admissions exam are needed to gain entry and residency. The criteria are based on age, language, education, and work experience. If an applicant for permanent residency scores a minimum number of points, they may be granted permanent residency – higher scores usually are achieved based on age (younger individuals are given a higher number of points), education level, language skills (especially the ability to speak English and/or French), and work experience, including managerial. The United Kingdom uses the same system, but has options for migrants to attain permanent or temporary residency. Here too, skilled migrants have a better chance to achieve higher scores in the areas of education and work experience that lead to permanent residency, whereas low-skilled laborers do not. In fact, permanent residency admissions in the United Kingdom are dominated by migrants with experience and education in finance and business, information and communication technology, and medicine (Luckanachai 2010).

"Brain Drain"

For destination countries, attracting and retaining skilled labor means a stronger competitive edge in both the local and global markets (commonly known as "brain drain"). For the migrant, it means better wages and often times, better workplace stability. Although there are benefits for the country of origin in terms of increased remittances, which in some cases can be higher than GDP or foreign aid, and increased transfer of knowledge and information, the loss of skilled and well-educated workers can have a devastating effect on the local economy and population (UNDP, 2009).

Most skilled labor migrants are currently from Asia, about 35% of the world's total. Europeans are very close behind with 34%, followed by North America, Latin America, and the Caribbean which together make up 23%. African migrants are about 7% of the world's total skilled mobile population. The Asian skilled labor movement is primarily the result of people from developing countries searching for improved opportunities, whereas Europeans tend to move mostly within their region due to a common history and culture, along with the expansion of the European Union (IOM, 2008).

Even though Asians account for a large portion of the skilled migrants received by the United States and Canada, a significant portion of the skilled labor movement occurs within regions. Thirty-three percent of the United States' skilled migrants are from Canada and Mexico. The same is true for Europe, and other Asian countries account for the largest share of skilled migrants in both the Republic of Korea (South Korea) and Japan.

One of the industry areas in which local brain drain is most prominent is health care. For some small countries, the numbers are staggering. In Africa, estimates are that as many as 19% of doctors and 8% of nurses currently work in other countries. In sub-Saharan African countries, it is reported that 28% of doctors and 11% of nurses trained domestically work in other countries. In some African countries, the figures are even more alarming. Mozambique has lost 75% of its doctors to migration; Liberia has lost 81% of its nurses. An important note is that while Africa accounts for 24% of the global disease burden, it only has 3% of global health workers (UN, 2010).

In terms of absolute numbers, India is the top country of origin for the number of doctors practicing medicine in OECD countries, about 56,000. OECD countries also account for 17,000 German doctors and 32,000 nurses; 17,000 doctors and 46,000 nurses from the United Kingdom; 16,000 doctors and 110,000 nurses from the Philippines; 16,000 Chinese doctors; 31,000 Jamaican nurses; and 25,000 nurses from Canada. Emigration rates for nurses alone are highest in the Caribbean: Haiti has a current nurse emigration rate of 94%; Jamaica, 87.7%; Grenada, 87.6%; St. Vincent and the Grenadines, 81.6%; and Guyana 81% (IOM, 2010). Almost half of all foreign-born doctors living in OECD countries live in the United States, 40% live in Europe, and the remaining 10% in Australia and Canada. The World Health Organization (WHO) reported in 2006 that 14 countries had more than 50% of their native-born doctors living abroad: Antigua and Barbuda, Grenada, Guyana, Mozambique, Angola, Dominica, Fiji, Sierra Leone, the United Republic of Tanzania, Trinidad and Tobago, Liberia, Cook Islands, Saint Vincent and the Grenadines, and Haiti. Of those, six countries, Angola, Haiti, Liberia, Mozambique, Sierra Leone, and the United Republic of Tanzania, were considered to be experiencing severe and critical shortages of health professionals. Research indicates that people in these countries are motivated to migrate by the success of others as a result of their education and migration to pursue careers as health professionals (UN, 2010).

This movement or concentration of medical professionals is also observed in rural to urban migration. In March 2010, the United Nations reported that while almost half of the world's population lives in rural areas, only 25% of the world's doctors and 38% of nurses live in a rural area. Health professionals who stay in their countries of origin often pursue work in the private sector and live in urban areas, causing additional shortages of health services for the poor in rural areas (UN, 2010).

In an effort to improve the experiences of migrant medical professionals in destination countries, and to strengthen health systems where losses in medical professionals are high, in March 2011, WHO developed a survey instrument and introduced voluntary guidelines for member states to use the survey to monitor the international recruitment of health personnel. WHO proposes that governments complete the survey every 3 years beginning in 2012 with the goal of advancing global cooperation on the ethical international recruitment of health professionals and strengthen health systems worldwide (WHO, 2011).

Another sector that has seen much growth in the area of skilled labor migration is information, communications, and technology (ICT). Beginning in the 1990s and up through the end of 2001, skilled migration in this industry grew from 15% of all migrants to more than 25%. During the initial period of the ICT economic boom, the United States had about 25% of all recently arrived ICT skilled migrants, reaching 30% by the mid-1990s. At about the same time, however, the share of intake of ICT-skilled migrants by European countries grew significantly, from 15% to 25%, peaking around 2000. Many European countries implemented specific policies designed to attract this skilled labor set during that period and beyond (IOM, 2008).

Low-Skilled Labor

Low-skilled migrants are also highly sought after, but they are almost always temporary and/or seasonal. The number of temporary foreign workers admitted for employment in OECD countries in Europe and North America, Australia, and New Zealand has increased steadily since 2000. However, this category of migrants also moves significantly between developing countries, most prominently from South Asia and Southeast Asia to GCC countries, and within developing regions such as Latin America and South Africa. A notable area of growth of movement of low-skilled migration is women. Although women make up approximately 50% of all migrants in the world, the majority of female migrants are in temporary labor categories which are dominated by traditional gender roles like domestic caretaking and the entertainment industry, which often means they are vulnerable to exploitation, including forced labor and/or slavery (IOM, 2008).

Irregular migrants ("undocumented") are those without formal permission for entry into the host country. Irregular workers also tend to be those with low skills and little or no formal education, especially those migrating to OECD countries. Not all irregular migrants have entered a country in an unauthorized fashion, however. Many overstay the expiration date of their temporary work or tourism permits; it is estimated that two thirds of Europe's irregular migrants have overstayed.

It is difficult to obtain accurate figures on the number of irregular migrants, thus estimates are based primarily on census counts because census counts attempt to capture the number of all residents, regardless of citizenship or residency status. But, irregular migrants and those who provide harbor for them tend to omit information about irregular migrants in fear of government authorities, therefore creating an undercount of irregular migrants. These migrants are also more mobile than others by the nature of their seasonal work and fear of deportation, and this adds to the difficulty of assessing their true numbers. According to the United Nations, one third of all migration in developing countries is irregular, which translates into an underestimation of official migrant counts of about 30 million migrants worldwide. It is estimated that irregular migrants currently living in the United States make up 4% of the total population, which accounts for 30% of all migrants in the United States. European estimates in 2005 suggest that from 6% to 15% of migrants were irregular migrants, equaling about 1% of the total population of the European Union (UNDP 2010).

Women

Although women account for half of all migrants, there is a general lack of data regarding the movement and experiences of women across the globe. A 2008 World Bank publication, however, provides some insight into female migration. In 2005, there were about 95 million female migrants worldwide. Oceania had the largest proportion of women immigrants at 51%; Latin America and the Caribbean with 50%; Africa, 47%; and in the former Soviet Union, 58% of its migrants were women. Asia, on the other hand, reported a decrease in the number of female migrants, from 46% to 43%. In the Middle East, female migrants made up 38.4% of all migrants.

Most women, like men, migrate voluntarily. Family reunification is a major driver for female migration. Since men have traditionally dominated migration, women are much more likely than men to be migrating spouses. The United States registers twice as many women than men as migrating spouses of citizens and permanent residents; European reports are similar (Martin, 2003). However, more and more women are migrating for work. Low-skilled labor is predominant among women, including such jobs as picking farm crops, garment manufacturing, meat and poultry processing plants workers, nursing home and hospital aides, and maidservants in hotels. These jobs can be attained via official contracted labor with the host country, or through information networks prior to or after irregular migration. However, more women are also migrating as part of the skilled labor pool. One of the most prominent industries is health care, where women make up the vast majority of migrating nurses, but an increasing number are in academia, research and development, and ICT, to name a few (Martin, 2003).

Currently, women and their dependent children make up 70–75% of the world's refugees and displaced persons. This is not true, however, for asylum-seekers, who are predominantly men. Women who are forced to migrate as refugees often face serious challenges. In many parts of the world, rape and sexual violence are used as weapons of war and are, in fact, considered by most countries to be war crimes. Women residing in refugee camps around the globe may also be under the threat of rape, precluding them from performing daily tasks such as gathering firewood or water. Sometimes, in order to procure food for themselves and their families, they are forced to provide sexual favors (Martin, 2003).

Another way women migrate is through smuggling and trafficking. Smuggling and especially trafficking are highly exploitative and third only to drugs and guns in the realm of international crime smuggling rings. The act of smuggling people across borders has existed since the establishment of the regulation of movement across international boundaries; however, the scale of smuggling has increased exponentially in recent years (UNDP, 2009). Smuggling can be informal where individuals help each other cross borders illegally, or it can be organized where smugglers help migrants obtain travel documents, provide transportation and access to houses in which they can hide from immigration and other authorities, and provide links to employment. Along the US-Mexico border, for example, male migrants tend to use experienced smugglers, also referred to as "coyotes," to help them cross deserted and desolate border areas, whereas women migrants are more likely to purchase fraudulent documents to gain access through legal points of entry.

Trafficking involves not just being smuggled across borders, but also exploitation and abuse. Although men are trafficked as forced labor, women and children are especially vulnerable and predominantly trafficked for the purposes of prostitution. Because human trafficking is usually conducted by international organized crime rings and other highly clandestine operations, there is no precise information regarding the actual numbers of women who are trafficked. In 2000, the United Nations estimated that four million women and children had been trafficked worldwide. Since then, despite the attempt of many countries to curtail trafficking, that number is very likely to have risen.

Traffickers obtain female victims a variety of ways: kidnapping, enticement with false promises of well-paying jobs in foreign countries, advertising bogus jobs and fake marriage opportunities. Most women who are trafficked are under the age of 25; many are still teenagers, with some victims as young as 7 years old. Trafficking victims are often physically, sexually, and mentally abused by their traffickers, forced to live in squalid conditions that are confined and secluded, often starved or malnourished, forced to take drugs, and forced to have unprotected sex with large numbers of partners over many long hours. Victims suffer emotional and mental breakdowns, become ill with sexually transmitted and other diseases, may be denied medical care and, once they become a "burden" to the trafficker or pimp, are sometimes killed. There may be few to no opportunities to escape their situation, either by running away or paying off the "debt" imposed upon them by the traffickers. For example, if the women are moved to a new location, which happens frequently in an effort to avoid law enforcement, the costs of the move are imposed upon the women as a debt, thus creating a never-ending situation of financial obligation to the traffickers (Martin, 2003).

Conflicts and War

In 2008, there were 14 million refugees as a result of conflicts around the globe. This number represents about 7% of all international migrants. People who are displaced by conflict and violence within a country number even higher, with some estimates at 26 million displaced persons. Of those, 4.9 million were in Sudan, 2.8 million in Iraq, and 1.4 million in the Democratic Republic of the Congo (UNDP, 2009).

Despite the 1951 Refugee Convention (UNHCR 1951), which has assisted millions of people to move to safer environments, most people who escape from war and insecurity do not typically fare well. To an increasing and growing extent, war is associated with large population movements as the displacement of civilians is used as a deliberate weapon of war, as is the case in Darfur, Sudan. Since most displaced individuals – 80% of whom are women and children – relocate within their country's borders, refugee camps host only about one third of all displaced persons, with the remainder left to survive on their own. Unfortunately, this is representative of the dilemma of the poor in many war-torn areas, most especially on the African continent (UNDP, 2009). Even so, refugees have certain internationally recognized legal rights, whereas the majority of displaced persons do not (UNDP, 2009).

Although conflict drives a very small share of global movement, only 1/10th of international and 1/20th of internal movement, the sudden need to flee their homes and livelihoods often destroys all forms of existing sources of income, access to services and social networks, leaving these migrants extremely vulnerable in general. They face overwhelming challenges including local hostility, harassment, and animosity not just from other people, but also from government officials, especially in the case of civil war (UNDP, 2009).

Africa is affected more by war and instability than any other area of the globe, and war accounts for 13% of international movement on the continent. Some of the largest migrations of people fleeing conflict include Sudan with 4.9 million displaced individuals, the Democratic Republic of Congo with 1.4 million, Somalia with 1.3 million, and Zimbabwe with figures as high as one million. In some countries, like Liberia and Rwanda, the number of people who have fled war and conflict remains undetermined (UNDP, 2009).

Environment

According to the United Nations and the Internal Displacement Monitoring Centre, more than 36 million people were displaced because of environmental events in 2008. Those events included earthquakes and severe weather occurrences – 15 million due to the Sichuan, China earthquake alone. The most affected region was Asia, which had almost 31.4 million persons displaced as a result of natural disasters. The Americas were the second most environmentally affected region (IOM, 2010).

The environment has always been an important driver of human movement as people have moved in search of water sources and fertile land for crops and favorable animal grazing conditions. Most experts agree that environmental factors, more specifically climate change, will be an increasingly important driver of human migration in the future. Over the last 30 years, drought has affected twice as many people as storms, demonstrating that slow-onset changes in the environment are likely to have a greater impact than sudden-onset disasters which usually receive much of the policy-focused attention (IOM, 2010).

Future predictions, although subject to considerable uncertainty, include the reduction by half of the agricultural output in Southern Africa by 2020 due to drought with the potential of causing severe famine. The area of the Himalayas will also suffer a severe reduction in water from river flows due to diminishing glacial water banks. Rising sea levels will affect people in coastal areas, especially in East and South Asia. Some predictions are that as many as 145 million people are currently at risk of rising sea levels, and some countries, like the Maldives, are contemplating buying land in other countries in expectation of having to move entire communities due to severe flooding and water submersion. The most extreme prediction is that climate change will force anywhere from 200 million to 1 billion people to move. Of course, many people who will be affected by environmental change, whether it's sudden or over time, cannot afford to move. In fact, some studies have found that the effects of rainfall, for example, on migration patterns is determined by socio-economic conditions and the ability to finance the cost of moving. Examples of this can be found in Mexico and Nicaragua where people who moved due to lack of rainfall in Mexico and as a result of Hurricane Mitch in Nicaragua were more often than not people who had the ability to finance the cost of moving (UNDP, 2009).

Economic Crisis

The countries that have been hit hardest by the current economic crisis are the more developed countries, and they also happen to be the same countries where most migrants live. By April 2009, Spain, for example, had reached a national unemployment rate of 15%, with rates as high as 28% among migrants. Since economic growth has drastically slowed down, countries where migrants have been experiencing good employment opportunities besides the OECD countries are also likely to be significantly affected, such as the GCC countries, East Asia, and South Africa. A jobs crisis can be especially difficult for migrants – just as economies tend to seek migrants from abroad to fill labor shortages, they tend to lay off migrants first during a recession. In fact, studies have shown that the unemployment rate of migrants tends to increase more rapidly than that of any other group during a recession (UNDP, 2009).

There is some evidence that declines in migration flows toward developed countries started as early as 2008. One of the measurements used as an indicator of this comes from the United Kingdom, where there was a 25% drop in the number of applications for national insurance cards from foreign-born individuals. Another indicator comes from the United States, where a census in August 2008 revealed that there was a 25% decline in the flow of migrants from Mexico. Historically, an economic crisis does not indicate that there will be major return flows of migrants to their country of origin as they are generally encouraged to ride out these periods of economic uncertainty for a variety of reasons. Primarily, the prospects of reentry to the host country are diminished, and the needs of family members and conditions in the country of origin have a profound effect on a migrant's decision to remain. In addition, the generosity of the host country's welfare system also plays a critical role (UNDP, 2009).

Some countries have already introduced policies to reduce the number of permanent and temporary migrants they admit for the first time in many years. Beginning as early as 2009, Australia reduced its permanent skilled labor admissions from 155,000 to 108,000 a year and has removed several job categories from its list of "critical skills" such as bricklaying, plumbing, and carpentry. English language skill demands were also introduced for lower-skilled occupations. New Zealand implemented policy changes that curtail the inflow of labor migrants such as mandating certain processes to ensure that no local workers are available for any work permits issued to migrants, and those work permits have been reduced from 3 years to 1 year. In a 13-month period beginning December 2008, the issuance of work permits to foreign laborers declined by 20% (UNDP, 2009)

In addition to job losses, another consequence of the current economic crisis for migrants and countries of origin is the effect on remittances. Collectively, migrants send home a substantial amount of money; women tend to send a larger portion of their incomes on a more regular basis – even though their lower wages mean that the absolute amounts are less (UNDP, 2009). Although it is difficult to obtain precise numbers because of the many channels used to send money abroad, some of which are informal, some estimates of the total dollar amount of remittances in 2009 were US $414 billion, US $316 billion of which went to developing countries. For some for the smaller island nations of the Caribbean and Pacific Islands where GDP is very low, remittances are often higher than GDP and/or the total amount of foreign aid (*World Migration Report*, 2010). In some areas of India and Bangladesh, poverty rates in households with a migrant fell by roughly half between 2001 and 2006. It should not be assumed, however, that remittances always go to the neediest households. Studies of remittances to Peru and Nicaragua showed that money tended to flow to residents who had higher education and income levels. This could be a result of limited opportunities for low skilled labor to move across borders (UNDP, 2009).

The effect of remittances on the receiving households and communities can be substantial. Remittances can be spent in ways that generate local employment such as starting or expanding a business, and even home building. In fact, some studies indicate that remittances encourage entrepreneurship and investments. Remittances can help create a store of capital which can be used to finance future migration of additional household members. Because remittances are spent on consumption, they can also lead to improvements in nutrition. Studies indicate that families receiving remittances often prioritize the use of this money to pay for education, and the rates of children attending and remaining in school have improved for remittance-receiving families in Mexico, Bangladesh, Fiji, and the Philippines, among others (UNDP, 2009).

The economic crisis has shrunk the flow of remittances to developing countries with evidence of significant declines in Bangladesh, Egypt, El Salvador, and the Philippines – all countries that are heavily dependent on remittances (UNDP, 2009). El Salvador's remittances have accounted for more than 18% of its GDP. Remittance shares are highest in Moldova and Tajikistan, 45% and 38%, respectively, and were projected to shrink by at least 10% in 2009. Three fourths of the remittances to sub-Saharan Africa come from the United States and Europe – two of the hardest hit countries by the economic downturn. The full effect of the current crisis on migrants in general remains to be seen (UNDP, 2009).

Conclusion

At the microlevel, migration can sometimes seem random: an individual or family decides to pick up and move to another country or from their rural home to an urban area in search of a job to improve their standard of living. From a global perspective, however, migration is quite systematic, with treaties and policies either by individual countries or in coordination with other countries prescribing how many people can move, where they can move to, what their conditions will be upon arrival to new destinations, and when they may have to depart. Depending on how the current global recession plays out, countries and regions that have not traditionally been the ultimate migrant destinations, such as the United States or Canada, may become much more important and desired as destinations should they fare better through the economic turmoil. Developed countries that experience labor shortages may soon have labor surpluses as evidenced by increases in unemployment rates, especially in the United States and major migrant destination countries of the European Union.

Furthermore, demographic trends are expected to play a large part in the future picture of global immigration as many developed countries have significantly large aging populations. Younger labor pools will be needed to not only fill jobs, but to offset the costs of supporting an older aged population. Natural disasters and especially climate change are also expected to play significant roles in predicating future human movement. War and other conflicts, political and civil unrest have always been, and will likely remain a permanent feature of human societies and major drivers of people to leave their places or countries of origin. At the time of this writing, political upheaval, civil unrest, and violence are forcing thousands of people in Libya to flee the country, moving primarily toward the Tunisian border and arriving on the shores of Italy in significantly large numbers. Tunisia itself has very recently experienced mass civil unrest leading to the ouster of its president of 23 years. Following Tunisia, this same scenario is currently being playing out in Egypt, Bahrain, Yemen, and Lebanon, along with Libya. Refugees will no doubt continue to be an international responsibility.

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- ▶ United States
- ▶ Women

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Immigration Processes and Health in the U.S.: A Brief History

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Introduction

Concern with contagion from travelers from afar existed in the colonies that were to become the United States, as evidenced by colonial laws mandating quarantine of foreign passengers and the exclusion of those who were ill or disabled (Proper, 1967). And, ever since its formation as an independent nation, the United States has promulgated laws that exclude prospective immigrants from entry into the United States on the basis of specified health conditions. Even individuals who have legally immigrated to the United States but not yet obtained United States citizenship have been and continue to be potentially inadmissible because of certain health conditions. Although the specified health conditions have changed over time, three themes are evident throughout this history: (1) fear that citizens of the United States would be contaminated by germs and disease carried by foreigners to the United States; (2) concern that the admission into the United States of individuals deemed to be of an inferior “race” would diminish the quality of the national “stock,” a viewpoint borne from eugenics; and (3) alarm at the prospect that the US economy could be faced with the costs of caring for individuals from other countries who were too ill or disabled to support themselves, who would, in other words, become a “public charge.” These three themes were often intertwined in the immigration policies and procedures that were developed to protect the US populace. In order to allay such fears, elaborate procedures for the medical examination of prospective immigrants were established. The specific components of this “inspection,” as it is known, have changed over time, but the goals and basic framework have remained constant. (These same concerns have been shared and continue to be shared by many countries, which have also implemented their own procedures in order to address them. Readers are referred to other sources for discussions about the health-related exclusion provisions and procedures in Canada (Comeau & Allahar, 2001; Gushulak & Williams, 2004), Australia (Bashford, 2002; Bashford & Howard, 2004; Leask, Sheikh-Mohammed, MacIntyre, Leask, & Wood, 2006), and the United Kingdom (Hansen & King, 2001).)

This chapter first provides an overview of each of these three major themes in relation to the immigration statutes, regulations, and medical examination procedures as they have existed over time. It is beyond the scope of this chapter to address these issues in great depth, and the reader is referred to additional sources for a more detailed examination (Kraut, 1994; Markel, 1997). The discussion then focuses on current medical examination procedures for individuals wishing to enter the United States as permanent residents, also known as holders of a “green card” or “mica.”

Health and Exclusion: Major Themes

Foreignness and Fear of Contagion

In the mind of the larger public, illness and epidemics have been associated with or attributed to newly arriving foreigners to the United States since the earliest days of the nationhood. In part, the association drawn between foreignness or differentness and illness represents scapegoating, most easily recognizable in recent years in the context of the response to HIV/AIDS, but also evident in the response in the United States (and other nations, for that matter) to leprosy, typhus, and various other diseases (Cartwright & Biddiss, 1972). As examples, consider the following:

- Yellow fever epidemics in Philadelphia during the early 1790s were attributed to arrivals from the Caribbean; the disease was then called “Barbados

Sana Loue & Martha Sajatovic (eds.), *Encyclopedia of Immigrant Health*, DOI 10.1007/978-1-4419-5659-0,

distemper." In 1793, the disease was renamed "Palatine fever" when it was observed that many of its victims hailed from that particular area in the German states (Powell, 1949).

- The cholera epidemic of 1832 was attributed to the arrival in the United States of increasing numbers of immigrants from Ireland, many of whom were Roman Catholic. Although cholera was then believed to be caused by bacteria, media representatives, Protestant clergy, and even public health officials accused the Irish Catholic newcomers of harboring and transmitting the disease through their perceived intemperance, uncleanliness, and excessive eating. Protestant clergy, in particular, viewed the disease as a scourge from God, sent in retribution for the victims' violations of natural law (Rosenberg, 1987).
- Dr. John Meares, the city health officer for San Francisco, blamed the city's 1876 smallpox epidemic on the "willful and diabolical disregard of [the city's] sanitary laws" by the 30,000 "unscrupulous, lying and treacherous Chinamen" who resided in the city (Shah, 2001, p. 53).
- In arguing against Chinese immigration in 1882, Oregon senator James H. Slater advised the US Senate that immigrating Chinese would "bring with them their filth and frightful and nameless diseases and contagions" (Slater, 1882, p. 1636).
- Officers of the United States Public Health Services attributed the appearance of bubonic plague in Honolulu's Chinatown in 1899 to the perceived Chinese proclivity to live in filthy and overcrowded conditions, despite existing knowledge that the disease was transmitted by rats. In an effort to end the epidemic, the president of the city's Board of Health ordered in January 1900 the burning of all buildings in the city's Chinatown; the fire destroyed 4,000 homes and left 4,500 people homeless (Shah, 2001).
- Native-born Americans variously attributed the arrival of the influenza pandemic of 1918 to the United States on immigrants from Italy and Germany. Germans were especially targeted as the causative agent of the disease, with many believing that they had intentionally spread the disease as part of their war effort (Kraut, 2010).
- A temporary nurse working in Irwindale, California, in 1916 reported having difficulty obtaining accurate records due to "the secretive nature of the Mexican" and the one case of syphilis that had been diagnosed evidenced the lack of privacy and the low "moral tone" that prevailed among the village's Mexican inhabitants (Anon, n.d.).
- Efforts were made in the 1920s to expel Filipinos from the country, based on claims that they were importers of "loathsome diseases" and, as such, required expensive medical care (Abel, 2004, p. 936).
- As recently as 1982, within a year of identifying the first cases of what would come to be called AIDS, the Centers for Disease Control and Prevention (CDC) labeled Haitians a "risk group." This emphasis on group membership as a risk factor, rather than relevant activities or behaviors, ultimately resulted in the medical and social construction of "risk groups," whose members were presumed to be at higher risk of contracting and transmitting the infection by virtue of their membership in the specified group, regardless of their individual behaviors (Schiller, Crystal, & Lewellen, 1994). Haitians, together with homosexuals, heroin addicts, and hemophiliacs, came to be known as "the 4-H club." Indeed, the United States was so fearful that the admission of HIV-infected Haitians would result in contagion of those already in the United States that HIV-infected Haitian refugees were initially prevented from entering into the country and were quarantined by the US government at Guantanamo Bay. The quarantine ended and the individuals were admitted into the United States only as the result of a lawsuit and worldwide condemnation for the establishment of what was the only prison camp for HIV-infected refugees in the world (*Haitian Centers Council, Inc. v. Sale*, 1993; White, 2007). (Many countries in addition to the United States perceived HIV/AIDS as a foreign problem, including India, Japan, South Korea, Malaysia, Indonesia, and Singapore (Garrett, 1994, pp. 457–527).)

Indeed, our immigration laws have consistently excluded those individuals believed to carry disease that could potentially infect those already present in the United States (see ➋ *Table 1*). These exclusion provisions have been established by the US Congress through the promulgation of statutes. The meaning of

Table 1

Health conditions serving as basis for denial of admission to prospective immigrants into the United States

Legal and other sources	Key grounds of exclusion or revisions	Definition
Act of 1882	Lunatics	
	Idiots	
Act of March 3, 1891	Lunatics	
	Idiots	
	Loathsome and dangerous contagious disease	
Act of February 5, 1917	Loathsome and dangerous contagious disease	Included trachoma (granular conjunctivitis), favus (fungal infection of the scalp and nails), venereal diseases, parasitic infections, tuberculosis
Casimano v. Commissioner of Immigration (1926)	Insanity	
Patton v. Tod (1924)	Feeble-minded persons	
Saclarides v. Shaughnessy (1950)	Imbeciles	
United States Public Health Service (1917)	Idiots	
	Epilepsy	
	Insane persons	
	Persons who have had one or more attacks of insanity at any time previously	
	Persons of constitutional psychopathic inferiority	
	Persons with chronic alcoholism	
	Tuberculosis	
	Mental or physical defect	Physical defect being of a nature which may affect the ability of such an alien to earn a living
Act of June 27, 1952	Retained provisions relating to chronic alcoholics, tuberculosis, and dangerous contagious diseases	No longer referred to diseases as "loathsome" Included chancroid, gonorrhea, granuloma inguinale, infectious leprosy (Hansen's disease), lymphogranuloma venereum, infectious-stage syphilis, active tuberculosis (TB). Leprosy added.
Senate Report No. 1137 (1952)	Feeble minded	Considered to be "an inclusive generic term represented by subclasses of idiots, imbeciles, morons, and persons of borderline intelligence"
United States Public Health Service (1985a, b, 1987)	Insanity	Aliens "who exhibit signs and symptoms of a psychotic disorder" Psychosis defined as an "impairment in a person's ability to think, respond emotionally, remember, communicate, interpret reality, and behave appropriately, so as to interfere grossly with the capacity to meet the ordinary demands of life"
	One or more attacks of insanity	Recovery said to be demonstrated if the individual was free of symptoms for 1 year or more

Table 1 (continued)

Legal and other sources	Key grounds of exclusion or revisions	Definition
	Psychopathic personality	"History of continuous and chronic antisocial behavior in which the rights of others are violated, persistence into adult life of a pattern of antisocial behavior that began before age 15, and a failure to sustain good vocational performance over a period of several years." Diagnosis required onset before age 15, age of 18 or older at time of examination, persistence of behavior for 5 years or more, and at least four of the following: an inability to work continuously, an inability to be a responsible parent, a "failure to accept social norms," an inability to maintain attachment of a sexual partner, a failure to plan, recklessness, a disregard for truth, and irritability and aggressiveness Encompassed "sexual deviation" including paraphilias, including fetishism, transvestism, zoophilia, pedophilia, exhibitionism, voyeurism, sexual masochism, sexual sadism, homosexuality
	Mental defect	
	Narcotic drug addition	Evidence of either tolerance or withdrawal Tolerance referred to the need for increasing amounts of the substance to achieve a desired effect or a diminished effect with maintenance of the usual dose Withdrawal referred to a constellation of symptoms resulting from cessation of the substance's use or from a reduction in intake of the substance Factors to be considered included the amount of drug used, the frequency of use, and the duration of use
	Chronic alcoholism	Synonymous with alcohol dependence Said to be characterized by a pattern of "pathological use" or "impairment in social or occupational functioning and evidence of tolerance or withdrawal" Evidence from laboratory procedures and physical examination were required to justify this diagnosis
	Dangerous contagious disease	Included chancroid, gonorrhea, granuloma inguinale, lymphogranuloma venereum, infectious-stage syphilis
	Tuberculosis	
	Leprosy	
	Physical defect, disease, or disability	Any other significant finding from the immigration medical examination that could affect the individual's ability to earn a living
Act of September 26, 1961	Deleted leprosy and tuberculosis as specific grounds of exclusion; replaced with a broader provision excluding "aliens who are afflicted with any dangerous contagious disease"	

Table 1 (continued)

Legal and other sources	Key grounds of exclusion or revisions	Definition
Immigration and Nationality Act Amendments of 1965	Deleted provisions relating to feeble minded and replaced it with mental retardation	
	Added sexual deviation, following court decision that homosexuality was not encompassed in provision relating to psychopathic personality	
Act of July 11, 1987	Added human immunodeficiency virus (HIV) to list of dangerous contagious diseases contained in regulations	
Immigration Act of 1990 United States Public Health Service (1991) 73 Federal Register 58056 (October 13, 2008) President Executive Order 13295 (2003)	Communicable disease of public health significance	Initially included chancroid, gonorrhea, granuloma inguinale, infectious leprosy (Hansen's disease), lymphogranuloma venereum, infectious-stage syphilis, active tuberculosis (TB), and human immunodeficiency virus (HIV) Expanded in 2008 to include (1) diseases listed in a presidential order pursuant to Section 361(b) of the Public Health Act: cholera, diphtheria, infectious tuberculosis, plague, smallpox, yellow fever, viral hemorrhagic fevers (Lassa, Marburg, Ebola, Crimean-Congo, South American, and others not isolated or named), and severe acute respiratory syndrome (SARS); and (2) any communicable disease that "may pose a public health emergency of international concern" HIV was removed from the list in January 2010. (Congress voted in July 2008 to repeal the HIV ban. The United States Department of Health and Human Services did not publish a proposed rule to remove HIV from the listing of communicable diseases of public health significance until July 2009. In October 2009, President Barack Obama announced the lifting of the HIV immigration ban at a ceremony at the White House and characterized the ban as having been "a decision rooted in fear rather than fact" (Eleveld & Garcia, 2009). HIV was officially removed from the list in January 2010.)
	A physical or mental disorder and behavior associated with the disorder that may pose, or has posed, a threat to the property, safety, or welfare of the alien or others	"Harmful behavior" is defined as a "dangerous action or series of actions by the alien that has resulted in injury (psychological or physical) to the alien or another person, or that has threatened the safety of the alien or another person, or that has resulted in property damage"
	An alien who has had a physical or mental disorder and a history of behavior associated with the disorder, which behavior has posed a threat to the property, safety, or welfare of the alien or others and which is likely to recur or to lead to other harmful behavior	See above

Table 1 (continued)

Legal and other sources	Key grounds of exclusion or revisions	Definition
	Drug abuser or addict	Refers to any nonmedical use during the previous 5 years of any substance listed in Section 202 of the Controlled Substances Act and any nonmedical use during the previous 2 years of any psychoactive substance not listed in Section 202 of the Controlled Substances Act
Illegal Immigration Reform and Immigration Responsibility Act of 1996	Failure to obtain or present documentation of specified vaccinations	Encompasses mumps, measles, rubella, polio, tetanus, diphtheria, pertussis, influenza type B, hepatitis B, and any others recommended by the Advisory Committee for Immunization Practices. These have included varicella, haemophilus influenza type B, and pneumococcus

Sources: Baynton, 2006; Fairchild, 2004; Loue, 2009; Shah, 2001

the statutes has been amplified by regulations established by the federal agency or agencies designated to do so in the statute. The agencies currently responsible for the interpretation or enforcement of the statutory provisions relating to these health grounds are the United States Departments of State, of Homeland Security, and of Health and Human Services. The United States Public Health Service is responsible for the development of instructions for the physicians involved in conducting immigration-related medical examinations, which are discussed further below. (Changes in these technical instructions for physicians have been issued at irregular intervals during the effective periods of controlling legislation. Consequently, the interpretation of a specific ground of inadmissibility may vary even though the controlling statutory and regulatory provisions do not. ➲ *Table 1* provides a general overview of the statutory and regulatory provisions, but does not for the most part reflect interim changes in interpretations occasioned by the United States Public Health Service.)

Eugenics, Immigration, and Immigrants

Eugenics, first defined by Sir Francis Galton as the science of improving heredity, became the basis for eugenicists' efforts in the United States and elsewhere to improve human heredity (Pernick, 1997). Eugenicists concerned with the integrity of humans in the United States premised their agenda on concepts derived from animal breeding, such as those of the zoologist Michael Guyer, who opined in 1916 that the breeding of unrelated species would bring about the "mongrelization" of species. Although eugenicists understood the relationships between germs and disease, many believed that hereditary resistance would both prevent and cure the disease (Guyer, 1916). The segregation of "defectives" through institutionalization or other isolation strategies would prevent their reproduction and limit the spread of hereditary disease (Pernick, 1997).

The eugenicists' equation of race with disease and degeneracy was clear. Some advocated for the exclusion of all non-Germanic people from the United States, arguing that they were of inferior intelligence in comparison with immigrants from Germanic nations (Brown, 1922). Immigrants arriving from Southern Europe to the United States during the 1920s were perceived to be of an inferior "race" and, it was claimed, were often feeble minded, while those arriving from Eastern Europe were characterized as genetically defective (Nelkin & Michaels, 1998). One physician with the United States Public Health Service charged with the responsibility of examining arriving immigrants to Ellis Island characterized Jews as "a highly inbred and psychopathically inclined race" with defects "almost entirely due to heredity" (Wilson, 1913, p. 271). This equation of race and culture with deficiency continues to persist; it has been suggested, for example, that the admission of Latino and Black immigrants will result in the "downward pressure on the distribution of intelligence" (Herrnstein & Murray, 1995, p. 342) and that some immigrant groups will cause an increase in crime because of their "impulsiveness and present orientation" (Brimelow, 1995, p. 184).

The eugenicists of the 1920s–1940s advocated a variety of strategies in furtherance of their goal, including the imposition of restrictions on immigration and the forced sterilization or euthanasia of those deemed to be degenerate or deficient in some way (Enoch, 2005; Kluchin, 2007; Nelkin & Michaels, 1998; Stern, 2005). Health officials inspecting intending immigrants to the United States could make use of the laws' disease categories to safeguard the population from the threat of "inferior races." Accordingly, public health officials were able to easily effectuate the repatriation of Mexican immigrants and Mexican-American citizens in the West on the basis of tuberculosis (TB) (Abel, 2003).

Even after gaining admission to the United States, immigrants deemed to be of an inferior race remained vulnerable to efforts designed to stem their reproduction. Twenty-seven states had promulgated laws by 1932 that permitted compulsory sterilization of those deemed to be defective, which included immigrants perceived as being of an inferior race (Reilly, 1991). These legislative provisions were nevertheless viewed as inadequate protection of the nation's populace from potential degeneracy. Newspaper columnist Fred Hogue nevertheless wrote in dismay in 1941 that "in this country we have wiped out the mosquito carriers of yellow fever and are in a fair way to extinguish the malaria carriers: but the human breeders of the hereditary physical and mental unfit are only in exceptional cases placed under restraint" (Hogue, 1941, p. 27). Many of the state laws facilitating the sterilization of those deemed to be deficient remained in force through the 1970s, at the very time that family planning efforts were being championed and abortion was being legalized (Stern, 2005).

California justified its legislation through the 1950s as an attempt to rid the population of undesirable qualities and strengthen the state. Efforts "to restrain" those deemed to be unfit disproportionately impacted persons who had been born outside of the United States. For example, Gosney and Popenoe (1938) found from a survey conducted of California state hospitals and homes in the late 1920s that 39% of the men and 31% of the women who were sterilized had been born outside of the United States. Those who were most frequently affected had arrived here from Britain, Germany, Italy, Poland, Russia, and Scandinavia (Stern, 2005).

Illness, Disability, and Public Charge

From the earliest days of this nation, our immigration laws have excluded those who have been viewed as potentially unable to earn a living or, in the language currently used by US immigration law, "are likely to become a public charge." It has been argued that the underlying intent of such provisions at the time of their initial promulgation was not to restrict immigration to this country, but rather to control immigration in order to ensure that those who were allowed entry were healthy enough to support themselves, to contribute to the burgeoning industrial economy, and could find employment even during periods of economic downturn (Fairchild, 2004).

Nevertheless, individuals with apparent ability to earn a living or who had sufficient family assets to ensure their support could be and were denied admission to the United States on the basis of perceived inability to support themselves. These perceptions often reflected existing beliefs based on intertwined conceptualizations of race, disease, and disability. As an example, during the period from 1882 through 1924, deaf individuals were almost invariably denied admission to the United States based on a belief that deaf people were social dependents rather than social contributors and, like those of inferior race, they were "bearers of a potentially defective heredity" (Baynton, 2006, p. 395). Their exclusion both safeguarded public dollars from unwanted burden and protected the integrity of the nation's populace from degeneracy, thereby addressing the varied concerns of the public, Congress, and the eugenicists.

Concerns relating to immigrants' reliance on public support and taxpayer burden continue to this day, reflected in the promulgation of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996. With relatively few exceptions, the law bars most lawfully admitted permanent residents from receiving Supplemental Security Income, food stamps, cash assistance, and Medicaid and Medicare. Although permanent residents may become eligible to receive some forms of assistance 5 years after becoming permanent residents, the amount of assistance will be reduced by the amount of their sponsor's – typically a family member who is either a United States citizen or permanent resident – income and financial resources that are "deemed" to be available to the individual. Individuals who are in the country illegally are entitled to few services, with the exception of vaccinations and noncash forms of assistance (Loue, 2009).

The Medical Examination for Immigration

Discussion of the immigration medical examination or inspection still conjures up for many an image of the "line" at Ellis Island, the major processing center for immigrants to the United States (Fairchild, 2004). Similar procedures existed at Angels Island in San Francisco, Port Huron and Detroit in Michigan, and in El Paso and Laredo along the US–Mexico border. An individual's future could be determined in a split second based on the assessment of the public health inspector. However, as Baynton (2006) has cogently argued, the selection procedure likely began long before individuals arrived at Ellis Island.

Many individuals wishing to come to the United States may have ultimately decided against undertaking the voyage. The requirements for entry were widely advertised in Europe and individuals with limited means who were uncertain about the likelihood of being granted admission may have decided to save themselves the time and expense. Additionally, ships may have refused passage to individuals with a physical disability in order to avoid the possibility of a fine for the rejected passenger and the costs of returning the individual to his or her country of origin. Agents for steamship lines may have refused to sell tickets to individuals with physical disabilities for much the same reason; they could be fined if they sold a ticket to a passenger who was later denied boarding (Baynton, 2006). Indeed, it was estimated in 1911 that 10 times as many people were denied transportation because of medical reasons as were refused admission to the United States upon arrival (Immigration Commission, 1911).

Only six physicians from the Public Health Service were on hand at Ellis Island in 1892 to screen the passengers arriving there. During peak immigration years, prior to World War I, that number had increased to 25 (Markel & Stern, 1999). It was unlikely that these few physicians could give each arriving passenger more than a cursory inspection. Only 2% of those who were excluded at Ellis Island in 1898 were rejected for medical reasons (Markel & Stern, 1999). That percentage rose sharply, however, so that in 1913, 57% of the denials were premised on medical grounds and in 1915, 69% of the denials were for medical reasons (Kraut, 1994; Yew, 1980). As Baynton (2006) observed,

> ► The process of judging which immigrants to admit and which to reject was inevitably, to some extent, arbitrary and capricious. The criteria were never clear-cut and could not possibly be precisely constructed to cover every individual case. Instead, officials had to make rough-and-ready judgments of employability, eugenic worth, and general social desirability. Their decisions necessarily relied in good part on unexamined assumptions and prejudices . . . Multiple factors came into play, such as immigrants' ethnicity, class status, and general appearance . . ..

Angel Island in San Francisco processed approximately 100,000 individuals during its operation, in comparison with more than 10 million individuals processed through Ellis Island (Markel & Stern, 1999). The majority of the individuals processed through Angel Island were Asian. Arriving passengers were screened for hookworm, threadworm, liver fluke, pneumonic plague, bubonic plague, trachoma, sexually transmitted diseases, tuberculosis, and a variety of chronic physical conditions, including hernias, varicose veins, and cardiac abnormalities.

Similar screenings were conducted at checkpoints along the US–Mexico border. Immigrants arriving through the El Paso station, however, were required to be disinfected. Following the outbreak of a typhus epidemic in Mexico in 1915, Mexicans arriving at the El Paso checkpoint were subjected to showers with kerosene, an examination for lice, and vaccination for smallpox. Although in 1910 less than 1% of individuals arriving through the border stations were denied admission on the basis of medical grounds, that proportion increased following the Mexican typhus epidemic (Markel & Stern, 1999).

By the end of World War II, the inspection process had been revised to require the medical examination prior to departure from one's country of origin, a procedure which continues to the present day. All individuals seeking permanent resident status are required to undergo a mental and physical examination as a part of the application process, whether they are overseas applying through what is known as consular processing or in the United States applying through the process known as adjustment of status. Additionally, some individuals seeking entry for only limited periods of time are also required to undergo the medical examination. In general, the medical examination now consists of a medical history, serologic testing for specified diseases (see ➋ *Table 1*), and, depending on several factors, either a tuberculin skin test or chest x-ray (United States Public Health Service, 1991, 2008). The medical examination can only be conducted by a physician authorized to perform immigration-associated medical examinations: a panel physician in the case of an individual applying for a visa through a consulate or a civil surgeon, in the case of a person applying for adjustment of status in the United States (8 Code of Federal Regulations, 2010; 42 Code of Federal Regulations, 2010).

Only individuals who can demonstrate that they are the spouse or unmarried son or daughter or the minor unmarried and lawfully adopted child of a United States citizen, an alien lawfully admitted for permanent residence, or an alien who has been issued an immigrant visa can potentially qualify for a waiver of excludability due to "a communicable disease of public health significance." This relationship is not required for those seeking a waiver of excludability for mental illness or failure to fulfill the vaccination requirement. An exemption from the vaccination requirement is potentially available to those who are able to demonstrate that they are opposed to vaccinations in any form, that the objection is based on religious belief or moral conviction, and that the belief or conviction is sincere. In almost all circumstances, waivers are not available for drug abusers or addicts.

Conclusion

The United States has attempted to protect its population from disease and its economy from undue burden through the promulgation of health-related immigration restrictions and procedures, and to simultaneously accommodate the need to preserve families and to respect diverse belief systems through the implementation of waiver provisions. Specific exclusion provisions have changed over time in response to perceived threats of disease and contagion. In retrospect, it is evident that many of these provisions were premised on fear rather than the knowledge that was available even at the time that these provisions were conceived. Increased globalization and international travel have underscored the oft-stated observation that disease knows no political boundaries. Accordingly, immigration restrictions designed to halt disease transmission and susceptibility at a national border can only be doomed to fail.

Related Topics

- ► Ellis Island
- ► Illegal Immigration Reform and Immigrant Responsibility Act of 1996 (U.S.)
- ► Immigrant visa status
- ► Immigration Act of 1924 (U.S.)
- ► Immigration and Nationality Act of 1952 (U.S.)
- ► Immigration Act of 1990 (U.S.)
- ► Inadmissibility on health grounds
- ► Panel physician
- ► U.S.–Mexico border

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Alternative and Complementary Medicine

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History and Background

Biomedicine is at the height of its success, delivering more health care products and services to more people, at greater expense than ever before (Jonas, 2002). Prior to this, historical events such as The Meiji Restoration in Japan, the Scientific Revolution, and advancement of colonialism emphasized scientific enquiry and empirical thought over traditional healing methods (Mkize, 2009; Nishimura et al., 2009; Twohig, 2008). The introduction of antibiotics, rapid expansion of pharmaceuticals, and improved public health programs further contributed to the decline of traditional medicine (TM), and later complementary and alternative medicine (CAM) especially after World War II (Twohig, 2008). To maintain continuity throughout this entry, we will define traditional medicine (TM) as indigenous health traditions of the world in their original settings, and complementary and alternative medicine (CAM) as health care therapies outside the biomedical mainstream in industrialized countries. Where we discuss forms of healing from all settings, we will use traditional, complementary, and alternative medicine (TCAM) (Bodeker et al., 2007).

Biomedicine has achieved great strides in treating acute illness, and combating infectious disease; however, it has been unsuccessful in combating the endemic increases in many chronic diseases among Western countries such as the USA, Canada, UK, and Australia (Leonard, 2001). In the USA, 80% of all illnesses are considered chronic that are long lasting with regular occurring episodes (Keegan, 2001). This increase can be attributed to inadequate health promotion and prevention in health care systems, as well as societal/individual behaviors that have contributed to ill health and disharmony (Hales, 2009; Larson, 2007).

People are recognizing a need to take greater control of their health, and are increasingly embarking on their own personal path by seeking out holistic approaches to restore or maintain health (Keegan, 2001; Larson, 2007). The concept of holism was first developed in South Africa in the mid-1920s, although whole person theories came to prominence in North America after research discovered a correlation between lifestyle and the onset of illness (Keegan, 2001). Holistic health care practitioners recognized that wellness included looking after one's mind, spirit, thoughts, feelings, emotions as well as the physical body (Keegan, 2001). The bio-psychosocial perspective stems from this belief that our bodies, emotions, and thoughts are connected (Keegan, 2001) and that social, psychological, biological, and environmental factors impact health and wellness (Sarifino, 2008). This perspective supports the principle that optimum health is best achieved with a holistic approach taking into account diet, lifestyle, exercise, spirituality, social and work environments as key determinants of health (Keegan, 2001). This has led to growing public demand for diverse health care services, based on the perception that no one type of health care modality can provide the full range of benefits desired (North, 2008). The Internet and advanced communications have facilitated the flow of and access to health information, coupled with global migration that has resulted in increasing exposure to diverse health beliefs and medical systems (Twohig, 2008).

Although the earliest societies have been dependent on TM for many centuries, countries such as Canada, the UK, Germany, and Australia have been experiencing surging interest in CAM (Bodeker et al., 2007). For

Sana Loue & Martha Sajatovic (eds.), *Encyclopedia of Immigrant Health*, DOI 10.1007/978-1-4419-5659-0,

example, the UK is experiencing a significant increase in the use of CAM with one in ten individuals having consulted a practitioner, and 90% of these health seeking behaviors occurred outside of the National Health Service (Thachil & Bhugra, 2009).

Some of this increase may be attributed to the perceived effectiveness of traditional, complementary, and alternative medicine (TCAM), a lower incidence of adverse effects, greater emphasis on partnership building, and a holistic approach to individual problems (Thachil & Bhugra, 2009). Indications are that consultations with TCAM practitioners provide simple language and lay explanations, recognition of the existence of illness without pathology, and investigation of emotional and social factors as potential underlying causes for illness (Thachil & Bhugra, 2009). Other authors and scholars have pointed out that emotions are important for healing, and that having positive emotions may trigger endorphin release and aid in health restoration (Larson, 2007). Similarly, research has found that expressing positive emotions in biomedical consultations was also strongly associated with shared understanding between physicians and their patients (Lee et al., 2010).

The National Centre for Complementary and Alternative Medicine classifies TCAM into the following groups (Hales, 2009; National Centre for Complementary and Alternative Medicine, 2010):

1. Traditional, whole medical systems – these are complete systems of theory and practice that have evolved independently from or parallel to biomedicine (Satow et al., 2009). These include Traditional Chinese medicine, Ayurveda (from India), and Indigenous healing.
2. Mind–body integration – this involves behavioral, psychological, social, and spiritual approaches (Keegan, 2001) designed to enhance the mind's ability to heal and stimulate optimal body functioning (Hales, 2009).These approaches follow closely the historical view that mind and body are seen as one, and that positive attitudes are core for optimal psychological functioning, quality of life, and overall health and wellness (Hales, 2009). These approaches benefit all patients irrespective of culture, gender, or age with minimal physical and emotional risk, and are especially beneficial for those with chronic physical and mental illness (Hales, 2009). Mind–body approaches include hypnosis, meditation, yoga, prayer, visual imagery, aromatherapy, animal-assisted therapy, and other forms of creative expression such as art, music, and dance therapy.
3. Biologically based therapy – these therapies involve the use of natural, biologically based products divided into the following categories: phytotherapy or more commonly called herbalism, orthomolecular medicine, and special diets (Keegan, 2001). Herbalism involves the use of plant derivatives for therapeutic and illness prevention. Orthomolecular medicine refers to nutritional and food supplements used for preventive or therapeutic purposes. Special diets such as macrobiotics and the Atkins diet are used to promote health and aid in the treatment of chronic diseases (Keegan, 2001)
4. Manipulation and body-based methods – these involve manipulation or movement of the body and are classified as follows: chiropractic, elements of bodywork, Pilates, reflexology, craniosacral therapy, and various types of massage therapies. All of these focus on the musculoskeletal system and spinal column which are thought to be the framework for healthy functioning (Keegan, 2001).
5. Energy therapies – these came to prominence in the 1800s drawing upon Oriental medicine meridians and Indian chakras (Keegan, 2001). These therapies are based upon the belief that energy fields surround the physical body, and that the transference of energy within the body will open blocked channels and realign unbalanced energy. Domains within energy therapies are therapeutic touch, aura healing, chakra opening and closing, and electromagnetic healing (Keegan, 2001).

Traditional Whole Medical Systems

Traditional Chinese Medicine

Traditional Chinese Medicine (TCM) is a total system of health care that has been documented to exist for 3,000 years (Keegan, 2001; Larson, 2007). The practice of TCM is based on the philosophy of Taoism and belief that a "life force" or "chi" energy flows through the human body via 12 meridians (Benfield & Korngold, 1991; Keegan, 2001). Four methods of diagnosis are observing, listening, questioning, and pulse taking, which are used to understand the psychological factors related to diseases (Zhao, 2009). Illness is thought to be the result of blockages in the feminine and masculine energy flows called yin and yang, with a variety of methods such as acupuncture, acupressure, moxibustion (heat therapy), herbal remedies, massage, diet, tai chi, breathing, and meditation used to restore the flow or chi energy. Acupuncture is a widely used form of TCM and consists of inserting needles along points of the meridian to restore the flow of chi energy, used mainly for pain control, skin disorders, fertility problems, asthma, and arthritis (Keegan, 2001; Larson, 2007).

Indigenous Healing

Ancient societies are intimately connected with nature, animal, and plant kingdoms, believing that they possess a spirit or soul (Keegan, 2001). Illness is attributed to spiritual deficits that can be mediated with interventions intended to restore harmony and health. Shamanism is one type of intervention originating among indigenous populations and is one of the world's oldest forms of human healing (Wurges, 2001). The shaman is called upon to mediate between the people in the community and the spirit world to cure disease, and bring balance between the physical and spiritual worlds. Shamans believe that disease is caused by straying souls which come into contact with evil spirits and demons. The shaman's role is to provide relief from emotional and physical suffering by communicating with spirits in order to gain insight needed for healing. To accomplish this, shamans enter into an altered state of consciousness where they travel to other plains of existence. For example, shamans in the Americas, South Asia, and Tibet use hallucinogenic plants, herbs, chemicals, crystals, amulets, chants, and drums, to aid in spirit flight, soul retrieval, and healing (Gadit, 2007; Wurges, 2001). Teaching involves training by master shamans on altered states, techniques, spirit names and functions, mythology of clans, and forces that threaten the soul (Wurges, 2001). Shamanism is still practiced widely among indigenous people from Africa, the America and in the South Pacific, South Asia, Far and Near East, and Arctic regions, especially in rural locations where access to Western medicine is limited (Gadit, 2007).

Ayurveda

Ayurveda, meaning science of life, has its origins in Hinduism, and has been practiced in India for more than 5,000 years (Larson, 2007). Although a longstanding traditional therapy in India, the introduction of Western medicine during the colonial period resulted in a de-emphasizing of traditional medicine (Selby, 2001). Ayurveda does not purport to treat serious conditions, but is a preventive medicine and philosophy that aims to reduce stress, enhance the immune system, improve chronic illness, and increase energy levels (Selby, 2001). The underlying tenets behind this system of health care are that to be healthy one must achieve harmony within oneself and the outside world. Second, one must achieve a balance within the body and soul, which will act as a defense mechanism against illness (Selby, 2001). Diagnosis and treatment involves analyzing one's emotional and physical state, one's natural constitution/body type or prakriti, and the unhealthy behaviors that are contributing to imbalance (Larson, 2007). In Ayurveda, the human physiology is divided into three doshas which are vata (circulation and nervous system), kapha (immune system), and pitta (digestive system) (Larson, 2007). When dosha becomes aggravated it will lead to system imbalance and feeling unwell. The aim of Ayurveda is to overcome these imbalances, and restore natural harmony (Selby, 2001). The methods utilized are vast and can include breathing techniques, time management, massage, diet, exercise, herbal remedies, and yoga (Satow et al., 2009; Selby, 2001). Some health conditions that are treated with Ayurveda include colds, arthritis, gastrointestinal problems, heartburn, as well as general overall well-being (Satow et al., 2009).To become a licensed Ayurvedic practitioner in India requires completion of training at a state approved school; however, in the USA there are no standards or state licensing requirements (Satow et al., 2009).

Mind–Body Integration

Spirituality and Prayer

Spirituality is a belief in a higher power, specifically "someone or something that rises above the boundaries of self" (Hales, 2009). Prayer is defined as an active process of appealing to a higher spiritual power specifically for health reasons, and is the most commonly used form of TCAM worldwide (Hales, 2009; Qidwai et al., 2009). Prayer is thought to decrease the side effects from disease, hasten recovery, boost immune functioning, and improve the efficacy of treatment (Hales, 2009). Other benefits include better physical health, and less use of health services (Hales, 2009; Qidwai et al., 2009). Brain imaging techniques have shown that prayer may assist in reducing blood pressure, decreasing anxiety, and slowing down the heart rate (Hales, 2009). Although prayer for health is an ancient form of healing, the majority of patients from Pakistan indicated that they consider prayer an important complement to conventional medicine, rather than an alternative one (Qidwai et al., 2009).

Meditation

Meditation is the art of bringing harmony to the body, mind, and conscience, by soothing the body and decreasing stress (Kayne, 2009a). It is a systematic focus on aspects of inner and outer experiences in association with religious and spiritual contexts. One type of meditative practice is mindfulness where attention is paid to emotions, perceptions, and sensations, cultivating open-mindedness in life (Kayne, 2009b). Meditation is an effective intervention for emotional and psychological dysfunction, and has been used for chronic pain, drug addictions, and posttraumatic stress syndrome (Freeman & Lawlis, 2001). Other health problems such as anxiety and panic disorders, chronic fatigue syndrome, insomnia, separation anxiety, and hypertension are also amenable to meditation (Freeman & Lawlis, 2001; Kayne, 2009b).

Positive Thinking

A significant breakthrough for medicine in the last century was renewed interest in the role that attitudes, emotions, and beliefs have for health outcomes aptly described as "mind-body medicine" (Dossey, 2006). Central for many types of TCAM is the concept that the mind is powerful, and that thoughts and feelings impact the body at all levels. Positive thinking and feeling enables the body to work smoothly and efficiently (Jouret, 2010), restoring an individual's sense of personal empowerment, control, and efficacy (Adamson, 2003; Jouret, 2010). Some of the most important benefits from positive thinking are better immunological strength, absence of negative mood, increase in health promoting behaviors, better medical compliance, and less depression (Levin, 2009; Seligman, 2000). Frequent users of positive thinking are cancer and palliative care patients, as evidence suggests that a hopeless coping style is associated with unfavorable outcomes for patients (Adamson, 2003).

Animal-Assisted Therapy

The bond between animals and people has existed for centuries, with animals taking part in therapeutic treatments during the ninth century (Morrison, 2007). Since then, research has demonstrated health benefits in the form of lower depression and blood pressure, as well as other lasting beneficial physiological effects (Johnson & Meadows, 2002; Morrison, 2007). Studies conducted in the USA have found that many institutions include animals as part of psychotherapy. Other studies have indicated that introducing animals to postoperative pediatric patients improved their emotional and physical pain (Morrison, 2007). Owning a pet was also found to have health benefits for older Latino adults who have more chronic conditions than other ethnic groups (Johnson & Meadows, 2002) and who may be experiencing loss of family support, adjustment difficulties, and depression, especially if immigration occurred later in life (Gelfand, 1994). The Delta Society was formed with its mission as follows: "To promote animals helping people improve their health, independence, and quality of life" (The Delta Society, 2009). The society has developed "Standards of Practice for Animal-Assisted Activities and Therapy," and offers training toward certification in animal-assisted therapy (Morrison, 2007).

Aromatherapy

The term "Aromatherapy" was introduced by French chemist René-Maurice Gattefosse during the 1920s, although the practice dates to ancient Egypt (Harden & Harden, 1997). It is a therapeutic modality in which highly concentrated essences from plant extracts are placed in baths/showers, absorbed through the skin, and/or inhaled inducing emotional responses from the limbic system in the brain (Keegan, 2001). They may also be used in conjunction with other types of TCAM such as acupuncture, reflexology, and chiropractic, and are used to treat wide ranging ailments including emotional problems such as stress and anxiety (Keegan, 2001; Shealy, 1999).

Relaxation Techniques

Chronic stress produces physiological changes in the body, impairs sleep, and can trigger other unhealthy behaviors such as excessive smoking, drinking, and food consumption (Sarifino, 2008). These stressors can wear on the body and eventually lead to the onset of illnesses such as cardiovascular disease and reduced immune function. Effective relaxation techniques can help to prevent flare-ups from chronic conditions such as asthma and diabetes caused by stress and anxiety (Sarifino, 2008). Specific relaxation techniques include deep breathing, naps, stretch breaks, and eye breaks (Keegan, 2001).

Art Therapy

Art therapy uses art mediums, images, the creative process, and patient/client responses to express one's unique development, abilities, personality, interests, concerns, and conflicts (National Coalition of Creative Arts Therapies Associations, 2010). Art therapy began in England and the USA, with European scholars describing art created by patients hospitalized with mental illness. Art therapy draws upon theories of psychoanalysis and art education, and allows for an expressive outlet to reconcile emotional conflicts, manage behavior, and reduce anxiety. In particular, Asian immigrants described the art therapy group as a way to express their feelings of isolation and distress coping with a new culture (Liebmann, 2002). It is suitable for all population groups, and immigrants of different ethnic backgrounds, with training programs and graduate degrees regulated by the American Art Therapy Association. Upon completing graduate level education, supervised work experience, and a written exam, art therapists are board certified to use the designation ATR (National Coalition of Creative Arts Therapies Associations, 2010).

Music Therapy

Music therapy involves the use of music to bring about positive changes in the psychological, physical, cognitive, and social functioning of individuals with health problems, and is an ancient healing modality that dates to 500 B.C. (Kayne, 2009b). Children with developmental and learning disabilities, elderly people with age-related conditions such as Alzheimer's disease, drug addicted individuals, the physically disabled, and those suffering with pain are the groups most benefiting from music therapy (Kayne, 2009b). In the USA, hospitals routinely utilize music therapy as a CAM modality, and in particular it was found to reduce patient stress and anxiety in the surgical waiting area (Winter et al., 1994).

Biologically Based Therapies

Herbal and Botanical Medicine

The use of plants for medicinal purposes has been practiced in many cultures and regions for thousands of years (Saper, 2010). Herbal medicine, also referred to phytotherapy, is the use of plant-based products for prevention or treatment of disease (Keegan, 2001). Botanical products are those that also include woody plants where the main structure is comprised of wood. Herbs, in contrast, grow from seed, dry up and fade after the season's growth (Keegan, 2001). Herb usage in Europe is extensive with up to 40% of physicians in France and Germany using them in their daily practices (Keegan, 2001). Formal training on phytotherapy is provided in medical schools in these countries and is also a component of the training program for licensed naturopaths. About 65% of herbs have positive health benefits, promoting optimal health and reducing the effects of chronic conditions (Keegan, 2001). Several studies have indicated that ethnic groups in the USA use more herbal medicine than Caucasians, and that immigrants obtained them from pharmacists in their own cultural community, home gardens, botanicas, trips abroad, picking in the woods, ethnic stores, and mail order (Gomez-Beloz & Chavez, 2001; Graham et al., 2005; Mackenzie et al., 2003; Satow et al., 2009; Tagintseva, 2005).

Manipulation and Body-Based Therapies

Chiropractic

The chiropractic system was founded in the USA in 1895 by David Daniel Palmer (Coulter, 1992). This system is based on the premise that the spinal cord is central to well-being and fundamental for a healthy nervous system (Hales, 2009). A misalignment of vertebrae will result in pressure to be applied to the spinal nerves, causing impaired functioning. By adjusting the spinal vertebrae through manipulation, the flow from the nerves to spinal column can be restored. Other modalities such as massage, applied kinesiology, X-rays, and magnetic resonance imaging are also utilized. Research has indicated that chiropractic care helps relieve acute lower back pain, with other ongoing research investigating its benefits for menstrual cramps, headaches, and arthritic pain (Hales, 2009). This is the most widely accepted type of CAM among managed care health systems, with licenses to practice issued by all 50 states in the USA (Hales, 2009).

Massage Therapy

There are over 75 different types of massage, all with common approaches such as manual manipulation of muscles, ligaments, tendons, and other soft tissues (Tarver, 2003). Massage has been an important therapeutic treatment for thousands of years with extensive use in TCM and Indian Ayurveda, and later during the Hellenistic and Roman Empire periods (Keegan, 2001). After a period of relative anonymity during the Middle Ages, Per Henrik Ling (1776–1839) formulated Swedish Massage to relieve pain, improve blood circulation, and eliminate lactic acid buildup (Harden & Harden, 1997; Keegan, 2001). It can benefit infants and adults by reducing anxiety, depression, hypertension, and pain (Sarifino, 2008). Massage therapy continues to be an important component of TCAM in Eastern and Western culture.

Yoga

Yoga is an ancient modality derived from the religious beliefs of the Indian religions and Buddhism (Kayne, 2009b). It is a Sanskrit word meaning union of the mind, body, and spirit and is an intervention that uses a combination of muscular activity, self-awareness, and breathing to promote mental and physical vitality (Collins, 1998; Kayne, 2009a). In Indian traditional medicine, yoga helps to prevent disease by enhancing the flow of energy through the body, keeping energy meridians open, calming the nerves, as well as balancing the body, mind, and spirit (Kayne, 2009a). In the USA, 20–30 million people practice yoga (Jeng et al., 2011), however, in contemporary societies the emphasis for some becomes muscle stretching, mental relaxation, and improving vitality (Kayne, 2009b). Yoga is beneficial for a variety of health issues such as geriatric depression, palliative care, renal disease, and mental and sexual health (Kayne, 2009b). Yoga alone, or in combination with other therapies, decreases stress and tension (Kayne, 2009b), and is effective in reducing back and neck pain (Jeng et al., 2011).

Energy Therapies

Biofeedback

Biofeedback is a form of electromagnetic healing and is used to empower the mind to take control of conscious and autonomic processes (Keegan, 2001). This therapeutic modality provides light, sound, or metered feedback on metabolic changes such as temperature, blood pressure, heart rate, muscle tension, and brain waves provided through the use of biomedical sensors and instrumentation (Burton Goldberg Group, 1997; Keegan, 2001). The theory underlying this therapy is that as one becomes aware of autonomic body functions (e.g., breathing, heartbeat, bladder control), meditative concentration and repeated practice can be used to control physical changes and psychological states. Biofeedback is also used to teach individuals to become aware of physiological responses associated with elevated emotional states caused by stress or anxiety, in an effort to achieve a more balanced inner state (Keegan, 2001; Shealy, 1999). Disorders that are amendable to interventions by biofeedback and neurofeedback include alcoholism, epilepsy, asthma, arthritis, attention deficit disorder, incontinence, irritable bowel syndrome, and chronic pain (Sarifino, 2008). The Association of Applied Psychophysiology and Biofeedback has operated the Biofeedback Certification Institute of America in order to establish and maintain professional standards for biofeedback services, to certify qualified professionals, and provide citations for research studies in support of these health claims (Association of Applied Psychophysiology and Biofeedback, 2008).

Other Therapies

Homeopathy

Homeopathy was developed by Samuel Hahnemann (1755–1843), a late eighteenth–early nineteenth century German physician. In experimenting with quinine, which was, at that time, a preferred treatment for malaria, Hahnemann noted that it produced symptoms similar to those associated with the disease (Coulter, 1984). From this arose "*The Law of Similars*" or the notion that "like could be used to cure like." The idea of 'like curing like' has been around from the time of the ancient Greeks, and Hahnemann's contribution was a refinement of this basic idea (Coulter, 1984). Through further refinement came the process of "proving." In the process of "proving" a chemical compound is ingested with careful note of its physiological and psychological effects. These effects are then matched with a disease whose symptoms are reproduced by ingestion of the compound in a healthy person. The compound, thus "proved" is used as the basis for treatment of the matched disease. As Hahnemann continued to develop homeopathy, he asserted that the smaller the dose of the compound the more powerful its curative effects. Current homeopathic treatment consists of the homeopathic practitioner taking an elaborate case history from the patient, noting all physical and psychological symptoms no matter how seemingly insignificant. The homeopathy then prescribes a "proven" compound that matches the patient's unique symptoms. Today, there are over 5,000 compounds that have undergone the process of "proving" and are used to treat many types of illness (Coulter, 1984).

Naturopathy

Naturopathy was formulated in Western culture using only natural substances and techniques to treat illness; it draws upon ancient healing remedies from China, India, Greece, and Native American cultures (Lovellm, 2009; Shealy, 1999). Naturopathy is an eclectic combination of various "natural" treatments, for example, herbalism, homeopathy, acupuncture, hydrotherapy, massage, osteopathy, and chiropractic (Burton Goldberg Group, 1997). What contributes to the naturopathic modality is its commitment to a drug and surgery-free, natural approach to holistic wellness, encompassing positive thinking, a balanced diet, detoxification, exercise, and healthy lifestyle habits. It can encompass a wide range of treatments including nutritional advice, herbs, homeopathic medicines, iridology, reflexology, kinesiology, vitamins, and mineral supplements (Twohig, 2008).

The Canadian Association of Naturopathic Doctors (formerly Canadian Naturopathic Association) highlights six "principles of naturopathic medicine" (Canadian Association of Naturopathic Doctors, 2010):

1. *Primum Non Nocere* – "do no harm."
2. *Vis Medicatrix Naturae* – "recognize, respect, and promote the self-healing power of nature inherent in each individual human being."
3. *Tolle Causum* – "strive to identify and remove the causes of illness, rather than to eliminate or suppress symptoms."
4. Doctor as Teacher – "the Naturopathic Physician shall educate his/her patients, inspire rational hope, and encourage self-responsibility for health."
5. Treat the Whole Person – "treat each person by considering all individual health factors and influences."
6. Health Promotion, the Best Prevention – "emphasize the condition of health to promote well-being and to prevent diseases for the individual, each community, and our world."

Health Care Systems

Despite the popularity of CAM, most health care insurers in Western countries do not provide insurance coverage for the full range of CAM products and services (Tillman, 2002). Explanations put forth include: (1) lack of scientific evidence to support medical efficacy of the products, in contrast to conventional medicines that have undergone stringent clinical trials; (2) practitioner training outside of accredited educational institutions; and (3) administrative difficulties with existing health care billing and accounting systems oriented toward diagnosis and treatment of underlying pathology/disease (Tillman, 2002). In Australia, CAM is regarded as health care practices that operate parallel with but not part of the biomedical system, limiting reimbursement to services such as acupuncture and chiropractic (Bodeker et al., 2007; Twohig, 2008). This differs from neighboring New Zealand which reimburses for services provided by Maori traditional healers (Burford et al., 2007). In the USA, medical insurers provide reimbursement for chiropractic, massage, and acupuncture through employee programs, with limited support for other CAM services (Bodeker et al., 2007). Canada's health care system provides reimbursement for a portion of chiropractic services, (North, 2008) and regulates naturopathy and TCM in only a small number of provinces (Andrews & Boon, 2005). In Europe, 22 countries provide full or part coverage for a number of services comprising mainly chiropractic, acupuncture, homeopathy, and massage (Bodeker et al., 2007). In most cases, providers must be registered allopathic physicians, or belong to professional organizations (Burford et al., 2007). In China, Latin America, India, and Africa biomedicine exists along with traditional healing with efforts made to facilitate access to both systems (Bodeker et al., 2005; Burford et al., 2007; Mkize, 2009; Zhao, 2009). The provision of basic health services and mental health services in these regions is underdeveloped in rural locations, with traditional healing mainly practiced (Mkize, 2009; Zhao, 2009).

Japan's traditional Kampo medicine is similar to TCM in that the government provides coverage under public health insurance (Nishimura et al., 2009). The Chinese system issues licenses for TCM practitioners separate from allopathic physicians, in contrast to the Japanese system which licenses only biomedical Western style trained physicians who prescribe Kampo medicines. The Japanese health care system has combined the modern and traditional to form an integrated health care system. Kampo education is provided in all medical schools, more than 70% of physicians prescribe in practice and hospital settings, and all traditional medicines are manufactured by pharmaceutical companies (Nishimura et al., 2009).

Immigrants and TCAM

Mass immigration from the European colonies to Europe began after World War II in light of the economic boom associated with post-war reconstruction (Ben-David, 2009). This is in contrast to the eighteenth, nineteenth, and early twentieth centuries which saw widespread exodus of Europeans and enslaved Africans to continents such as Australia and North America (Gelfand, 1994; Roberts, 2009; Twohig, 2008). Today, the majority of immigrants to the USA are from Latin America and Asia, followed by India and Canada. Immigrants from India, Australia, UK, and South Africa have the highest median household income, while immigrants from Somalia and Latin American the lowest (Roberts, 2009). Similarly, Muslims comprise a large number of immigrants to Europe with forecasts for increasing immigration from other ethnic groups as well (Ben-David, 2009; Thachil & Bhugra, 2009). Many of these newcomers will be refugees, who left their home country due to fear of persecution because of political, economic, or social affiliation (MacDuff et al., 2010). Many obtain initial health care from benevolent organizations and traditional healers' during the early immigration period if access to state provided health care is not available or affordable (Bollini, 1992; Neumann & Bodeker, 2007).

Safety of TCAM

While most TCAM therapies pose little or no safety risk, consumption of some types of herbs poses a safety risk from toxic effects, allergic reactions, contaminants, and herb–herb or herb–prescription drug interactions (Keegan, 2001; Tagintseva, 2005). Some argue that the safety and efficacy of herbal medicine has been proven over the centuries; however, others argue that this does not take into account the advent of modern illnesses such as AIDS, and the manner in which the public uses herbal medicines today (Barnes, 2007). Areas of concern that are put forth include the following: (1) Climate conditions, harvesting, and storage of some herbs can change from crop to crop, resulting in varying strengths of the plants' pharmacologic properties (Barnes, 2007; Bent & Ko, 2004; Saper, 2010). (2) Inadequate regulation and monitoring of herbal products. For example, the USA classifies herbal medicines as dietary products which are not subject to FDA regulation (Hales, 2009; Tagintseva, 2005), and in other cases herbs from China are marketed without having to demonstrate quality and safety (Barnes, 2007). In India, only a small percentage of Ayurvedic product manufacturers belong to the manufacturing association, resulting in medicines not controlled, supervised, or inspected (Satow et al., 2009). In comparison, some of the former Soviet bloc countries, the Japanese, and some European countries regulate, test, and approve herbal products for distribution in the same manner as pharmaceutical drugs (Keegan, 2001). (3) Herbal medicine and prescription drugs are frequently taken simultaneously without guidance and counseling from a health care professional or pharmacist (Barnes, 2007; North, 2008; Tagintseva, 2005).

Healthy adults are better able to metabolize herbal medicines; however, there is increased risk associated with these medicines for children, the elderly, and those with chronic diseases (Crone & Wise, 1998). In particular, children and the elderly have reduced ability to metabolize active agents, and those with chronic disease have reduced physiologic reserve (Barnes, 2007; Crone & Wise, 1998). In the USA, ginseng, kava, valerian, echinacea, garlic, St. Johns Wort, and ginkgo biloba account for one-half of all sales of herbal medicines (Bent & Ko, 2004; Hales, 2009). Many of these herbs have documented reports of interactions, such as echinacea in combination with anabolic steroids, and perioperative bleeding associated with ginkgo biloba and saw palmetto (Hales, 2009; Saper, 2010). Another example is valerian, used for medicinal purposes by the ancient Greeks, and in recent times to treat anxiety (Yager et al., 1999). Under certain conditions it has the potential to interact with conventional psychopharmacologic drugs (Yager et al., 1999).

Adults have the ability to choose from a wide range of TCAM for themselves, and this right is exercised by many immigrants who frequently utilize alternative care that reflects their cultural heritage (Dudley, 2004). However, parental rights to insist on TCAM together with or instead of biomedicine to treat their acutely ill minor children may not be deemed to be in the best interest of the child, and may be overruled by the courts. This originates from child abuse reporting laws passed in the USA which included medical neglect in the definition of child abuse. Inevitably tension is bound to exist when parents feel that TCAM is the appropriate care for their child, but the state determines that such care would be inadequate or detrimental (Dudley, 2004). Further challenges exist because of a lack of statistical success rates with many forms of TCAM, inhibiting the courts from assessing the risks and benefits for the different treatment options. Some health professionals now advocate for a shared understanding approach with regards to the use of biomedicine and TCAM, which will enable a more positive outcome for children (Dudley, 2004).

Health Services

A National Health Survey conducted in Canada during the 1990s indicated that new immigrants were healthier with many fewer chronic conditions as compared to Canadian-born citizens (Barimah & van Teijlingen, 2008). However, with increasing years of residency, the prevalence of chronic conditions among immigrants reached levels similar to the Canadian-born (Barimah & van Teijlingen, 2008; Chen et al., 1996). The Canadian study classified immigrants into “Europeans” and “non-Europeans,” with the former including those from Europe, USA, Australia, and New Zealand, and the latter from all other countries (Chen et al., 1996). The non-European group recorded much higher levels of chronic conditions than the European group. Difficulties speaking a new language and problems acculturating to Western culture all contributed to poor adjustment in the host country. This is in contrast to immigrants of European origin, who more often speak the host languages and are acclimated to Western culture (Barimah & van Teijlingen, 2008). For example, Chinese immigrants attributed their onset of illness to underemployment, while factors such as inadequate housing, social status, and discrimination have been highlighted in other studies (Barimah & van Teijlingen, 2008; Thachil & Bhugra, 2009). Many immigrants will be accustomed to traditional healing practices, and will look for outlets in their host countries to continue with these traditions, especially for mental health concerns (Tagintseva, 2005; Thachil & Bhugra, 2009; Zhao, 2009). Patients felt that the encounter provided them with a comfort zone, where they feel relaxed, without having to reveal explicitly their mental health problems (Zhao, 2009). In addition, more severe difficulties adjusting to host countries arise from refugees who have fled their home country to escape persecution (MacDuff et al., 2010). In many cases they will be traumatized and used to predominantly traditional healing practices with internalized majico-religious beliefs, world views, and illness constructs different from Western-trained doctors (Neumann & Bodeker, 2007). The provision of traditional healers who have compatible world views, language, interaction styles, and belief systems may be the most appropriate, safe, and sensitive non-acute medical care for refugees at the point of first contact with their host country (Neumann & Bodeker, 2007).This will help avoid situations in which application of biomedical care resulted in false diagnosis and inappropriate care for refugees from Asia and Africa (Neumann & Bodeker, 2007).

Depression and anxiety are two of the leading indications for using TCAM worldwide (Thachil & Bhugra, 2009). Research from the UK has indicated that immigrants with mental health problems use both biomedical and traditional medicine, with increasing usage of biomedicine as they acculturate in the host country over time (Thachil & Bhugra, 2009). This pattern is similar with Chinese immigrants; however, if they had minor mental health problems, TCAM was the preferred choice (Choi & Kim, 2010; Zhao, 2009). Herbal medicines in the UK are taken to treat acute and chronic conditions such as cancer, AIDS, multiple sclerosis as well as gastrointestinal problems, arthritis, heartburn, constipation, and menopause (Gomez-Beloz & Chavez, 2001; Satow et al., 2009). Better physical and mental health reduced the use of herbal treatments (Lai & Chappell, 2007), whereas poor health status increased the use of herbal medicine for both prevention and treatment of illness (Tagintseva, 2005).

There were also differences in use of TCAM within cultural groups, reflecting divergent health beliefs. Health professionals need to consider that individual health beliefs are more likely to be the determining factor for the use of TCAM, rather than cultural affiliation (Lai & Chappell, 2007). Factors that had an impact on this were cost, accessibility, type of illness, quality of the TCAM practitioner, and the success rate of TCAM in treating the problem or illness (Barimah & van Teijlingen, 2008). Some people also choose not to use TCAM because they are unwilling to follow the lifestyle and diet changes that comprise most treatment plans (Barimah & van Teijlingen, 2008; North, 2008; Tagintseva, 2005).

Combining both TCAM and biomedicine simultaneously is widespread and applicable to many immigrant groups such as Ghanaians and Chinese in Canada, Jewish and Arabs in Israel, Russians, Latinos and Indians in the USA (Barimah & van Teijlingen, 2008; Ben-Ayre et al., 2009; Gomez-Beloz & Chavez, 2001; Lai & Chappell, 2007; Satow et al., 2009; Tagintseva, 2005). One precipitating factor behind this is that when whole medical systems such as TCM and Indian Ayurveda are practiced outside of their origins, not all components of TM may be retained, and they tend to become CAM once incorporated in Western countries (Bodeker et al., 2007; North, 2008). For example, traditional elements of Indian Ayurveda such as diet, social and cultural elements are modified to be more compatible with Western palate and context (Bodeker et al., 2007; Burford et al., 2007; Selby, 2001; Satow et al., 2009; North, 2008). One other significant finding is that patients may not tell their health care providers about their use of TCAM, and patient records are not always updated when disclosure has been made (Barnes, 2007; Golomb et al., 2003; Gomez-Beloz & Chavez, 2001; Lovell, 2009; Satow et al., 2009). The rates of non-disclosure have been found to be particularly high among Asians, Hispanics, and African Americans, necessitating the need to be proactive in investigating TCAM use among immigrant and minority patients (Graham et al., 2005). In a study of immigrant children being treated at a stroke clinic, more than 50% were reported to be using herbs and medications which had potential to affect coagulation and inhibit platelet activity (Golomb et al., 2003).

Maternal Health

Some of the more commonly experienced health problems particular to many immigrant women include cardiovascular disease, breast cancer, arthritis, menopausal symptom, osteoporosis, major depression, migraine headaches, and reproductive system issues (Murphy et al., 1999). Many health problems could be amenable to TCAM, however, there is a lack of well-organized evidenced-based studies among immigrant women (Adams et al., 2009; Checa et al., 2005). It is impractical to consider all immigrant women as a homogenous group, as each individual has unique social, cultural, and religious influences as well as beliefs, attitudes, and health practices that determine how they view and cope with, for example, pregnancy and child bearing (Checa et al., 2005).The pain and discomfort associated with menstruation, pregnancy-related complaints, labor preparation, and menopause are often the triggers that lead women to utilize alternative forms of health care to manage symptoms, especially when these negatively impact their quality of life (Adams et al., 2009; Murphy et al., 1999). Some of the more common TCAM practices in pregnancy include acupuncture/acupressure, aromatherapy, massage, yoga, homeopathy, and chiropractic care (Adams et al., 2009). Other commonly used methods of TCAM were vitamins, nutritional supplements, and herbal medicine (Chaves et al., 2010).

Postpartum depression (PPD) is another pressing immigrant women's health issue with approximately 12–14% of women at risk to develop PPD (Fonte & Horton-Deutsch, 2005; Fung & Dennis, 2010). Exposures to stressful life events, immigration, inadequate social support, and poor housing are significant predictors for PPD in immigrant women (Fonte & Horton-Deutsch, 2005; Page, 2004). Among Pakistani immigrant women living in Norway, the prevalence of PPD was 7.6%, reported to be lower than elsewhere in the world (Bjerke et al., 2008). In contrast, Asian Indian immigrants in the USA presented with symptoms of PPD similar to Caucasian women (Goyal et al., 2005).

Mexican immigrants have better birth outcomes as compared to US-born women, especially regarding low-birth-weight in infants (Page, 2004). Page has suggested that many Mexican women who emigrated with family and friends share housing, and have access to significant social support, including neighboring family and friends. Religion and prayer for health were significant predictors of a positive attitude toward pregnancy, providing ways to lessen emotional stressors, and ensure healthier outcomes for their babies (Page, 2004). Prayer and meditation were also important forms of TM that immigrant Muslim women desired for their PPD therapy sessions as they provide a connection with Allah, increase self-awareness, lessen anxiety, and promote better mental health (Fonte & Horton-Deutsch, 2005).

Herbal medicines are commonly used for women's reproductive health issues, including menstrual problems and infertility, morning sickness, labor preparation, and menopause (Beal, 1998). Ginger is one common effective herbal treatment used for nausea and vomiting during pregnancy (Adams et al., 2009; Zoorob et al., 2010). Other herbs commonly used were ginger, raspberry leaf, and enchinacea (Adams et al., 2009). Although herbs and nutritional supplements are commonly used among women, minimal data exist with regards to the safety and efficacy for the fetus or the mother (Chaves et al., 2010). There is a pressing need to assess how consumption of herbs affects women's health and consequences for fetal growth and development (Murphy et al., 1999).

Acupuncture and acupressure are two common forms of TCM used for pain relief. Reduction in pain is linked to the release of serotonin and endorphins during stimulation from the acupoints (Zoorob et al., 2010). Acupuncture has been used for centuries as TCM for fertility improvement in China (Zoorob et al., 2010) and pain relief during delivery (Kvorning et al., 1998). Research conducted in Sweden using acupuncture during labor and delivery indicated that it is a less invasive analgesic method for pain relief, is cost-efficient, easy to apply, with a low incidence of side effects. This was a popular form of therapy, with 94% of the participants indicating that they would consider acupuncture for their future deliveries (Kvorning et al., 1998).

Men's Health

A qualitative study of Korean male immigrants in Australia found that if they were seeking asylum, Chinese or Indian doctors were preferred for traditional medicine (Han, 2000). Use of herbal medicine, ginseng, nutritional tablets, royal jelly, aloe, deer antler, and acupuncture were commonly used for illness prevention, with one participant indicating he used it to enhance his libido. Some men indicated that they felt fatigued and had no time, and so consequently were neglecting their health, only visiting a doctor when they were seriously ill. However, once they obtained immigrant status, they would evaluate their state of health before deciding whether to use a biomedical doctor or TCAM (Han, 2000).

Studies of men who are HIV-positive in the USA found that the majority of participants were using some form of TCAM, alongside Western medicine (Jernewall et al., 2005). Among gay and bisexual Latino men, those using traditional Latino medicine and plant-based remedies had the highest rates of non-adherence to their medical treatment. This is particularly alarming as lower adherence correlates with increased disease progression. Providing access to some form of CAM such as acupuncture in the same location as their medical treatment facilitated better adherence to the medical regime. This same study indicated that acupuncture, massage, meditation, and herbs were the most commonly used TCAM therapies among this population group (Jernewall et al., 2005).

Prostate cancer is the second leading cause of death from cancers among men. Mortality rates are twice as high among African men as Caucasian men (Jones et al., 2007). A qualitative study of older African American men in the USA indicated that prayer for health, herbs, and meditation were the most commonly used forms of TCAM. Almost all of the men interviewed believed that prayer for health was an effective coping mechanism, and helped to reduce the stress associated with cancer. In particular it was a form of relaxation and was beneficial in gaining peace of mind. Most participants thought that prayer should be a compliment to their biomedical treatment, not a replacement (Jones et al., 2007).

Gender and Health

Some studies have indicated that there are no differences between males and females in their use of TCAM, with both parties wanting more control over their health (Satow et al., 2009). Other studies indicate that men use more acupuncture and chiropractic in contrast to females who use more herbal medicine, mind–body techniques, body movement, and prayer (Hales, 2009). A study of Chinese immigrants indicated that women used more TCAM than men, however, there were no sex differences in the use of biomedicine (Choi & Kim, 2010). Similarly, a study in Israel indicated that women used more CAM than men, especially body movement therapies (Ben-Ayre et al., 2009).This same study also found that among Jewish and Arab women there were significant differences. The Arab women used more traditional and herbal medicine in contrast to the Jewish women who used more CAM therapies such as meditation, chiropractor, body movement, and homeopathy (Ben-Ayre et al., 2009). Prayer for health purposes is one of the most utilized forms of TCAM, with use by African American women significantly higher than all other ethnic women, reflecting the degree of importance that they attach to spirituality as part of their approach to health (Graham et al., 2005).

In a global context, indications are that women are significant users of TCAM, which may also mirror their greater usage of health services in general (Bodeker & Burford, 2007). Our findings suggest that further inquiry and research are needed to understand, first, how TCAM can be used for immigrant men, women, boys, and girls to promote and/or restore their health (Bodeker & Burford, 2007), and second, how this knowledge can be used by health care systems in a constructive way to improve population health, and garner effective and efficient usage of health care services.

Conclusion

The vast majority of immigrants adopt a "mix-and-match" approach to their health care needs, with indications that this trend will continue for the foreseeable future (Barimah & van Teijlingen, 2008). Various authors have indicated that TCAM is sought for chronic conditions, when biomedicine is perceived to be inappropriate or ineffective (Lai & Chappell, 2007; North, 2008). Other authors have indicated that for health care systems to be patient-centered, consideration of TCAM should be part and parcel of culturally competent care (Leonard, 2001; Mackenzie et al., 2003).

Practitioners and patients have overwhelmingly indicted that there should be regulation to protect consumers from under-qualified TCAM practitioners (Gadit, 2007; North, 2008). For example, in Karachi, Pakistan, there are approximately 400 shamans who treat mental health problems among a significant percentage of the population, partly due to limited numbers of available psychiatrists (Gadit, 2007). There is, however, little collaboration between shamans and psychiatrists, with the lack of licensing and regulation of shamans a strong deterrent to an integrative mental health system in Pakistan (Gadit, 2007).

It is interesting to note that from all of the various articles and studies we examined throughout this entry, it is apparent that at least among developed and transitional continents and countries, TCAM is used to "complement" biomedicine, rather than become an "alternative" to biomedicine. Finally, we endeavored to cover many forms of TCAM. However, there are others, and some of these are described in the references, and in the suggested readings and websites.

Resource Organizations/Institutions

Addictions

Center for Addiction and Alternative Medicine Research (CAMMR)

University of Minnesota Medical School
914 S 8th Street, Suite D917
Minneapolis, MN 55404

Thomas J. Kiresuk, PhD, Principal Investigator
Contact: Tacey Ann Boucher
e-mail: caamr@winternet.com

Aging

Complementary and Alternative Medicine Program at Stanford University (CAMPS)
730 Welch Road, Suite B
Palo Alto, CA 94304–1583
William L. Haskell, PhD, Principal Investigator
Contact: Ellen DiNucci, MA
Contact: dinucci@scrdp.stanford.edu
Web: http://scrdp.stanford.edu/camps.html

Asthma, Allergy, and Immunology

Center for Alternative Medicine Research in Asthma, Allergy, and Immunology
University of California at Davis
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U.S. Department of Agriculture. http://probe.nalusda.gov. Free access to records on taxonomy and use of herbs

NAPRALERT. College of Pharmacy, University of Illinois at Chicago
http://www.pmmp.uic.edu
Scientific articles on pharmacology of plants (requires a subscription fee plus search fee)

Herb Research Foundation. http://www.herbs.org
Private library of papers covering botanical issues (fee for searching plus a per-page charge)

MANTIS (formerly CHIROLARS). http://www.healthindex.com
Database of natural and alternative medicine compiled by Health Index, including chiropractic, osteopathic, homeopathic, and manual medical literature

IBIS: The Interactive BodyMind Information System
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Culture-Specific Diagnoses

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Introduction and History

Culture-specific diagnoses, also referred to as culture-bound syndromes, ethnic psychoses, and atypical culture-bound reactive syndromes, have been studied since the early eighteenth century. Culture-specific diagnoses encompass a diverse group of illnesses whose syndrome constellations are unique to certain cultural groups. While general medical conditions which localize to certain geographic regions or genetic groups have been historically included with the culture-specific diagnoses, the term is now primarily used to refer to mental health conditions. Culture-specific diagnoses are distinct from idioms of distress. Idioms of distress are a culturally unique presentation of coping with and expressing negative experiences and emotions (Kirmayer & Young, 1998). Idioms of distress are most commonly manifested as somatization with the body system and form of physical manifestation of the emotional distress varying by culture. Knowledge of both culture-specific diagnoses and idioms of distress is important in order to recognize treatment needs in immigrant populations whose culture-based illness presentations may vary from the native population.

A review of the terms race, ethnicity, and culture is helpful in the study of culture-specific diagnoses. The United States Department of Health and Human Services defines culture broadly as a common heritage or set of shared beliefs, norms, and values. Culture can be defined anthropologically as a system of shared understanding or meaning. Cultural beliefs are not static over time, but shift with changing moods and attitudes (Mental Health: Culture, Race, and Ethnicity A Supplement to Mental Health: A Report to the Surgeon General. Department of Health and Human Services, 1999). Additionally, one's own cultural identification can also change over time. Immigrants to a new country can slowly alter their own cultural identity to reflect their new home. The term race is defined in a report to the United States Surgeon General not as a biological or genetic category, but rather a social categorization that is defined by the culture itself. Ethnicity, on the other hand, is a common set of historical experiences, rites, and shared language. While individuals of the same racial or ethnic group may consider themselves a part of the same culture, this is not always the case and should not be assumed.

As early as the eighteenth century scientists were identifying differences in illnesses based on the geographic origin of the sufferer. In 1733, George Cheyne, a Scottish physician practicing in England, wrote of disorders which he felt were more common amongst the English in *The English Malady* (Cheyne, 1733). He attributed these disorders of low spirit, nervous distempers, melancholy, and hypochondria to the cultural factors of poor diet, "manner of living," and geographic factors including weather. By the late nineteenth century, the now famous Malaysian-specific disorders of amok and latah were identified by W. Gilmore Ellis (Prince & Tcheng-Laroche, 1987). In the 1950s and 1960s, P.M. Yap, a psychiatrist based at the Hong Kong University, wrote several papers examining these phenomenon commonly referred to at the time as "peculiar" (Tseng, 2006). He went through several descriptive terms for these illnesses and finally settled on the now commonly used term culture-bound syndrome in 1967. New disorders continued to be reported as mental health practitioners traveled to other lands, finding what they perceived to be unusual symptom constellations and "folk remedies." In the 1970s and 1980s, there was an emphasis on the subgrouping of disorders and ways to conduct empirical studies comparing and contrasting disorders across cultures. By the 1990s, culture-specific diagnoses began to decrease somewhat in relevance as more emphasis was placed on cultural sensitivity and consideration in all facets of psychiatric diagnosis and treatment.

Sana Loue & Martha Sajatovic (eds.), *Encyclopedia of Immigrant Health*, DOI 10.1007/978-1-4419-5659-0,

Classifications of Disorders

Because of the clinical similarities between certain culture-specific disorders, there has been a push to classify these diseases by their constituent behaviors (Simons & Hughes, 1993). A grouping of symptomatically similar culture-specific diagnoses was first referred to as a taxon by Ronald C. Simons, and the concept quickly spread (Simons, 1985). Sorting the culture-specific diagnoses into sets was meant to facilitate an appreciation of the similarities of distinct disorders. These groupings also served to facilitate easier study of the disorders with less distraction by the confounding influence of the foreignness of the given culture. Taxa (plural of taxon) allow for reconciliation of what are referred to as "orphan cases," in which typical presentations of culture-specific diagnoses occur in other cultures. Simons suggested the following taxa: genital retraction, sudden mass assault, running, fright, startle matching, sleep paralysis, and cannibal compulsion. By arranging the culture-specific diagnoses in this manner, scientists can better study etiology and underlying psychological processes in related disorders. In the future, this may also allow for the study of genetic or neuro-imaging data.

The World Health Organization's *International Classification of Diseases 10th edition* (ICD-10)'s Classification of Mental and Behavioural Disorders (World Health Organization, 1992), used by most European countries, does not include culture-specific diagnoses as diagnostic criteria. The authors instead cite the dwindling interest in a separate category for such diseases and the lack of "sound descriptive studies, preferably with an epidemiological basis." The authors go on to suggest that these disorders can be considered local variants of existing mental disorders within the ICD-10 and, therefore, should be coded accordingly with additional notation as to the nature of the culture-specific disorder involved and any feigning of symptoms or attention-seeking behaviors observed.

The Diagnostic and Statistical Manual – 4th Edition, Text Revision (*DSM-IV-TR*) (American Psychiatric Association, 2000) includes a glossary of culture-bound syndromes. In the introduction, the authors define culture-bound syndromes as "recurrent, locality-specific patterns of aberrant behavior and troubling experience that may or may not be linked to a particular DSM-IV-TR diagnostic category." The manual goes on to explain that culture-bound syndromes are localized to a specific society or culture and "frame coherent meanings for certain repetitive, patterned, and troubling sets of experiences." The DSM-IV-TR lists 25 of the most commonly encountered culture-bound syndromes in North American mental health practice.

Review of Culture-Specific Diagnoses

Over 200 disorders have been identified as being culturally specific. Many syndromes have multiple names in different languages, and there is a great degree of overlap between certain disorders (Simons & Hughes, 1993). Some disorders have fallen out of favor over the years. The following represents the most common and most studied culture-specific diagnoses arranged by geographic area.

Africa/Middle East

Baridi

Dr. Anitta Juntunen wrote in 2005 about the baridi syndrome among the Bena people of Tanzania (Juntunen, 2005). Through interviews with the local people, she was able to identify the signs and symptoms of this disorder as consisting of feelings of restlessness, fatigue, drowsiness, lack of appetite, and general feelings of illness. Advanced baridi was identified by joint deformity, extremity weakness, and mental disturbances. The Bena consider baridi to be caused by acting against the interests and norms of the tribe, being disobedient or critical of elders, neglectful in familial duties, using slanderous or insulting language, or breaking sexual taboos. Treatment is in the form of a return to cultural norms by apologies, gifts, and herbal remedies under the direction of a healer.

Boufée Délirante

The *DSM-IV-TR* defines boufée délirante as a French term used to refer to a sudden outburst of agitation seen in West Africa and Haiti (American Psychiatric Association, 2000). There is typically irritable behavior, confusion, and psychomotor agitation. Hallucinations and paranoia may be present, causing a presentation similar to the *DSM-IV-TR*'s Brief Psychotic Disorder (American Psychiatric Association).

Johnson-Sabine and his colleagues reviewed discharge diagnoses of all patients discharged over a 4-year period in a Paris psychiatric hospital (Johnson-Sabine et al., 1983). They found that boufée délirante represented between 2% and 12% of all diagnoses in the 30 cases which they reviewed. When they compared the individuals who had been diagnosed with boufée délirante with those diagnosed with affective psychosis or schizophrenia, they found that the boufée délirante group was more likely to have been born outside of France and of foreign parentage, and that 40% had lived in France for less than 5 years.

Brain Fag

Brain fag is listed in the *DSM-IV-TR* as a West African disorder typically affecting high school and university students (American Psychiatric Association, 2000). In response to academic pressures, students or others who work in academic fields experience an inability to concentrate, comprehend, read, or recall information, physical sensations of numbness or tingling, emotional presentations of sadness, irritability, or anxiety, or impaired sleep (Jegede, 1983). Individuals can have other somatic symptoms which focus on the head and neck and include muscle tension, pressure, pain, burning sensations, and blurry vision (American Psychiatric Association, 2000) or physiological disturbances of palpitations, tremor, weight loss, or breathing difficulties (Jegede, 1983).

Jegede studied 382 secondary school students in Ibadan, Nigeria, to see how common symptoms of brain fag were (Jegede, 1983). He found that the prevalence of symptoms ranged from 48.9% of boys and 45.6% of girls experiencing "heat in body" to 96.4% of boys experiencing headache and sleeping difficulties, and 98.9% of girls experiencing "crawling in body." In 231 third year university students, he found frequencies ranging from 7.36% of students experiencing headaches to 65.37% experiencing "crawling feeling in the body" and 67.53% experiencing "heat in the head." Jegede concluded that the symptoms commonly thought of as brain fag actually constitute not one disease entity, but multiple, with different etiological factors.

Zar

The *DSM-IV-TR* states that zar is a term used in several North African and Middle Eastern societies to refer to the possession of an individual by spirits (American Psychiatric Association, 2000). According to Grisaru, the word zar is Amharic and is a derivation of a pagan deity (Grisaru, Budowski, & Witztum, 1997). Women are particularly at risk for this condition which can be precipitated by physical ailments, infertility, or boredom. Individuals who have been affected typically present in a dissociative state. They may cry out, sing, laugh, shout or bang their heads. Longer possessions can be marked by withdrawal, and refusal to eat, drink, or carry out daily responsibilities (American Psychiatric Association). The village gathers in support of the afflicted and feasts and gifts are given to the possessing spirit to appease it. Many cultures do not see such behavior as abnormal. Grisaru found that some people experiencing zar actually find the experiences pleasurable and desirable (Grisaru et al., 1997).

Genital Retraction

Psychotic episodes of genital theft and retraction, similar to the Asian culture-bound syndrome koro, have been reported in Africa. Charles Mather (Mather, 2005) describes the case of an individual in Ghana who accused a stranger of genital theft. Cameroon, Nigeria, Gambia, and the Ivory Coast have all experienced mob lynchings of those suspected of removing men's genitalia. In some parts of West Africa, the victims have been females with perceived shrinkage of breasts and changing or sealing off of the vagina. There have been several mass hysteria-like episodes in which several people in the same village or town are affected and frequently take justice into their own hands through violence. Some explain these experiences as the impact of juju or witchcraft (Dzokoto & Adams, 2005).

Asia

Amok

Amok is a dissociative episode characterized by a period of brooding, followed by an outburst of violent, aggressive, or homicidal behavior directed at people and objects, according to the *DSM-IV-TR* (American Psychiatric Association, 2000). Episodes are also often accompanied by persecutory ideas, automatism, and amnesia. The violent acts are usually followed by exhaustion and a return to one's premorbid level of functioning. This disorder appears to come from Malaysia, but similar behaviors have also been observed throughout Southeast Asia. Countries including Indonesia, Laos, Philippines, Polynesia, Papua New Guinea, Singapore, Sumatra, and Thailand, all have documented cases of amok. The first documented case came from Captain Cook in 1770 when he toured the Malaysian archipelagos (Haque, 2008).

The term amok is a Malaysian word meaning to engage furiously in battle and is also known amongst the Malay as *matagelap,* which literally means black before the eyes (Gaw & Bernstein, 1992). It is also the origin of the English phrase "running amok" ("Culture-Bound Syndromes," n.d.). Some historians believe that amok dates back to ancient Indian warriors entering into a trance before battle. This hypnotic state allowed them to engage in combat without trepidation. These early warriors likely passed on their knowledge to the Malay people. Early Malay fighters would scream "amok" on the battlefield and with the knowledge of their predecessors they would fight without registering fear or pain. Malay fighters were instructed to engage in "fanatical charges, indiscriminant slaughter, and refusal to surrender" (Carr, 1978). Once Islam arrived to the islands, cases of amok were blamed on acts of religious fanaticism. Speculation exists that episodes were actually suicide attempts disguised as violence towards others. However, doubters argue that the Islamic faith opposes suicide and Malaysia is known to have one of the lowest suicide rates in the world. Nevertheless, one psychodynamic approach views amok as a projection of rage or an act against society instead of against oneself. Some of the folklore of Malaysia attributes cases of amok to evil spirits possessing an individual's body and forcing him or her to engage in violent acts. Other tales portray amok as a culturally sanctioned means of expression. It is a vehicle for aggression in a society that encourages social responsibility and repression of anger.

Currently, the typical sufferer of amok is a male who has suffered a loss or has undergone a perceived insult. He is young to middle aged, isolated from his family and home, poorly educated, and from a low socioeconomic class. Others often describe the afflicted as quiet and withdrawn, but not uncommonly there exists a history of behavior problems, including immaturity, impulsivity, mood lability, and lack of accountability. Although isolated cases exist, most cases occur following exposure to similar behavior in others. Some theorists describe amok as a "transmittable" illness and argue in favor of a social learning process as the necessary ingredient for manifestation. Epidemic patterns usually emerge during times of political, economic, or sociocultural discord. Previously, the Malay people viewed amok as a mental illness, and the *pengamok,* or perpetrator, was felt not to be responsible for his acts of violence. However, amok episodes are now considered crimes and carry the potential for punishment by death. Interestingly, when the Malay culture shifted political views and amok became a crime as opposed to a mental illness, the number of cases declined. Now amok is considered to be a rare phenomenon, even though documented cases do still exist.

Latah

According to the *DSM-IV-TR*, latah is a hypersensitivity to sudden fright (American Psychiatric Association, 2000). It is a trance-like syndrome characterized by an extreme response to startling stimuli which is often accompanied with echopraxia, echolalia, command obedience, and dissociative behavior. Latah usually affects middle-aged women of Malaysian descent. Although it is thought to have originated in Malaysia, this disorder has actually been identified in many parts of the world. A symptomatic individual will typically demonstrate hyperfocused attention, defensive posturing, coprolalia, mimicry, and an extreme suggestibility that generally absolves them of any responsibility for their actions. Any attempts to control them are usually met with resistance. When startled, these individuals will drop or throw objects held in the hand and often will start to utter obscenities. Onlookers frequently find the behaviors amusing and victims may be intentionally startled for the enjoyment of others. Many scholars do not consider latah to be an illness, but instead view it as a culture-specific reaction to the innate startle reflex.

Koro

The DSM-IV-TR (American Psychiatric Association, 2000) defines koro as an episode of sudden and intense fear that the penis (in females, the vulva or nipples) will retract into the body and possibly cause death. This syndrome is typically found in south and east Asia and is identified by a number of local terms. Despite the majority of cases being grouped in the East, there are documented cases in non-Asian patients as well, leading to controversy over the true nature of the disorder. Popular belief states that the word koro is derived from the Malay word for tortoise, *kuro,* since the tortoise can retract its head into its shell. Koro consists of perceptual, cognitive, and emotional disturbances (Buckle, Chuah, Fones, & Wong, 2007). The misperception that the body part is receding into the body and subsequent cognitive distortion that this will cause death, ultimately leads to intense feelings of anxiety and panic. Koro exists in both epidemic proportions and, more rarely, as isolated occurrences. One researcher compiled a list of cases and only uncovered 19 individual episodes in 15 years (Bernstein & Gaw, 1990). Nevertheless, given the ease of immigration and the ability to travel worldwide, solitary episodes and pockets of illness may occur more often in Western society.

Epidemics of koro are believed to stem from the cultural attitudes of the people living in any given region. Chinese mythology holds that ghosts of the dead have no male reproductive organs and will disguise themselves in order to steal penises from the living. The hysterical response to this folk belief has facilitated an epidemic of koro on more than one occasion. Traditional Chinese medicine views koro as an imbalance of Yin and Yang. Good health derives from the dual power of these two forces, and, in cases of koro, the equilibrium is upset by sexual indulgence. Excessive sexual activity is thought to deplete the sperm, cause retraction of the genitals, eventually resulting in death.

Early psychoanalysts postulated that koro represents a version of Freud's castration anxiety and that koro's clinical features stem from underlying sexual conflicts. The biomedical approach frequently describes koro as a symptom of a medical condition as opposed to being its own illness. Koro-like symptoms have been reported in individuals experiencing heroin withdrawal, brain tumors, epilepsy, strokes, and HIV. Psychiatry has classified koro as a body image disturbance, a sexual neurosis, an acute panic reaction, a hypochondriacal stress response, a somatoform disorder, a psychotic disorder, a depersonalization disorder and a conversion reaction. Some feel the belief in retraction is an overvalued idea while others consider it to be a delusion (Bark, 1991).

Research has actually shown that a perception of penile shrinkage may be associated with a reduction in penile circumference, suggesting that some cases of koro may have a physical basis. Given the multitude of potential diagnostic categories, Albert C. Gaw proposed a decision tree to help classify this disorder. Initially, a treating physician must determine whether the genital retraction is a primary psychiatric disorder or is due to a preexisting medical condition. Then a provider would need to frame the disorder in its specific cultural context, and determine whether the koro episode is an isolated case or is occurring in the context of an epidemic. Finally, a diagnosis of Genital Retraction Disorder, Culture-Specific single case versus epidemic or Genital Retraction Disorder, Not Culture-Specific may be rendered.

Dhat

According to the *DSM-IV-TR* (American Psychiatric Association, 2000), dhat is a folk diagnostic term used in India to refer to anxiety and hypochondriacal concerns associated with the discharge of semen. In colloquial terms, dhat is identified as a "neurosis of the Orient" (Sumathipala, Siribaddana, & Bhugra, 2004). Sufferers become severely preoccupied with the idea that they are losing semen in their urine and often present with associated feelings of fatigue and other vague somatic complaints. Open discussion about sexual issues is considered inappropriate in polite society, and those prone to overreaction may not have the necessary outlet in which to discuss misconceptions (Perme, Ranjith, Mohan, & Chandrasekaran, 2005). Innocent symptoms like fatigue may seem catastrophic when an individual simultaneously perceives his urine to be turbid or white in color. Cultural beliefs indicate semen loss is harmful to the body and, in a somatically preoccupied individual, any discoloration of the urine can lead to extreme health-related anxiety. The anxiety over semen loss traces back thousands of years to ancient Ayurvedic texts ("Culture-Bound Syndromes," n.d.). According to the writings, semen is the most precious body fluid, and the loss of even a single drop might completely destabilize a person.

Hwa-Byung

According to the *DSM-IV-TR* (American Psychiatric Association, 2000), hwa-byung is a Korean folk syndrome that translates into "anger syndrome." Symptoms are thought to result from anger suppression and include indigestion, anorexia, dyspnea, insomnia, fatigue, and generalized aches and pains. Perhaps the most classic symptom is the sensation of a mass in the epigastric area, "the upper abdomen-lower chest is consistently identified as the primary site of the pathology by the patients" (Lin, 1983). Inner conflicts develop into a "blood-muscle lump" known as *Hwa*, and its presence is felt in the abdomen, although no evidence of its presence is found on physical examination (Pang, 1990). Unfortunately, all of the somatic complaints are rather resistant to medical treatment, and the epigastric mass sensation has driven patients to surgical interventions with little relief. Hwa-byung is considered to be chronic; one study suggested the duration was, on average, 10 years from the onset of symptoms. The causative stress is frequently identified as an extramarital affair or strained in-law relationships, although financial hardship and separation from family and social supports also qualify as stressors. These domestic situations provoke anger which the victim suppresses. Eventually, the anger manifests itself as an epigastric mass sensation along with a myriad of other somatic complaints. Prevailing theories suggest hwa-byung is a "means of expressing misery and despair without stigma" (Park, Kim, Kang, & Kim, 2001). Many sufferers consider the illness to be their destiny and suppress their anger according to cultural norms, knowing their symptoms will be recognized by others as socially acceptable. The suppressed anger is projected onto a body organ or system, and the patient deals with the resulting symptoms with resignation and acceptance, although many will still try to alleviate some of their discomfort with medical treatments. Korean culture emphasizes restraint and temperance, and it is considered a virtue to endure life's misfortunes silently and without aggression, confrontation, or disobedience (Pang, 1990). Thus, sufferers view their illness as fate and translate their ire into physical problems that are culturally sanctioned.

Approximately 75% of hwa-byung cases are women. One survey found that the majority of female hwa-byung sufferers were of low socioeconomic status, lived in rural areas, used tobacco and alcohol, and were either divorced or separated from their spouse (Park et al., 2001). Many of those who were afflicted were aware that their illness was not necessarily physical, but were reluctant to view themselves as psychiatric patients. Sufferers retain insight as to the nature of their symptoms, but may prefer to utilize medical treatment alternatives rather than focusing on the emotional aspects of the illness.

Taijin Kyofusho

The *DSM-IV-TR* (American Psychiatric Association, 2000) defines Taijin kyofusho as a culturally distinct phobia in Japan that parallels the symptoms of Social Phobia in the West. Taijin means interpersonal, and kyofusho means fear. Taijin kyofusho together refers to an individual's intense fear that his or her body will somehow offend other people through appearance, odor, facial expression, or movement (Gaw, 2001). The dread of hurting or offending others typically takes one of four forms. *Sekimen-kyofu* is a phobia of blushing, *shubo-kyofu* is a phobia of a deformed body, *jikoshisen-kyofu* is a phobia of eye-to-eye contact, and *jikoshu-kyofu* is a phobia of foul body odor ("Culture-Bound Syndromes," n.d.). The syndrome typically afflicts young people, and symptoms are most salient during interpersonal situations. Included in the official Japanese diagnostic system for mental disorders, taijin kyofusho is likely fueled by a cultural emphasis on proper behavior in all social interactions. Due to the conviction that they are repulsing others, sufferers will take showers, brush their teeth, and change their clothes on a frequent basis, and may ultimately avoid public appearances (Suzuki et al., 2004).

Given the variability of its presentation, taijin kyofusho likely exists on a continuum from transient adolescent social anxiety to fixed delusions. Currently the most common form is a fear of blushing, which affects young males who are in the adolescent stage of self-consciousness and feelings of insecurity (Suzuki et al., 2004). Prognosis is uncertain, but generally symptoms will attenuate in the fourth decade of life (Russell, 1989). However, some cases progress and take on the characteristics of more debilitating illnesses such as schizophrenia. More mild cases of taijin kyofusho typically result in symptoms only when in the physical presence of others and are limited to encounters with "intermediate-level persons" such as classmates, coworkers, and neighbors. Complete strangers would not induce high levels of anxiety, nor would family or intimate friendships. Serious cases involve individuals not actually present and take on more of a delusional quality such as the belief that one is polluting the entire neighborhood and offending everyone within its borders. Strangers and intimates alike create fear and the victim may become housebound. Mild sufferers seek psychiatric help for their affliction; serious sufferers often lack insight into their condition and opt for more radical measures such as surgery to remove their offending physical flaws. Ultimately, individuals with taijin kyofusho pursue treatment out of concern that they are offending their fellow man. Theorists argue that this "altruistic" attempt to correct a weakness mirrors the Japanese values of maintaining quality interpersonal relationships.

Shenjing Shuairuo

The *DSM-IV-TR* (American Psychiatric Association, 2000) describes shenjing shuairuo as a Chinese condition characterized by mental and physical fatigue, dizziness, headaches, and impairments of sleep, concentration, and memory. Made famous by Arthur Kleinman, the symptoms are often synonymous with Western diagnoses of Mood or Anxiety Disorders (Hall, 2006). China recognizes shenjing shuairuo in the Chinese Classification of Mental Disorders, Second Edition, and the syndrome is also identified by the term Neurasthenia. Neurasthenia is a designation that was once recognized by the DSM as a part of Western medicine, but the disorder has been omitted in recent revisions. However, it is still recognized by the World Health Organization's ICD-10 (World Health Organization, 1992) classification system.

In translation, the term shenjing means "nervous system" and shuairuo means "weakness" (Gaw, 2001). It includes elements of depression and anxiety, and is frequently accompanied by gastrointestinal problems, sexual dysfunction, irritability, excitability, and other signs of autonomic dysfunction. At one time, it was the second most common diagnosis in Chinese psychiatric hospitals and one of the most common diagnoses overall. Neurasthenia, or "exhaustion of the nerves," (Parker, Gladstone, & Chee, 2001) once served as a mark of status since the upper class were considered more susceptible to these health problems in the same way that ulcers or high blood pressure might indicate a person of important occupational status today (Hall, 2006). Since neurasthenia was considered to be a diagnosis of the elite, members of upper-class society were treated by the most respected physicians, and these patients were not stigmatized as "mentally ill." Many neurasthenia patients are survivors of China's Cultural Revolution, a violent mass movement that began in 1966 and ended officially with Mao's death in 1976. The Cultural Revolution brought about widespread social, political, and economic upheaval. Many people developed symptoms of shenjing shuairuo in response to the economic chaos and massive social and political changes. Currently, the Chinese view the disturbance as a depletion of "qi," which translates into "energy flow" and is believed to constitute a fundamental part of every living thing. Symptoms of various illnesses are often believed to be the result of interrupted or blocked qi movement through the body's meridians, as well as deficiencies or imbalances of qi in multiple organ systems. The symptoms of shenjing shuairuo are not unique to China, and many societies across the globe have grouped similar symptoms together and label them according to their own cultural beliefs.

The Americas

Bilis and Colera

The *DSM-IV-TR* defines bilis and colera as a group of syndromes in which extreme anger results in disturbances between the spiritual and physical aspects of an individual (American Psychiatric Association, 2000). These disorders, which can also be referred to as muni, demonstrate the belief by many Latino cultures that anger is a strong and dangerous emotion. Individuals who have been afflicted by bilis or colera can present with nervous tension, headache, trembling, yelling out, GI disturbances, or fainting (American Psychiatric Association, 2000).

Coraje

Elizabeth Cartwright, Ph.D., identified coraje, a disorder similar to bilis and colera, during her time living among the Amuzgo Indians of Oaxaca, Mexico (Bender, 2003). While coraje has been translated as anger, this is an oversimplified Westernization of the disorder. The Amuzgo see coraje as a result of negative interactions and events in one's life. When coraje befalls an individual, it is believed to settle on a specific body region which will present symptoms of the illness

(Bender, 2003). For example, if it settles on one's head, the victim may have headaches, or if it settles in the limbs, it may cause pain or weakness. Coraje can move about the body. Extra care, including the wearing of special belts, is taken by the Amuzgo to prevent the migration of the disorder to the heart which they believe can result in death. One of the cardinal features of coraje is the fact that it can be contagious. The weak, elderly, and young are at particular risk. As a result the community is very careful to not become angry with one another or yell which could spread the disease (Bender, 2003). Curing this ailment is undertaken by a "curandera" who combines elements of traditional tribal beliefs with Roman Catholicism.

Nervios and Ataque De Nervios

Nervios translates as "nerves" and ataque de nervios as an "attack of nerves (American Psychiatric Association, 2000)." These disorders seen in people of Hispanic background have been described in the literature for over 40 years. Nervios is a more general chronic condition in which an individual suffers a constellation of somatic symptoms in response to ongoing stress. These symptoms can range from insomnia and headaches to heart palpitations, body aches, and chest pain. It is generally associated with overwhelming worry. Interpersonal stressors such as family and relationship difficulties are a frequent cause of nervios. Ataque de nervios is a more acute disorder with an abrupt onset in reaction to an intense stressor such as the death of a loved one, accident, war, or learning extremely bad news. The manifestations of such an attack can include dizziness, faintness, shaking or seizure-like activity, and palpitations. Aggression can also occur, frequently in the form of verbal threats, swearing, striking out at others, or harming oneself (American Psychiatric Association, 2000). Such episodes can serve an adaptive role within the community of bringing together an individual's family and friends for support in their time of need. Such brief and culturally accepted forms of ataque de nervios rarely necessitate the intervention of traditional or modern medical practitioners. It is only when the illness is long-lasting or atypical that help is typically sought.

Guarnaccia, Good, and Kleinman (1990) reviewed data suggesting that these nervous disorders presented with more numerous and more clinically significant symptoms amongst Puerto Ricans in New York City than other Hispanic groups. They found deficiencies in several of the prior studies, including the ways in which methodological differences and a lack of clear and consistent measures may have skewed results. Guarnaccia and his colleagues identified confounding factors that could increase the rate at which people of certain cultural backgrounds report mental and somatic symptoms, including the stigma associated with a given illness in the culture and the type of health care system an individual has been raised in (Guarnaccia et al., 1990). They also found that the immigrant role and its associated stresses may play a large part in the elevated rate of mental illness and severity of symptoms seen in Puerto Ricans in New York compared to native New Yorkers and Puerto Ricans who did not emigrate (Guarnaccia et al., 1990).

One of the major criticisms of the inclusion of nervios and ataque de nervios as distinct culture-specific diagnoses has always been their similarity to panic attacks and panic disorders. Meghan Keough and colleagues conducted a study in which more than 300 undergraduate students of different cultural and ethnic backgrounds were asked about their experiences of symptoms of panic attacks, ataque de nervios, and, as a test of reliability, koro (Keough, Timpano, & Schmidt, 2009). The names of the disorders were withheld to ensure the results were not confounded by an individual's familiarity with the diseases. Twenty-five percent of the sample reported a lifetime experience of at least one episode consistent with ataque de nervios, while only 17% endorsed symptoms of a panic attack, and none reported a history of koro symptoms. They found that only 9% of respondents reported a history of both ataque de nervios and panic attacks. Such a low co-occurrence rate supports a clinical distinction between these two disorders. They found that neither self-identification as Hispanic, nor rate of acculturation as measured by the Multigroup Ethnic Identity Measure (MEIM) or Psychological Acculturation Scale (PAS) correlated with the rate of ataque de nervios. This finding suggests that ataque de nervios may be more universal than previously believed.

In contrast to the low co-occurrence rate found by Keough, Ester Salmán and her colleagues found high rates of panic disorders in Hispanic individuals with a history of ataque de nervios (Salmám et al., 1998).

Salmán and her colleagues developed the Ataque de Nervios Questionnaire-Revised (ANQ-R) and administered it to 156 Hispanic individuals who had presented to a nonprofit anxiety disorder clinic in New York. Of those studied, 69.9% reported at least one episode of ataque de nervios. Of those who had a history of ataques, 41.3% also met criteria for panic disorder (with or without agoraphobia), 8.3% for generalized anxiety disorder, 4.6% for social phobia, and 8.3% for anxiety disorder not otherwise specified. They found no statistically significant difference in the specific ataque de nervios symptoms or coexisting psychiatric disorders between those respondents from Puerto Rico, Dominican Republic, or "other" Hispanic nationalities. The differences in co-occurrence rates in these two studies may be a function of the populations studied as Keough at al. interviewed a nonclinical sample of undergraduate students and Salmán et al. utilized individuals who had specifically presented for treatment at an anxiety clinic. Since individuals with "typical" ataque de nervios symptoms do not usually seek treatment, it would make sense that Salmán's sample had more coexisting pathology based on the fact that they had sought out treatment at an anxiety clinic.

Falling Out/Blacking Out

The *DSM-IV-TR* (American Psychiatric Association, 2000) defines episodes of falling out or blacking out as "a sudden collapse, which sometimes occurs without warning," but can be preceded by feelings of light headedness, dizziness, or a "swimming" feeling in the head. The person typically falls to the ground and feels unable to move. While their eyes are frequently open, they claim a lack of sight, though they can hear what is going on around them. Such episodes primarily occur in the southern United States and the Caribbean. The *DSM-IV-TR* comments that such episodes may correspond to a diagnosis of Conversion Disorder or Dissociative Disorder (American Psychiatric Association, 2000).

Weidman reviewed data collected from approximately 100 households comprised of various ethnic groups as part of a comparative study of health conditions, beliefs, and practices in inner-city Miami (Weidman, 1979). She found that 23% of the Bahamian sample reported instances of "blacking out," while 10% of the Southern African American sample reported "falling out." Weidman's colleague, Lefley, reviewed Miami Fire Department's "run reports" describing their emergency calls over an 8-month period (Lefley, 1979). She found that 12% of the 3,700 reports were for possible cases of falling-out. Of the possible falling-out cases African Americans represented over 49%, Latinos represented 21%, and non-Latin Caucasians represented 30%. They attributed the relatively low percentage of Latinos to their overall underrepresentation in total numbers of emergency service runs.

Locura

Locura is a "term used by Latinos in the United States and Latin America to refer to a severe form of chronic psychosis," according to the *DSM-IV-TR* (American Psychiatric Association, 2000). Individuals who are believed to be suffering from locura typically present with symptoms of incoherence, inability to function in society, hallucinations, aggression, impulsivity, and bizarre behavior that is outside of socially acceptable norms (American Psychiatric Association, 2000). Locura is believed to be caused by repeated stressors in life, a familial vulnerability to the disorder, or a combination of the two. Individuals who have been identified by family and friends as having locura would benefit from an evaluation for schizophrenia or other psychotic disorders.

Pinaeros and his colleagues reviewed an "outbreak" of nine cases locura in an indigenous Columbian population in their 1998 article (Pinaeros, Rosselli, & Calderon, 1998). They presented with bizarre behavior, headaches, convulsions, and visions. Trials of antipsychotic medications, religious healers, and herbal remedies were unsuccessful and individuals only responded to shamans of the same ethnic origin. They concluded that the presentation was a reaction to the psychosocial stress of culture changes in their community.

Rootwork

Rootwork, according to the *DSM-IV-TR*, is a belief in the ability of an individual to influence another's physical well-being with hexes, witchcraft, or sorcery (American Psychiatric Association, 2000). Physical symptoms can vary greatly and are believed to be the direct result of the type of supposed magic at work. Treatment is typically sought from a special healer or "root doctor." While rootwork is primarily seen in the Southern United States and the Carribean, similar versions referred to as *mal puesto* or *brujeria* are present in Latin cultures. This condition is also very similar to mal de ojo, a Mediterranean belief in the ability of those who wish someone ill to effectuate that wish through the use of magic, referred to as "the evil eye" (American Psychiatric Association, 2000). Those who have been affected may exhibit crying, fever, poor sleep, or gastrointestinal distress.

Mathews wrote extensively of the traditional medical practice of African Americans which he identified as having roots in the "slave culture of the antebellum South" (Mathews, 1987). She identified illnesses which are conceptualized as "natural" under this framework, including hypertension, anemia, and diabetes, in contrast to those thought of as "unnatural," including magical possession, fading, and magical poisoning. Natural illnesses are believed to be caused by blood imbalances that can be cured by natural substances, including food and herbs, while unnatural illnesses have their roots in magic and require treatment by a root doctor who can undo the harmful spells. She concludes by emphasizing that rootwork serves psychological and social needs which cannot be met by the general medical community and the importance of physicians to communicate with their patients in a culturally respectful manner.

Séizisman

According to Nicholas, DeSilva, and Grey (2006), séizisman or "seized-up-ness" is a disorder of Haitians in which an extreme emotion or unexpected event or situation brings on a physical reaction (Nicholas et al., 2006). The extreme emotion can be in the form of anger or joy and can be precipitated by learning of injury or death of a loved one or witnessing a fight. The physical consequences are believed to be a result of blood rushing to the head. This can result in difficulty breathing, weeping, confusion, or a state of paralysis. The effects can last from hours to days. Treatment is typically in the form of a rallying of social supports, massages, and herbal remedies. A particularly concerning form of Séizisman involves pregnant women and those who have recently delivered. In this group, an episode of Séizisman is believed to carry the risk of miscarriage, maternal death, premature delivery, deformations in the fetus, or tainted breast milk. As a result, it is common in this culture to delay the giving of bad news until after delivery, in an attempt to shield pregnant women from exposure to stress; special accommodations may be made if bad news or stress cannot be avoided.

Susto

The *DSM-IV-TR* states that susto is a disorder in which an extreme fright causes the soul to leave the body (American Psychiatric Association, 2000). Susto goes by many names, including espanto, pasmo, tripa ida, perdida del alma, and chibih, and is believed to affect Latinos in the Americas. The symptoms of susto are various and include sleep and appetite disturbances, pain, gastrointestinal disturbances, sadness, difficulty with social roles, or even death. There can be a delay between exposure to the stressor and the appearance of symptoms, and the illness can last for months or years. Treatment is often sought from indigenous healers who work to return the soul to the body and restore the balance between body and spirit.

Weller and her colleagues interviewed 200 subjects in a family medicine clinic in Guadalajara, Mexico, to determine if there was an association between a history of susto and current depressive symptoms (Weller, Baer, Garcia, & Rocha, 2008). Over 69% of the sample reported a past history of susto. They found that a history of susto was not significantly associated with age, marital status, educational level, income, or a rural background. Individuals who reported a history of susto had significantly higher levels of current stress and depressive symptoms than those who did not. Individuals with a prior episode of susto were twice as likely as those without it to have a high current likelihood of depression.

Arctic/Subarctic

Pibloktoq

First identified by Abraham Brill in 1913, pibloktoq has also been referred to as Arctic hysteria (Dick, 1995). Pibloktoq was first observed in the Inuit people of Greenland and later in other arctic and subarctic Eskimo communities. The *DSM-IV-TR* defines pibloktoq as "an abrupt dissociative episode accompanied by extreme excitement of up to 30 min duration"

(American Psychiatric Association, 2000). During the episode, the afflicted individual may shout obscenities, remove clothing, become aggressive, or eat feces. An episode may be preceded by social withdrawal or irritability. Following an attack, the individual may display convulsions and "coma" lasting up to 12 h. Seizure disorders should be ruled out in individuals who present with symptoms of pibloktoq as should excessive levels of vitamin A which can be found in high amounts in arctic marine life and mammals and which comprises a large part of many Eskimos' diet and can cause similar symptoms (Landy, 1985).

Religious Experiences and Culture-Specific Diagnoses

Historically, certain religious beliefs have been considered culture-specific diagnoses. While these beliefs can impact presentation and treatment of mental illnesses, they should not be confused with culture-specific diagnoses. The belief in spirit possession is one such example that can be seen in many different religions, including the Caribbean religion of Santería (Alonso & Jeffrey, 1988). Santería is a combination of African and Catholic rituals and beliefs. One aspect of Santería involves festivals during which participants try to be possessed by spirits of saints. In 1988, Drs. Alonso and Jeffrey discussed clinical cases in which four individuals' psychiatric presentation was confounded by their belief and practice of Santería. An important point made in their article is that while these beliefs are associated with culturally based religious practice, they are distinct from culture-specific diagnoses. Beliefs in ideas such as spirit possession and communication with the dead can represent a culturally and religiously accepted norm (Alonso & Jeffrey, 1988). The authors report that an examination of an individual's adaptive functioning can help distinguish those whose beliefs cross the threshold of accepted cultural belief into delusion. They suggest a review of the person's ability to carry out usual activities, to use good judgment, and to appreciate the limitations of their beliefs to aid in the assessment (Alonso & Jeffrey, 1988).

Erika Bourguignon's 1976 article, "Possession and Trance in Cross-Cultural Studies of Mental Health," further elaborates on the prominent role of trances in many cultures (Bourguignon, 1976). Dr. Bourguignon points out that, when reviewing trance states, it is important to look at not just the state of consciousness the person is in, but also the cultural significance of the experience and the beliefs and practices that surround attaining and interpreting it. She emphasizes that the dissociative state that is typical of both trances and possession is not pathological in itself, just as the dissociation induced by hypnosis or suggestion is not by itself a sign of psychopathology (Bourguignon, 1976). The cultural significance given to this dissociative state is frequently religious or sacred, and can deal with soul loss, spiritual possession, or spirit quests among other culturally significant concepts. Dr. Bourguignon defines a nonpossession trance as an intrapersonal event frequently involving hallucinations, which is knowable to others in the community only through the self-report of the individual. In contrast, a possession trance is a group event in which the possessed takes on the characteristics of the possessing animal or spirit and the audience or observers serve an important role (Bourguignon, 1976). In her 1972 review of 488 societies, she found that 90% recognized some form of trance or possession state within their culture (Bourguignon).

The *DMS-IV-TR* is also careful to point out that not all of the culture-bound syndromes it describes actually represent an illness; they can, instead, be a normal part of religious, spiritual, and cultural life (American Psychiatric Association, 2000). The authors point out that while "spells" or trance states in which individuals communicate with deceased relatives or other spirits may be misconstrued as a psychotic episode, they are not to be considered as medical events. The authors also point out that zar, which presents with spirit possession, is not considered pathological within the African culture. As a result, these states can only be understood within the context of the role they play within a given culture. These experiences warrant treatment only if they vary widely from the culturally accepted parameters of the experience or if they cause the individual some form of distress or impaired functioning.

Criticisms of Culture-Specific Diagnoses

During the past 3 decades, numerous criticisms have been leveled at the field of culture-specific diagnoses. Many of these began as there was a move toward greater respect and acceptance of the cultural practices of non-Westernized societies and an improved understanding of the impact that cultural differences have on all aspects of health care. These criticisms have grown so strong that many practitioners and even the World Health Organization have moved away from utilizing this category of diagnosis, instead applying mainstream or "typical" psychiatric diagnoses when clinically indicated, accompanied by a notation about cultural factors that are present.

One major criticism of culture-specific diagnoses is the fact that many of the beliefs and symptom clusters that make up these "disorders" are considered normal within their given culture. For example, many cultures have a strong belief in the supernatural and believe that spirits and witchcraft play a prominent role in the etiology of disease. Some Haitians have been found to believe that supernaturally induced illnesses are real and can result from a variety of sources including strained relationships with God, curses from angered individuals whether living or deceased, or retaliation from an offended lwa or spirit (Nicholas et al., 2006). These religious and supernatural issues are believed to cause illnesses directly or to be indirectly responsible for weakening the person and allowing illness to occur. These beliefs can serve as a lens through which genuine physical ailments are understood in this culture and can serve a useful role in rallying social and spiritual support as an individual battles illness. While some of these ideas may seem odd to Westerners, so too may the religious beliefs of Christianity or Judaism seem strange to other cultures. Respect must be given to cultural and religious practices. Acceptance of these beliefs and behaviors as normal for a given culture or religion can be undermined by naming them as syndromes or diseases.

Another key criticism of culture-specific diagnoses has been the overlap between many of these disorders and other DSM-IV-TR and ICD-10 diagnoses. Even the architects of the *DSM-IV-TR* note several likely overlaps between certain culture-bound syndromes and other diagnoses (American Psychiatric Association, 2000). They suggest that such falling-out spells may represent a form of dissociative disorder or conversion disorder and boufée delirante may represent brief psychotic disorders. One theory of why new culture-specific diagnoses were created when already existing psychiatric diagnoses could have been used to account for behaviors is a sort of "culture-shock" on the part of the clinicians visiting these foreign countries. It is possible that the differences of these newly studied societies in which culture-specific disorders were identified were so striking to the scientists that they were unable to appreciate the even more significant similarities, and, thus, "new" disorders were discovered (Hughes, 1993).

It is not surprising then that the vast majority of the culture-specific diagnoses are found within non-Western cultures or aboriginal groups that may reside within the borders of Westernized countries but whose cultural practices are nonetheless alien from the majority. Ronald Simons and Charles Hughes point out that Western diagnoses are also "bound" within the culture in which they were created, but are not distinguished as such because the cultural factors were not as visible to Western clinicians as were the cultural factors of "exotic" societies (Simons & Hughes, 1993). While knowledge of the impact of culture on a patient's presentation and illness course is important, so too is an accurate diagnosis and unnecessarily distinguishing disorders that could appropriately be grouped together can have negative consequences on patient care. With improvements in genetic studies of illness, brain imaging, and medications approved for specific diseases, accurately identifying the illness has become even more essential. It is important to keep in mind that even if a more traditional psychiatric illness can be diagnosed, there is always a need to appreciate and understand the individual's cultural background. Cultural awareness is essential in framing and explaining the diagnosis to the patient and his or her family and understanding reactions to treatment recommendations. Additionally, in some cases, it may also be useful to enlist the aid of cultural guides or indigenous healers and remedies just as one might enlist the assistance of a clergy member in the treatment of a patient with strong religious convictions (Guthrie & Szanton, 1976).

In the 1980s and 1990s, a backlash against the ethnocentric focus of the culture-specific diagnoses and an increased understanding and appreciation of the role of culture in diseases led to the characterization of several diseases in industrialized nations as culture-bound. One of the first diseases to be conceptualized in this way was anorexia nervosa, a mental illness that is, in part, defined by fears of gaining or maintaining an appropriate weight and distortions in the way one's body shape and size are perceived (Swartz, 1985). This disorder was first seen almost exclusively in countries in which food was abundant and there was a social preference for thinness (American Psychiatric Association, 2000). Cases of anorexia nervosa became increasingly more common in less affluent nations as exposure to this Westernized ideal of beauty became more widespread (Sing, 1996). The geographic creep of this illness demonstrates that as cultural norms shift, disorders thought to be culturally tied can become embedded in new regions.

In 1982, Cheryl Ritenbaugh took this argument one step further, demonstrating how even obesity could be thought of as a culture-bound syndrome within the United States (Ritenbaugh, 1982). In her article, "Obesity as a Culture-Bound Syndrome," she traces the history of cultural ideas about weight from positive associations with fertility to religious denouncements of gluttony, to the prominence of a more adolescent-appearing female figure in media. Around the same time that popular notions of beauty began favoring slim, athletic figures, the general public was becoming more aware of the negative health impacts of obesity. She finds support for her theory of obesity as a culture-bound disease in the prominence within the culture of the United States of diet-aids and health spas, and the amount of funds spent on treatment and research of obesity and obesity-related illnesses (Ritenbaugh, 1982). Several other conditions were briefly considered as Western culture-specific diagnoses, including premenstrual syndrome (PMS) (Johnson, 1987) and dissociative amnesia (Pope, Poliankoff, Parker, Boynes, & Hudson, 2007), before this movement was replaced by a more general understanding of the role that culture plays in all disorders.

Another major criticism of the field is the lack of consistency in the identification of diseases that constitute culture-specific diseases. Prince and Tcheng-Laroche delineated several potential pitfalls in assigning a constellation of symptoms the status of culture-specific disease or culture-bound syndrome (Prince & Tcheng-Laroche, 1987). These include the use of different names to refer to the same constellation of symptoms in different regions; the impact of different geographic factors on physiology, such as low iodine in the soil leading to similar disease manifestations; epidemiological differences such as gender distributions, age of onset, and frequency; and subtle differences in presentation between different cultural groups that do not inherently change the disease nature, duration, or course. All of these factors make it difficult to establish which conditions should be considered culture-specific diseases. Claire Cassidy (Cassidy, 1982) and her colleague Cheryl Ritenbaug (Ritenbaugh, 1982) sought to create a clear definition of culture-bound syndromes. They identified a culture-bound syndrome as "a constellation of symptoms which has been categorized as a dysfunction or disease," characterized by one or more of four factors: an inexorable connection to the associated culture or subculture, an etiology which reflects behavioral norms of the culture, a reliance on culture-specific ideology and technology to diagnose the illness, and the inability of a cultural outsider to accomplish successful treatment. While this is helpful in understanding how they conceptualize these disorders, it is not a concise definition and has not gained wide usage.

The lack of solid studies and empirical data on culture-specific diagnoses has been another criticism of the field. In 1990, Guarnaccia suggested that a major limitation of cross-cultural psychiatry was that studies were typically undertaken with Western diagnostic scales (Guarnaccia et al., 1990). They suggested that instruments should be developed to assess symptoms of local illnesses. The use of standardized instruments would allow more empirical studies which could help to differentiate culture-specific diagnoses from other DSM-IV-TR and ICD-10 recognized mental illness or provide firm data that no such difference actually exists. Guarnaccia and his colleagues further encouraged the inclusion of individuals who are knowledgeable about the local culture and are able to act as ethnographical interpreters in the design and implementation of such studies (Guarnaccia et al.).

Implications of Culture-Specific Diagnoses on Immigrants

Over the last several decades, countries outside the United States have been plagued by armed conflict, dictatorships, gender oppression, poverty, famine, and a myriad of other hardships. Their struggles have led to an increase in migrations worldwide. In 2000, the United Nations considered one out of every 135 living individuals to be a "refugee" (Pumariega, Rothe, & Pumariega, 2005). In the United States, "first and second generation immigrant children are the most rapidly growing segment of the American population, with the great majority of this population being of non-European origin" (Pumariega et al., 2005). Given the diversity of cultural backgrounds among immigrants to the United States and other countries, physician familiarity with identifying and treating culture-bound illnesses is essential. Older immigrants are especially likely to express distress in a pattern that is consistent with their own traditions and practices. However, older immigrants are less likely to seek medical care, in large part due to Western psychiatrists being unable to properly recognize and manage their symptoms. One study looked at Korean American immigrants and found that their mental health needs were not being addressed due to an underutilization of psychiatric services in the United States. Access to treatment barriers include "failure of mental health services to provide culturally relevant interventions," "an inadequate number of trained mental health workers, especially psychiatrists who are culturally sensitive," and a "belief in ethnic traditional medicine" (Lee, Hanner, Cho, Han, & Kim, 2008). Language barriers and the stigma many ethnic groups place on mental health conditions further reduce the chances of an immigrant population receiving appropriate psychiatric care.

In addition, immigrants remain a high-risk group given the complexity of their social situation. Many of them face separation from their families, detention in refugee camps, and discrimination once they arrive in their new country. They inhabit crime-filled inner-city neighborhoods and cannot afford health insurance, a quality education, or job security. Mental health treatment becomes a low priority, and those that seek care are faced with physicians who are ill-equipped to recognize their presenting symptoms. Given the growing ethnic and cultural diversity of the world, the challenges mental health care workers face in providing culturally competent care will continue to grow. Health care systems across the globe need to develop comprehensive research programs that will help address the complexity of culture-bound syndromes and allow psychiatrists to understand and treat foreign born populations who present with symptoms unique to their background (Guarnaccia & Rogler, 1999).

In summary, while the study of culture-specific diagnoses has helped to broaden mental health practitioners' understanding of some unique conditions, it has also been criticized for its apparent assumption that behaviors that differ from those that are common in one's own culture are a disease or disorder. In the last 20 years, there has been an improved effort to view all mental and physical disorders through the lens of culture awareness. This has led to an improved understanding of what is considered normal behavior within a given culture. Knowledge of culture-specific diagnoses is beneficial as it expands practitioners' familiarity with unique cultural experiences and symptom presentations. It is only through our understanding of culturally acceptable behavior that we will be able to identify and help those individuals whose presentation differs from the acceptable and treads into the pathological.

Related Topics

- ► Amok
- ► Ataque de nervios
- ► Brain fag
- ► Cultural background
- ► Curandero
- ► Dhat
- ► Ethnicity
- ► Hwa-byung
- ► Kwashiorkor
- ► Mal de ojo
- ► Nervios
- ► Pibloktoq
- ► Sangue dormido
- ► Santería
- ► Shenkui
- ► Shin-byung
- ► Somatic symptoms

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Health Determinants

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Introduction

Health determinants are often used to explain why some people become ill while others remain healthy. Specifically, a health determinant refers to a factor or event that influences human health throughout life. While professionals may seek reasons for health and illness based on their training, a wealth of evidence now supports the notion that the socioeconomic circumstances of individuals and groups are equally *or more* important to health status than medical care and personal health behaviors, such as smoking and eating patterns. The pathways from social experience to biological change are not fully established, but evidence is beginning to emerge.

Acute and chronic illness, injury, and even genetically mediated disorders develop because of social, economic, and environmental conditions that exist in the places where the person has lived, and as a result of the ways that a person has chosen, or been allowed to live his or her life. Through complex processes not fully understood, human beings incorporate environmental and social experiences into their biology, and they do so throughout their lives from conception to senility. Theoretically, human social experiences are received much like sensory stimuli and translated into biological signals that may strengthen resistance to illness or lead to disease that manifests clinically later in life. This *sociobiological translation* (Tarlov, 1996) may be the single most important macro- determinant of health for all individuals, and it should be clearly understood by those who may provide care for newcomers to any country.

The Public Health Agency of Canada (PHAC) offers a representative and widely articulated view of the factors influencing human health. The PHAC (2010) determinants include: early child development, income, income inequality, poverty, social status, education, literacy, employment and working conditions, gender, personal health practices and coping skills, social environments, social support, culture, physical environments, political and economic environments, genetic endowment and biology, medical care, and health services. None of these factors acts in isolation, and it is the combined influence of all of them *interacting across the life course* that ultimately determines health status. These principles are the foundation for the discussion of specific health determinants in this entry.

The Life Course Perspective

A life course perspective offered by Kuh and colleagues (2003) explains developmental factors acting across the life course that influence a broad range of outcomes, from general health to the ability to perform activities of daily living and to chronic disease. At an individual level, cumulative and programmed patterns mediate a complex array of regulatory processes such as psycho-neuroendocrine and immune function during critical and sensitive periods. The essential elements of such a framework assert that health is a consequence of multiple determinants operating in nested genetic, biological, behavioral, social, and economic contexts that change as a person develops. Health development is an adaptive process composed of multiple transactions between these contexts and the bio-behavioral regulatory systems that define human functions. Different health trajectories are the product of cumulative risk and protective factors and other influences that are programmed into bio-behavioral regulatory systems during critical and sensitive periods; and the timing and sequence of biological, psychological, cultural, and historical events and experiences will influence the health and development of both individuals and populations.

Health Determinants

Early Child Development

The nutritional and environmental conditions experienced by the infant during gestation are included

Sana Loue & Martha Sajatovic (eds.), *Encyclopedia of Immigrant Health*, DOI 10.1007/978-1-4419-5659-0,

among the most important determinants of health because the conditions in which the fetus develops play a key role in regulating the function of its physiological systems later in life. This is sometimes referred to as intrauterine programming. Changes in the intrauterine availability of nutrients, oxygen, and hormones may program tissue development, and can lead to abnormalities in adult cardiovascular and metabolic function. The timing, duration, severity, and type of insult during gestation will determine the specific physiological outcome. Intrauterine programming occurs at the gene, cell, tissue, organ, and system levels and may cause permanent structural and functional changes that can lead to disease in adulthood.

As infants develop, they interact with their environment and in turn shape the experiences to which they must adapt mentally, physically, and socially. Through this process the child's behavior itself influences genetic expression. Stimulation and positive early experience in infancy and childhood have profound impacts not only on the development of those neural systems subserving cognitive, emotional, neuroendocrine, and neuroimmune functions but also on genetic expression of factors that modify the effects of stress hormone receptors, and therefore the individual's responses to stress, throughout life. Keating and Miller (1999) posit that as a result of this biological embedding, developmental trajectories are characterized by acquisition of competence and coping skills and by regulation of responses to new or challenging experiences. An example of the origin of such a trajectory is infant distress, integrating neurophysiological, behavioral, and social responses that help babies to regulate their emotions as well as to facilitate parental responses. Infants who are successfully able to regulate their attention, emotion, and social functions are better able to learn and to cope with new experiences and challenges. The quality of interpersonal relationships and social environment strongly influences infant developmental trajectories involving self-regulation, competence, and coping. These experiences set the stage for future competence in learning, formal education, and prosocial behaviors, although the mature brain continues to adapt to positive and negative environmental exposures throughout life.

Income, Income Inequality, Poverty, and Social Status

There is a connection between health and wealth, as a great deal of research demonstrates. Studies of income and mortality have shown lower mortality following higher incomes. Curiously, this relationship has only been demonstrated *within* societies; among the different countries in the OECD there is no relationship between per capita annual income and life expectancy beyond a threshold of about $US 5,000. There are significant exceptions to the rule that more income equals more health. In countries with the greatest income inequality, including the United States and the United Kingdom, health status and life expectancies are lower, even among the wealthy, than in countries where national income is lower but individual incomes are less unequal. For example, in Sweden, on average the poorest citizens live longer than the highest class of people in the United Kingdom. In some populations, notably among Hispanics of Mexican origin living in the United States, income appears to have less effect on health status than in the general population. Among them, life expectancies and other health indicators such as infant mortality tend to be better than expected given the level of material resources available. This so-called Hispanic paradox has been studied extensively in the United States (Franzini, Ribble, & Keddie, 2001).

A person's income is one of the principal determinants of both neighborhood of residence and housing quality, and several health indicators such as life expectancy are highly correlated with household welfare. These and other contextual factors influence health throughout an individual's life course. Among key determinants of population health such as social status, social affiliation, and stress, place matters. "Place refers to both geographical location and to group membership in terms of family, friends or age, and on the basis of class, ethnicity, residence, and gender that arise out of the (political), social and economic structure of society" (Kuh, Ben-Shlomo, Lynch, Hallqvist, & Power, 2003, p. 780).

Low socioeconomic status is one of the strongest predictors of poor health and development. Socioeconomic status (SES) is a measure of one's place in society variously based on income, education, occupation, and wealth. It is a relational concept that takes into account an individual's work environment, combined with their economic and social position relative to others. Beyond and in addition to the serious effects of material deprivation that those living in poverty experience, psychosocial factors may mediate many of the negative effects of relatively low socioeconomic status that are influenced by the neuroendocrine mechanisms of the stress response. Such psychobiological adaptation occurs at home and at work. It is demonstrated that stress harms health, particularly in the workplace, and that other psychological factors, mediated through social interaction may affect health either directly through conscious and direct individual-level processes, or indirectly by constraining behavior and lifestyle choices, although the interrelationships among these fundamentally significant processes are not fully understood.

Literacy, Health Literacy, and Education

There is an extensive literature dealing with literacy and various aspects of adaptation to society, such as functioning effectively in the general community and in the workplace. Health literacy is an important determinant both of health and social functioning. It must be regarded as a key issue for those individuals coming to the United States whose native language is not English, and also for the unfortunately large number of native-born Americans who have low literacy skills.

Whereas well-being and illness are influenced by biological, environmental, and social experiences that occur throughout the entire life span, the roots of learning, literacy, and the adaptive behaviors that sustain physical and mental health are established during the first few years of a child's life. These exert long-term influences on adult health and ultimately on community and societal function. Human learning and education are potentially critical mediators of the relationship between political, economic, and social factors, and health.

Recent evidence suggests that what an infant experiences during the first three or four years of life may be far more critical than previously realized in determining that child's ultimate intellectual capacity and its ability to cope with stress. An early environment rich with sensory stimulation and emotional nurturing greatly increases the likelihood of the child becoming a productive, emotionally stable, and resilient adult. There is a strong correlation between positive early life experience, *readiness to learn* on starting kindergarten, subsequent mathematics achievement and adult literacy.

Educational attainment is a powerful determinant of adult life experience through its probable influence on employment opportunity, earning capacity, personal mastery, social networks, and standard of living. Educational performance among immigrant youth may be influenced by their perception of family obligation (Kao & Tienda, 1995). In the United States, income and years of education are both strongly associated with adult health status. In particular, completion of high school education is significantly associated with reduction in adult mortality (Kaplan & Keil, 1993). The duration and quality of the educational experience also affect health and quality of life in adulthood through a variety of pathways (Ross & Mirowsky, 1999). Self-reported general health status has also been shown to be a good predictor of adult mortality and is positively associated with educational attainment (Idler & Benyamini, 1997). It seems that in many Western countries the longer you stay in school, the longer you will live. Immigrants, for example, deprived of economic and educational opportunities may suffer health consequences.

Employment and Working Conditions

The nature of employment and associated working conditions are powerful determinants of health since these are integral to economic security, social status, individual development, self-esteem, participation, relationships, work-life balance, protection from physical and psychosocial harm, and access to adequate health care services (World Health Organization [WHO], 2008). Primary concerns are: job and employment security; physical conditions at work; work pace, control (decision latitude) and stress; working time (duration, shift predictability, vacation time); opportunities for self-expression and individual development at work; participation and relationships at work; and work-life balance (Jackson & Polanyi, 2004).

Unemployed persons are at greatest risk for ill health due to economic strain and limited social support networks. Unskilled, temporary, and underemployed workers experience significantly higher mortality than permanent, skilled, or professional workers. Women and immigrants or migrant workers are most likely to be in the first three job categories. As well as forming a large part of the unskilled or temporary labor force, many immigrant noncitizens lack health insurance and receive little or no primary health care services.

A personal sense of control over one's life circumstances, particularly in the workplace, is a powerful determinant of health status. Marmot's Whitehall Study has demonstrated a steep gradient of mortality between the principal grades or job classifications in the British civil service. A man working in the trades or as a manual laborer is four times as likely to die in a given year as a man in an administrative position. Perhaps most striking is the fact that a male civil servant is twice as likely to die as his administrative boss. It appears as if one's position in the hierarchy in some way gets embedded in one's biology.

High rates of anxiety and depression affect many workers in North America, especially among those who are part-time, temporary, or lack a contract for employment. Work-related stress has been associated with reduced social support, unhealthy behaviors such as tobacco smoking and overuse of alcohol, and poor health outcomes such as a 50% excess risk of coronary heart disease (CHD).

Adverse conditions at work can contribute to physical and mental illness. Unsafe or unpleasant working conditions, especially in lower-status occupations, are likely to expose employees to health hazards. Blue-collar workers experience poorer health than their white-collar counterparts. Exposure to job strain incurs psychosocial stress associated with unpredictable shifts, long work hours, inadequate vacation time, high job demand and pace, low perception of control over decisions, low quality or level of work relationships, and discordance between effort and reward. Better employee health outcomes are associated with greater ability to shape working conditions, especially for safety. Overall, male workers are at greater risk for CHD but female workers may experience health problems due to work-life imbalance (i.e., the addition of household labor and care giving to their daily workload), particularly among low-income immigrant populations (Borrell, Muntaner, Sola, Artazcoz, Puigpinos, Benach, & Noh, 2008).

Employment status is a significant determinant of social status, economic well-being, access to health resources, and, ultimately, to health. Unemployment or working in unsafe conditions may cause poor health or disability, and poor health or disability may increase the likelihood of becoming unemployed, underemployed, or working in unhealthy environments.

Gender

Gender is a relational rather than a biological concept that is shaped by socially constructed roles for males and females within sociocultural groups. Appropriate personality traits, attitudes, attributes, values, and behavior are ascribed to women and men, and girls and boys. Depending on the social norms and economic well-being of a particular society, gender may be characterized by relative differences in opportunities and resources available to either sex. This may differentially affect the power of men and women to exercise human rights, to reduce exposure to health risks, and to access and use health information, care, and services. This role discordance may be associated with an imbalance between leisure time and paid or unpaid work, particularly among some ethnocultural or immigrant groups. Women are more likely than men to fulfill role-related responsibilities for domestic management and provision of care to family members while working outside the home. Chronic stress from this disparity may disproportionately affect women, contributing to ill health over time. Systematic inequalities are associated with gender-based social status and differences in health outcomes (WHO, 2002). On most socioeconomic gradients, women are more likely to be disadvantaged than men when race/ethnicity, low level of education, or single parenthood are factors that interact with gender.

In the United States, mortality for males and females has worsened since 1990 compared to all of Western Europe and several lower-income nations. In North America, women tend to outlive men due to lower rates of cancer, heart disease, fatal unintentional injury, and suicide. This is most apparent among 20–34-year-olds when rates of potential years of life lost before age 70 are almost three times as high for men than for women. While they are less likely than men to die prematurely, women experience greater morbidity such as anxiety, depression, chronic stress, autoimmune disorders, musculoskeletal dysfunction, allergies, and arthritis, as well as injuries and death due to family violence.

Personal Health Practices and Coping Skills

Beginning in childhood, personal health practices and coping skills allow people to enhance their ability to protect and promote their own health. This involves developing an adequate capacity for self-care, problem-solving and self-management skills, dealing effectively with stress, and making informed choices to prevent or reduce their experience of illness. An individual's health practices and coping skills reflect personal choices, which are influenced by socioeconomic environments that enhance or limit/prevent opportunities for healthy lifestyles and behaviors. Physiological and biochemical pathways also play an important role by linking individual social experience to adverse health events such as injury, cardiovascular conditions, HIV/AIDS, and cancer.

Factors that impact health behavior choices affect individuals within five domains as they live, learn, develop, work, and play. These are personal life skills; coping with stress; social relationships and belonging; and personal sense of control (PHAC, 2010). Personal life skills can be defined as an array of abilities required by all individuals to help them to thrive in everyday life. The most important are social skills that mediate the maintenance of healthy relationships, family interactions, and interpersonal communication. Personal skills may include self-reliance, discipline, self-organization, goal setting, respecting oneself and others, motivation, and managing performance outcomes. Application of these skills may assist an individual to cope with challenges that most human beings experience throughout the life course, permitting them to maintain a sense of well-being regardless of the level of stress they perceive.

Associated with trust and membership in a social group, a sense of belonging seems to be of particular importance as a protective factor across age, gender, race/ethnic, cultural, occupational, recreational, and socioeconomic groups. Underpinning the sense of self is one's perception of the locus of control, defined as the personal belief about what causes good or bad things to happen in one's life. From a health behavior perspective, an internal locus is associated with a sense of personal responsibility for health practice choices while an external locus (e.g., luck, fate, and other people's actions) suggests that other people or events are perceived to be responsible for health outcomes. A persistent external locus of control may contribute to poorer health.

Some health-risk behaviors are likely to contribute to illness or injury. Causes of premature morbidity and mortality vary by age, gender, and race/ethnic groups but Americans are most likely to die from heart disease, cancer, stroke, chronic lower respiratory disease, or accidents (unintentional injuries) (Centers for Disease Control [CDC], 2010). The risk to health increases when people engage in multiple behaviors associated with poor health outcomes, such as those experienced by individuals who combine alcohol or drug use with driving a motor vehicle, or with unprotected sexual activity.

Tobacco cigarette smoking poses one of the most significant health risks in the world, and is associated with up to one-quarter of all deaths among adults 35–84 years of age. Its effects are primarily on the cardiovascular, respiratory, and immune systems that lead to lung and other cancers, coronary heart disease, stroke, chronic respiratory disease, and other illness.

Other health-risk behaviors that contribute to preventable illness and mortality are poor nutritional practices, especially the intake of excessive dietary salt and *trans*-fatty acid and inadequate dietary omega-3 fatty acid, and a sedentary lifestyle associated with nearly 1 in 10 deaths from overweight and obesity and physical inactivity (Danaei, Ding, Mozaffarian, Taylor, Rehm, Murray, & Ezzati, 2009). Ranked 11th as a cause of mortality, suicide was cited as the cause of 33,000 deaths in 2006. This lethal form of intentional injury is closely linked to depression and other types of mental illness, substance abuse disorder, family history of suicide, family violence including physical and sexual abuse, marital separation and divorce, firearms in the home, and poor coping skills (National Institute of Mental Health [NIMH], 2009).

Ultimately, personal health practices and coping skills shape many individual health outcomes within the context of socioeconomic and physical environments throughout the life course. People's beliefs, attitudes, and skills influence their capacity to promote or adversely affect their own health as well as the health of other people around them.

Culture, Social Environments, and Social Support

The term *culture* implies a particular way of viewing social relationships that are established over time within specific groups of people who share common beliefs, values, and perceptions of normative behaviors and practices. Within one's perceived cultural sphere, an individual may choose to adopt health behaviors that are more or less risky to them and to others living and working in proximity. Strong social connections and networks, especially of others within one's culture, may serve to protect people from illness and harm.

The nature of the society in which we live matters greatly to our health. Social support is a significant factor in promoting and maintaining healthy lifestyles at an individual and population level, probably as important as risk factors such as hypertension, obesity, and smoking. Individual and community-level support offers practical and psychosocial resources to help people to cope with daily stress, illness, and many of life's challenges. Low levels of emotional support and social participation are associated with increased overall death rates.

A supportive society is one whose values and norms contribute to a variety of assets such as social stability, safety, positive working relationships, respect for diversity, and cohesive communities that reduce many potential risks and provide opportunities for healthy behavior choices. Such social cohesion and civic vitality depend on strong formal and informal social networks within a community, region, state, or nation through institutional, organizational, and individual support practices that share resources and strengthen interpersonal and group affiliations (PHAC, 2010). Life expectancy is greater in states and regions where there is broad participation in civic affairs and a high degree of social trust. States where there are high rates of volunteer activity report lower mortality rates and incidence of heart disease.

Lack of social support can also arise from lack of provision or access to social goods and services (e.g., language services for immigrants, housing for the homeless, and legal sanctions to prevent discriminatory practices). Without adequate opportunity for contributing to society, people may not be socially active or productive and they may face inadequate or unequal access to means of livelihood. Recent immigrants are often considered to be among the most marginalized groups in US society, encountering high risk for reduced earning capacity, increased poverty, unemployment or underemployment, discriminatory practices in the workplace, segregation due to lack of equal access to neighborhood housing, contact with the criminal justice system, reduced access to health care services and insurance, and poor experience of overall health. For example, many children living outside the United States may endure long-term separation from their migrating parents if they must remain in their country of origin, often with inadequate supervision that may lead to harmful consequences such as sexual abuse or neglect (Pottinger, 2005). Among Mexican-origin Latinos, the largest immigrant group in the United States, family support is positively associated with self-rated physical and mental health, while family cultural conflict may be negatively associated. This conflict may arise, in part, from different generations' culturally-related beliefs and behaviors and appears to be mediated by language, although the mechanism for this is not well understood. Although important for community cohesion, Latino neighborhood-level social cohesion may not be significantly related to self-rated physical or mental health when the effects of education, income, and other demographic measures are taken into account (Mulvaney-Day, Alegría, & Sribney, 2007). Overall, however, social networks and number of social contacts seem to matter to everyone's health, regardless of cultural background, age, or gender.

At the other end of the spectrum of social support and community cohesion, violent crimes pose serious threats to health. Worldwide, women and children are most likely to be exploited by human trafficking and transported to US destinations. In the United States, experience of family violence tends to follow race/ethnicity. From 2006 to 2008, the US child mortality rates due to assault, negligence, and maltreatment were the highest among all countries with reliable data – three times higher than other Organization for Economic Cooperation and Development (Organization for Economic Cooperation and Development [OECD], 2010) nations except for Mexico. Indirectly, an individual's health may be adversely affected over time through lost productivity or ability to work or attend school, increased need for mental health and medical care, as well as greater involvement with law enforcement and criminal justice systems.

Physical Environments

Aside from the importance of clean air and water, proper waste disposal, absence of toxins from the soil, and adequate control of disease vectors, the environment in which we live our daily lives has profound effects, especially on gestating mothers, infants, and children. North Americans on average now spend 90% of their time indoors, in their homes, schools, workplaces, recreational facilities, shops and malls, etc. The broader built environment of human settlements (villages, towns, suburbs, and cities) is also important, because these are not only physical environments, they are also social environments where people gather and relate to one another.

In addition to being safe and providing shelter, housing also should be hygienic. This means having clean water, sewage and solid waste removal, and clean food storage and preparation areas. These subjects have been at the core of traditional public health work for many decades. Housing should also support mental and social well-being – it should be attractive, pleasing, and well maintained, preferably with green space and play areas for children.

The quality of the urban built environment is also important to health. Outdoor air pollution comes from industry and from motor vehicles. Particularly in the summer months, nitrogen oxides and volatile organic carbons from these sources combine to form ground-level ozone, while particulate pollutants and acid emissions contribute to smog in summer or haze in winter. Motor vehicle accidents are a major cause of death and injury. Traffic noise is a major irritant, while large roads and highways impede access for pedestrians and isolate neighborhoods from each other. Urban settlements also contribute enormously to water pollution. Human wastes, industrial wastes, urban runoff from the streets and parking lots, pesticides and herbicides from parks, lawns, golf courses, and gardens – all end up in rivers, lakes and streams.

The design of urban environments also has an important influence on crime and violence. It is not just the violence, but the fear of violence that is debilitating. If people do not feel safe, they will not use their community's streets and facilities, and increasingly will wall themselves off in gated neighborhoods. This only serves to increase the isolation and the disparity between rich and poor, young and old, Black and White. Indeed, the social impacts of the urban environment are at least as important as the physical impacts. High-rise apartments, deserted streets, poor public transportation, gated communities, urban sprawl – these and other aspects of modern cities can contribute to isolation, lack of access for the disadvantaged, and alienation.

Housing quality is one of the principal determinants of children's health, both while they are children and later as adults. Persistent cold, dampness, mold, fungi, pesticides, lead-based paint, vermin, insects including mosquitoes, cockroach droppings, and a host of other household contaminants and agents all have negative effects on a growing child. Immigrants in rural and urban areas experience many of these conditions in the colonias, refugee camps and other locations where they may have to live. The health effects of negative exposures in childhood last a lifetime, even if the individual's economic status increases later in life.

Political and Economic Environments

Governments and their policies are important and can have profound effects on health. Aside from the obvious negative health effects of war and conflict in which civilian women and children always suffer the most, administrative decisions about resource allocation, taxation, income redistribution, education, provision of health services, infrastructure development, transportation, food and water supply, personal safety and security and social services all have some effect on the health status of many individuals in the population.

It has been clearly demonstrated that in some countries, income inequality itself is associated with poorer health for those at the lower end of the scale. These economic inequalities are not accidental. They result from decisions made about taxation policy, home ownership, business regulation, welfare and unemployment benefits, education funding and access, healthcare funding, etc. For example, market-generated child poverty in Sweden, the United States, and the United Kingdom is 23.4%, 26.7%, and 36.1%, respectively. Tax and transfer policies in Sweden reduce this child poverty burden to below 3%, while in the United Kingdom it is only reduced to about 19.8% and in the United States to 22.4%, and child poverty is a powerful determinant of health (Graham & Power, 2004). Among developing nations, the Indian state of Kerala has long been cited as a model of what can be accomplished with very little in the way of material resources. Average incomes there are very low, but inequalities are deliberately minimized in law and the people enjoy the highest rates of literacy and the longest average life expectancy on the Indian sub-continent. By contrast, in Britain, the economic reforms of the Thatcher era were followed by increasing death rates among the lower classes. As Nobel laureate Amartya Sen (2002) has said, "Health is an exquisite mirror of social circumstances."

Genetic Endowment

Genes determine many things about us, including normal biological characteristics such as eye and skin color, hair pattern, earlobe shape, blood type, and probably longevity. They are also responsible for a number of abnormal conditions and diseases. Because parents pass on their genes to their children, like certain aspects of physical appearance, some diseases tend to cluster in families. Comparing the genes of people affected by a disease with the genes of unaffected people has revealed genetic variations that substantially increase the risk of age-related macular degeneration, type 2 diabetes, Parkinson's disease, and heart disorders, for example.

Cell division involves a network of signals that work together to determine when and how often a cell will divide, and how errors can be fixed. Cancer occurs when cell division gets out of control. Mutations in one or more of the nodes in this network can trigger cancer, through exposure to some environmental factor (e.g., tobacco smoke) or because of an inherited predisposition, or both. With some exceptions, no single risk is sufficient to trigger the development of cancer. Many factors other than genes, including diet, exercise and environmental exposures will determine health and malignancy risk.

Biology and Disease

Ultimately, disease will manifest as some kind of disturbance of normal biological functioning. The nature, extent, and location of the disturbance will constitute a disease that can be labeled and understood in the western scientific tradition, but may be viewed very differently by those who follow the much more ancient traditions of China (Qi or Chi), India (Ayurveda), or Africa, for example. Caregivers should be aware that they may form the entire foundation of beliefs about health and disease of many newcomers to America and native-born citizens alike.

The top ten leading causes of death worldwide (according to western science) are heart disease, cerebrovascular disease, respiratory infections, HIV/AIDS, chronic pulmonary disease, perinatal conditions, diarrheal disease, tuberculosis, malaria, and respiratory tract cancers. Some of these, like HIV/AIDS and malaria are most prevalent in one region of the world or another, while others like heart disease and stroke are ubiquitous, and the prevalence of these chronic diseases is growing. Heart disease, stroke, cancer, chronic respiratory disease, mental illness, and diabetes together account for half of all deaths worldwide. Cardiovascular disease is now the leading cause of death in all regions of the world except sub-Saharan Africa. These chronic diseases are related to lifestyle and the environment, most particularly unhealthy diets, lack of physical activity, tobacco use, harmful alcohol use, certain infectious agents, and air and water pollution. Those conditions that contribute most to disease burden are poor sanitation, lack of potable water, little or no access to health care services, low levels of education, and undernutrition – all associated with poverty.

Infectious diseases previously considered under control are experiencing a major comeback, especially in those areas of the world where the climate is warm and damp. Infectious diseases may require an intermediary insect host or vector such as a mosquito or tick, or zoological hosts like swine or cattle. Some infections are spread through direct contact sexually or through contact with inanimate objects (fomites), contaminated food or water, blood products, or respiratory droplets.

Emerging and reemerging diseases are a growing concern, including HIV/AIDS, Ebola, severe acute respiratory syndrome (SARS), avian influenza, West Nile virus infection, malaria, and tuberculosis. Vector-borne diseases are reemerging for a number of reasons including resistance to pesticides, climate change and changes in agricultural practices. Malaria is the most important infectious disease worldwide, and ninety percent of cases occur in Africa. Among the sexually transmitted illnesses (STIs), 95% of those with HIV also live in developing countries, accounting for more than 25 million deaths since 1981 (Avert, 2010).

It should not be overlooked that while they are generally not killers, syphilis and gonorrhea are more common than HIV. The incidence, prevalence, and mortality due to STIs continue to increase. Finally, tuberculosis is a problem in every low-income country in the world and is a growing problem in the United States. One-third of the world's population is estimated to be infected, and successful treatment requires multiple medications to prevent the development of resistance.

Medical Care and Health Services

The saving of lives in acute life-threatening emergencies is an important contribution of medical care to health, but that is a small part of the total medical effort. Much larger efforts are devoted to preventive or curative measures, and an even greater proportion of the total is devoted to preventing or to minimizing the poor quality of life associated with chronic disease (i.e., to the relief of pain, disability, and disfigurement).

Since the 1960s, advances in medical technology and scientific knowledge have both contributed greatly to human well-being. Much of the benefit has been due to advances in dealing with newborn babies (notably the availability and use of surfactant) managing heart disease, particularly acute myocardial infarction, and prevention of stroke with TPA. According to John Bunker, one of the few investigators who have attempted to quantify the contributions of medical care to health, medical care is now the major determinant of life expectancy.

Health care is not available, accessible, and provided equitably to all people in many nations, including the United States. Research by the Institute of Medicine revealed that racial and ethnic minorities tend to receive a lower quality of health care than nonminorities, even when insurance status and income are controlled. Patients may not look for necessary care because they fear being misunderstood or disrespected, or may not adhere to medical advice because they do not understand or trust the provider. Language barriers have a negative impact on utilization, satisfaction, and compliance with prescribed care. Improving the quality of physician–patient communication and cultural sensitivity enhances outcomes.

Conclusion

All of these health determinants were summarized by Sir Michael Marmot (Wilkinson & Marmot, 2003), a pioneer in the field of population health research, who noted there are some "solid facts" that can be relied upon by caregivers and policy makers alike. Regardless of their country of origin, people's social and economic circumstances affect their health throughout life; stress harms health; the effects of early life experience last a lifetime; one's life context matters, including the family and neighborhood; functional literacy and education are major determinants of health and life success; social exclusion creates misery and costs lives; social support matters; stress in the workplace increases disease; a personal sense of control and reward for effort matter greatly; unemployment and job insecurity have powerful negative effects on health; dietary intake and food security are very important but the availability of healthy food is a major political issue in virtually all countries; and environmental degradation is dangerous to life and health. Many of these factors influence the health of immigrants who may experience life course events that disrupt their family and social networks, place them in impoverished environments exposed to health and safety risks, and compromise their basic food and nutrition sources. Education and health care are often inaccessible to them, while economic, language, and cultural barriers impede their healthy development. Understanding health determinants and their effects can lead to a more informed approach to health and social interventions in this vulnerable population.

Related Topics

- ► Access to care
- ► Community
- ► Disease prevention
- ► Health beliefs
- ► Health disparities
- ► Housing
- ► Poverty

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Occupational and Environmental Health

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The Boundaries Between Occupational and Environmental Health and Safety

Occupational and environmental health are often considered together because they are largely similar and, in many ways, overlap or intersect with each other. Indeed, the boundaries are mostly social rather than scientific. In the USA, the same individual who is in a car crash while driving for work would be classified as an occupational injury, whereas if the crash occurred under identical circumstances off work time it would not be considered occupational. Likewise, a waiter who is exposed to secondhand smoke at the restaurant where he/she works has an occupational exposure, whereas if he/she were a customer in that same restaurant, his/her exposure would be environmental.

The political separation into occupational and environmental exposures has led to distinct regulatory approaches. Critically also, exposures at work often differ from those in the general populations both in form and intensity. While secondhand smoke exposure and car crashes may be similar in both spheres, in other instances workers may be exposed to much more intense repetitive strain injuries (meat cutting, for example) or more concentrated airborne pollutants due to being close to the source. In addition, susceptibility to harm may differ as the general population includes children, elderly people, and people too ill to work.

Thus, we accept the bifurcation into occupational and environmental categories and frame both this chapter and the entries in the encyclopedia along these lines.

Where Immigrants Live and Work

The International Organization for Migration estimates that there are 214 million international immigrants. The countries hosting the largest number of immigrants are the United States, the Russian Federation, and Germany. According to the International Organization for Migration (IOM), those sending the most immigrants are China, India, and the Philippines. Wikipedia reports that net immigration is mostly from low-income countries to high income countries (➲ *Fig. 1*).

Reasons for immigration may differ considerably and range from fleeing violence or political persecution to seeking economic opportunities, to following family members, among many other reasons. But the majority of immigrants move from lower-income settings to economies where they at least perceive that they can make economic gains. Thus, these immigrants are usually at or near the bottom of the economic ladder when they arrive. If they have a limited proficiency in the dominant language(s) of their new home, that might also hold back their advancement. These are important factors when thinking about environmental and occupational health as the housing, neighborhoods, and jobs that these people find are driven by their social situation. In general, recent immigrants will be concentrated in the worst living and working conditions, living in low-income or public housing that may be poorly maintained in neighborhoods with multiple social problems and working in jobs, often hazardous, that the higher income native populations are unwilling to take.

Sana Loue & Martha Sajatovic (eds.), *Encyclopedia of Immigrant Health*, DOI 10.1007/978-1-4419-5659-0,

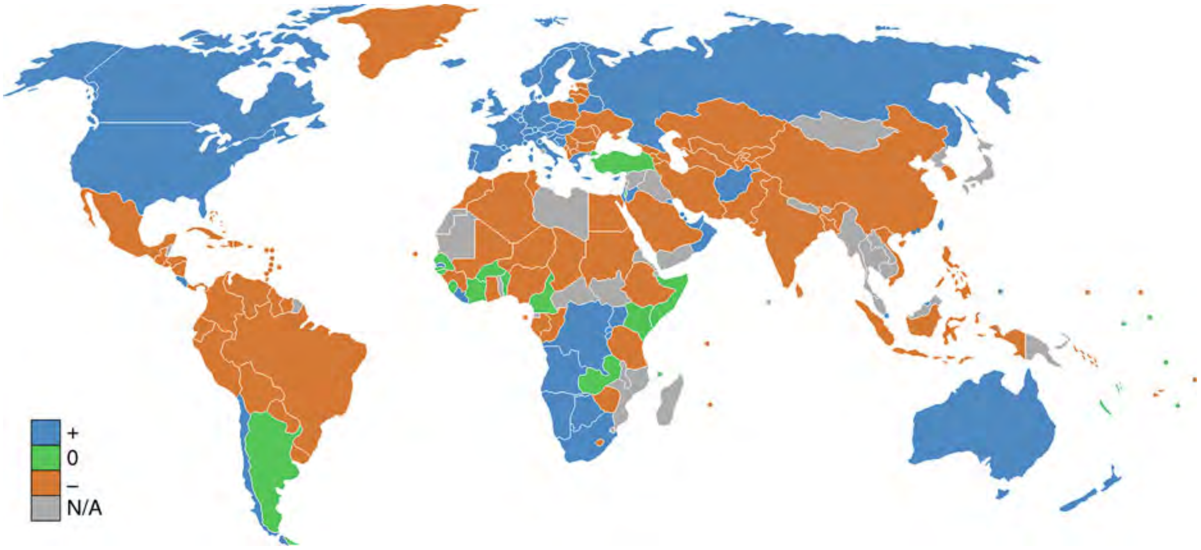

Fig. 1
Net migration rates for 2008: positive (*darkest*), negative (*dark*), stable (*light*), and no data (*gray*) (http://en.wikipedia.org/wiki/File:Net_migration_rate_world.PNG)

Environmental Health

Air Pollution

Ambient Air Pollution

There is a deep and growing literature that shows that ambient air pollutants, including particulate matter, ozone, oxides of nitrogen, carbon monoxide, sulfur oxides and others, adversely affect the health of people. While pollution levels are greatest for most contaminants in major cities in the developing world, Beijing or Mexico City for example, it is also clear that the relatively lower levels of pollution in North America and Europe are still sufficient to elicit adverse health outcomes, including increased mortality.

Most research on ambient air pollution has either not included or not separated out immigrants from nonimmigrants. This situation may be changing with studies such as the Multiethnic Study of Atherosclerosis air pollution sub-study which includes large numbers of Chinese and Hispanic Americans (Diez Roux et al., 2008). Critical to the case that immigrants might have different exposures to air pollutants is the fact that these pollutants vary across time and space so that some people will be exposed more than others, even within a single city. The ways that pollutants vary are complex and differ by type of pollution. For example, ozone is a regional pollutant that forms at a distance from the source of its precursors. Conversely, the smallest particulate pollution, ultrafine particulates, is elevated mostly within hundreds of yards of major traffic routes.

A small number of air pollution studies have reported analysis of air pollution data by immigration. One team of researchers looked at "air toxics" levels as reported by the US EPA in relation to multiple demographic factors, including immigration. One of their studies, which converted toxic air pollution levels in California into predicted cancer risk, found, after controlling for many possible factors, that census tracks with higher percentages of recent immigrants had a statistically significant association with cancer risk (Pastor et al., 2005). Another study by this team suggested that, again in California, Latino and Asian children had higher exposure to air pollutants and, consequently, higher "respiratory risk." Further, this analysis suggested a possible relationship to lower academic performance (Pastor et al., 2006). A third study in this series found that residential segregation was associated with estimated cancer risk for Asian and Hispanic populations across the USA (Morello-Frosch & Jesdale, 2006).

A second team, working with data from Phoenix, Arizona, found that Latino immigrants experience higher levels of carbon monoxide independent of their socioeconomic status (Grineski et al., 2007), but found no association of Latino immigrants with asthma hospitalizations in a separate analysis (Grineski, 2007). US inner city populations, which include many immigrants, have higher exposures to air pollution and may experience poorer health outcomes, especially cardiovascular and respiratory, as a result of those exposures.

Clearly the literature to date does not adequately answer the question of how different ambient air pollution exposures and risks are for immigrant communities compared to native-born communities. That the literature is US-based leaves a particularly large gap. But the findings, limited as they are, suggest greater exposures and health risks for immigrants.

Indoor Pollution

In developed countries, people spend a large percentage of their time indoors, including time inside their homes. Thus, in these countries indoor exposures, including infiltration of ambient pollutants, are more important than outdoor levels. Time spent indoors may be much less in developing countries, but sources of indoor pollution may be more extreme, for example, poorly ventilated smoke from solid fuel fires used for cooking. It is worth noting that this means that many immigrants who move from developing countries to developed countries experience dramatic changes in the nature of their indoor exposures.

Combustion is a significant source of indoor exposure via inhalation. Indoor combustion products, whether from a wood fire or a gas stove or from infiltration from outdoors, include particulate matter, polyaromatic hydrocarbons, carbon monoxide, oxides of nitrogen, and sulfur oxides. All are well known to be toxic and to cause or exacerbate health problems. For indoor combustion, exposure may be particularly high since dispersion of the pollutant is impaired by the enclosure of the building.

Other important indoor contaminants include products of biological organisms, pesticides, lead in paint, asbestos, and secondhand tobacco smoke, among others, some poorly studied or not well defined. Biological contaminants include cockroach, dust mite, cat, dog, and rodent antigens. In people who are immunologically sensitive, one or more of these antigens may contribute to allergies and asthma. Some of these exposures, cockroaches for example, may be more common in low-income housing more frequently occupied by immigrants, while others may be preferentially found in higher income suburban homes, such as dust mites.

Pesticides, often applied indoors to counter pest infestation, may accumulate and remain on surfaces for relatively long times and many are nerve toxins and/or carcinogens. Lead paint is found on indoor surfaces in countries, the USA, for example, that did not ban its use following early indications of its toxicity to children.

The difference in time spent indoors and in the sorts of exposures encountered indoors may be an important change for immigrants who move from developing to developed countries or from rural to urban settings in the course of immigration. For example, a report from Washington State in the USA found that a majority of carbon monoxide poisonings were among immigrant families during storm and power outages, and that burning charcoal indoors to stay warm was a common error on the part of these families (Gulati et al., 2009). A study from Boston, Massachusetts, found that pesticide residues in public housing often included restricted use pesticides that were not supposed to be applied in homes (Julien et al., 2007). Hispanic families were buying these pesticides at local bodegas and using them, undiluted and without training on their hazards, to counter cockroach infestations in their apartments.

Biomass (coal, wood, charcoal) is widely used as fuel for cooking and heating in much of the world. Burning biomass produces large quantities of smoke that is poorly dispersed in many indoor environments, exposing residents to particulate matter, oxides of nitrogen, carbon monoxide, and other combustion products. These pollutants have been associated with disease, including respiratory diseases, cancer, ear infections, and low birth weight. In 2000, as many as two million deaths may have resulted from this practice, perhaps half in children.

Assessing exposure to this form of indoor pollution is complicated by the fact that levels of smoke are variable, rising, for example, when fuel is added to a fire, and due to variability in proximity to the fire. However, it appears that women are exposed more than men. Well-defined dose-response relationships have been reported when careful assessment of exposure was undertaken, with an almost eightfold increased risk of acute respiratory infections at the highest exposure levels. Intervention programs aimed at reducing exposure and associated health impacts need to account for actual circumstances in the field, not just idealized performance of, for example, stoves designed to reduce exposure (Ezzati & Kammen, 2002).

Secondhand Smoke

Secondhand tobacco smoke (SHS) is a mixture of thousands of substances, both gasses and particulate matter, many of which are known or suspected carcinogens and have other toxicological properties, including effects on the cardiovascular system. SHS is produced both during inhalation by the smoker and while the resting cigarette (or other tobacco product) smolders. The smoke produced during active smoking is called “mainstream” smoke and that produced while smoldering is “sidestream” smoke. Because sidestream smoke burns at a lower temperature and achieves less complete combustion, it may contain more toxic substances.

Exposure to SHS has been linked to cardiovascular disease, lung cancer, asthma (both occurrence and exacerbation), middle ear infection, pneumonia, low birth weight, and sudden infant death syndrome. In the 1990s the strength of the science was contested in widespread public debates in the USA with the tobacco industry and restaurant associations being the main skeptics, but the evidence base is strong and broadly accepted in the scientific community and there is much less doubt among public and industry groups expressed today.

Internationally, the regulation of smoking indoors varies widely, with at least some countries on every continent enforcing strong bans. Some countries have weaker regulations and some have a patchwork of rules that are enacted for locations within the country, such as states, provinces, or cities (➲ *Fig. 2*).

There is no overarching federal regulation or law in the USA that restricts exposure to SHS at work, making the USA a prime example of a piecemeal approach to regulation. The US Occupational Safety and Health Administration would be the agency to issue such rules, but it has not done so despite the fact that SHS is present in greater amounts and is more toxic than many other occupational exposures that are regulated. Thus, municipal and state regulations vary considerably from jurisdiction to jurisdiction, ranging from nonexistent to bans on smoking, especially in restaurants (American Nonsmokers’ Rights Foundation, 2010).

Although also subject to considerable debate in the past, it is now widely accepted that ventilation cannot reduce SHS to acceptable levels. This is largely because the level of air exchange needed to dilute the tobacco smoke would be far too great to be practical or cost effective. One calculation found that there would need to be over 220 changes of the air per hour in a 100 m^2 office in which two cigarettes are smoked per hour (Repace & Lowrey, 1985).

Today the leading edge for control of SHS exposure in locations where workplaces have been or are largely restricted is in-home exposure. Of particular concern are children and nonsmoking spouses of smokers.

For immigrants the SHS issue will depend considerably on the regulatory framework, or lack thereof, in their country of origin and the framework (or again lack thereof) in the country to which they have moved. Thus, an individual immigrant or his or her family might have moved from little or no regulation of smoking to more strict regulation and enforcement. Or they might move from a place with strong bans to a place with none or limited enforcement. Or, it is also possible to make a lateral move where the acceptability of smoking does not change much.

A common circumstance is for immigrants to move from locations with few or no restrictions on smoking (much of Africa and Asia) to places that enforce bans (parts of Europe and North America). This circumstance puts recent immigrants in a position in which they have to learn a new cultural and legal norm. Because of what is often a rapid immersion into the social environment of their new country, these immigrants may not understand the rationale behind bans or restrictions that have been debated in their adopted country for years before they arrived.

One consequence may be that immigrant enclaves enforce smoking bans or restrictions less vigorously than in other locations. But it is also possible that in

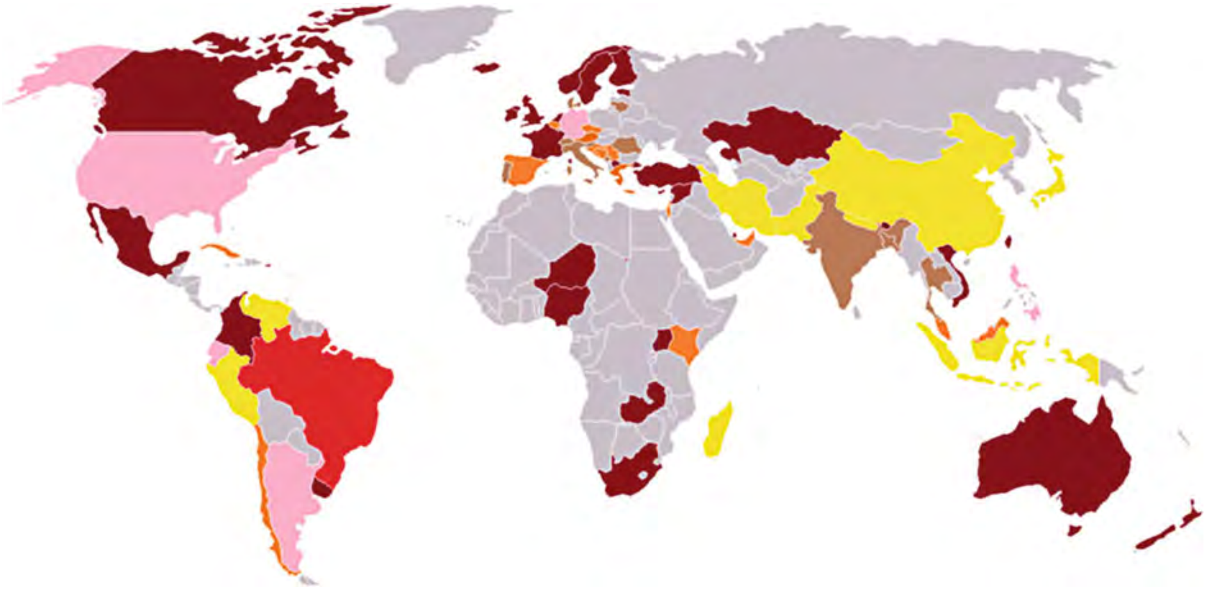

Fig. 2

Smoking bans worldwide as of Feb 8, 2010: ☐ no restrictions or no data; 🟨 patchy and incomplete bans, low enforcement; 🟪 no national ban, some localities have comprehensive indoor bans; 🟧 strong national ban in public areas except entertainment and restaurants, or weak enforcement in indoor entertainment areas; 🟥 strong national ban in public areas except entertainment and restaurants, some localities have comprehensive indoor bans; 🟫 strong national ban in all public indoor areas. Note: Countries with all subnational entities having a ban equates to a nationwide ban here, such as for Canada and Australia (http://en.wikipedia.org/wiki/List_of_smoking_bans)

countries with a patchwork of different smoking policies, immigrants are more likely to work around smokers because of "occupational segregation." That is, some jobs are less likely to have smoking bans than others. For example, a ban may be in place in restaurants, but not in all workplaces, leaving, again for example, warehouse workers free to smoke. Consistent with this, a 2009 study found that in a representative sample of the US population, persons of foreign birth were less likely to be covered by smoking bans than were US-born workers (Osypuk et al., 2009).

In what is perhaps a contrasting example, another 2009 study compared Mexican families living in two cities in Mexico or in one city in California. California has more strict smoking control programs than does Mexico. The study found that voluntary smoking bans were more common in the USA than in Mexico, while smoking prevalence was higher in Mexico. Importantly, smoking bans appeared to be more effective at reducing SHS exposure in the USA (Martinez-Donate et al., 2009).

In most legal jurisdictions with relatively strong programs aimed at reducing smoking and limiting exposure to SHS for nonsmokers, the extension of these programs to recent immigrant populations is in the early stages of development. Extending cessation programs and education about the need for and the legal prohibition on smoking to recent immigrant populations may entail both linguistic and cultural translation. Effective translation across both domains is not necessarily easy and certainly requires more than rote translation of words from one language to another. For example, Brugge et al. (2002a) developed message concepts for Vietnamese and Chinese immigrants living in Boston, Massachusetts. The approach was to understand better the values and concerns of the populations first through a series of focus groups and then to test messages derived from what was learned by showing them to people from the target populations. There is a need for more efforts not only to develop educational materials in this fashion, but also to assess their efficacy through empirical tests.

There may be wide variation of opinion among immigrants from different countries and living in different adoptive countries. However, a recent study (Osypuk & Acevedo-Garcia, 2010) found that immigrants in the USA were overall more supportive of smoking bans the more recently they had immigrated, with a gradient of decreasing support from first generation to third generation immigrants. While, as the authors suggest, this might be an opportunity to find allies to support tobacco control, it may also suggest that with time in the USA, and acculturation, their support for restrictions declines. Acculturation appears to be associated with being less likely to let people smoke in the home, at least among Asian immigrants in the Delaware valley. But the associations for acculturation variables were not statistically significant and stronger associations were seen for education, family size, current smoker in the household, and being Korean or Vietnamese (Ma et al., 2004). There is evidence, not surprising perhaps, that for Asian immigrants at least, social factors, including avoidance of conflict, contribute to attitudes toward smoking bans in ways that they might not for US-born residents.

Thus, it seems likely that we are only scratching the surface of what is a complex issue that deserves considerably more attention to be well understood.

Water Pollution

Infectious Diseases

Numerous infectious agents are transmitted through environmental exposure (in contrast to contagious organisms transmitted person to person, which we will not consider here). These environmental threats are often not as well known as diseases that are transmitted person to person, but they account for substantial morbidity and mortality worldwide. Among the most common of these diseases are:

- Helminthes, intestinal worms including Ascariasis, Trichuriasis, and Hookworm
- Schistosomiasis
- Elephantiasis
- Trachoma
- Onchocerciasis
- Leishmaniasis

Ascariasis is the most common, with prevalence above 800 million individuals infected, while other intestinal worms are not far behind with hundreds of millions of people infected. Schistosomiasis is also common with over 200 million cases. These diseases are usually contracted through unsanitary conditions, such as contact with human feces or water into which people have urinated. In some cases, the organisms pass through another species, as with Schistosomiasis and certain species of snails. In other cases, they pass through a soil phase and re-infect humans (Hotez, 2008).

These diseases are found mostly in rural, low-income populations in the developing world and are rarely present in cities where sewage systems, pavement, and shoes all interfere with their life cycles. They are chronic diseases that are rarely fatal, but can cause disability and disfigurement (Hotez, 2008). It is thought that these diseases have been with humans, and other vertebrates, for millions of years. Our coevolution probably explains the low-grade response to these infections. Indeed, the hygiene hypothesis suggests that infections such as these may modulate the immune system and that in their absence we acquire greater risk of immune system abnormalities, such as asthma and allergy or inflammatory bowel disease (Liu & Leung, 2006; Schaub et al., 2006).

For immigrants moving from developing countries, where these infections are common, especially in rural areas, to developed countries, the main effect will be that those who have been infected will lose their infection. There are undoubtedly positive consequences to this, such as reduced anemia due to intestinal worms. But these immigrants may also encounter new ailments to which they were previously unfamiliar, such as allergies. Research on immigrants to many developing countries has suggested, but is not yet conclusive, that allergies and asthma increase in populations following immigration (e.g., Brugge et al., 2008).

There is a need to better understand these “forgotten” diseases (Hotez, 2008), both to ameliorate the suffering and reduced productivity that they cause in people with the infections and to understand how these organisms might have affected our own evolution such that aberrations in immune function might develop more often in their absence.

Chemicals in Water

Chemical contamination in water is of many sorts and comes from many sources. Some well known and common contaminants include heavy metals, such as lead; transition metals, such as arsenic; or organic compounds, such as benzene or polychlorinated biphenyls. While there is natural contamination of surface and groundwater by some types of contaminants, activities undertaken by humans can either directly or indirectly increase chemical levels in water. They include sewage systems, especially in the absence of treatment plants or in instances where such plants do not effectively remove some chemicals. Also, direct discharge of industrial chemicals into water or onto soil, and from there into water may be better or less well regulated. Air pollution deposits on surfaces, including water, but also onto hard surfaces that then get rinsed by rainfall and end up in water.

In general, immigrants from low-income countries are likely to encounter improved water quality when they immigrate to high income countries. But there may be instances in which they move from relatively pristine rural areas to urban centers were water pollution is more of a problem.

Nonoccupational Injuries

Evidence to date suggests that immigrants to Europe and the United States experience less nonoccupational unintentional injuries than native-born persons. For example, a study found that both boys and girls of foreign-born mothers in Denmark had lower rates of injury (Laursen & Moller, 2009). A study in the USA reported lower percentages of reported injuries in the past year for Black, Hispanic, and Asian American immigrant children in comparison to US-born children, all of whom were low-income as they were recruited from Head Start programs (Schwebel et al., 2005). Apparently this trend extends to very narrow sub-groups of immigrants, as a study in California had similar findings for fatalities from injuries comparing Hmong to non-Hispanic Whites (Yang et al., 2009). There is some evidence counter to the dominant findings, for example, a study in Italy found that immigrant men, but not women, had higher rates of acute care and hospitalization for injuries than did native Italians (Baglio et al., 2010).

Road traffic injuries are more common in developing than developed countries (Donroe et al., 2008). But in developed countries the evidence is mixed with regard to whether immigrants experience higher risk of such injuries. Using nationwide data, a US study found that transportation-related injuries were more common among immigrants, despite overall injury prevalence being lower for immigrants (Sinclaire et al., 2006). On the other hand, a study in Sweden found that socioeconomic differences increased risk of traffic injuries, but that being an immigrant did not. Notably, most of the immigrants in the Swedish study were from Finland, which might suggest modest cultural differences.

There has been little research aimed at understanding why immigrants might experience injuries less often than nonimmigrants. One study produced evidence that language acculturation, learning English, was associated with increased injuries (Schwebel & Brezausek, 2009). Another paper by the same group raised the possibility that immigration might select for "well-adjusted and healthy children" (Schwebel et al., 2005, p. 505). Another concern with the studies to date is that they do not address well enough the possibility that there is differential reporting of injuries, including differential assessment of the level of severity that requires medical care. There are programs aimed at addressing injuries in immigrant communities, including a participatory program in Birmingham, England (Kimberlee, 2008), and an effort to address local planning to reduce traffic-related injuries in Boston Chinatown (Brugge et al., 2002b).

Occupational Health

Chemical Hazards

Immigrant hired farmworkers are commonly exposed to a variety of pesticides in fruit and nut, vegetable, horticultural, or field crops. There were over a million hired crop farmworkers in the USA in 2006, about a third of an estimated three million people employed in agriculture. Almost half of hired farmworkers lack authorization to work (Kandel, 2008), and 80% are males (Das et al., 2001). California alone has as an estimated 36% of the nation's farmworkers; almost all of them are Hispanic (99%) and most are born in Mexico (96%) (Aguirre International, 2005). In the last 10 years in California and Oregon there has been significant growth of indigenous farmworkers from Mexico (Mixtecs, Zapotecs, and Triquis) and Guatemala, who may not speak Spanish, (Bacon, 2006; Farquhar et al., 2008).

Das et al. (2001) analyzed California pesticide illness surveillance data and found that the most common causes of pesticide-illness cases in 1998–1999 in California were organophosphates and N-methyl carbamates (20.2%), followed by inorganic compounds such as sulfur and copper compounds (13.6%) and pyrethroids (8%). The most common illnesses reported were dermatologic symptoms and signs (44.2%), followed by those affecting the nervous (38.7%), gastrointestinal (38.1%), ocular (32.5%), and respiratory (23.7%) systems. These illnesses occurred mostly while farmworkers performed routine activities in the fields (64.4%), followed by exposures while mixing, loading, or applying pesticides (28.6%). The most prevalent exposure routes were dermal (41.3%), inhalation (24.2%), and ocular (11.3%). Though California has the oldest and most comprehensive surveillance system in the country, the authors note that there is significant underreporting of pesticide illnesses due to a variety of weaknesses and difficulties facing the surveillance system.

Strong et al. (2004) studied a sample of 211 farmworkers in Eastern Washington state, 92% of whom were born in Mexico, and found that exposure to organophosphate pesticides was common. They reported that health symptoms or signs such as headaches, pain in muscles, joints or bones, burning eyes, rash or itchy skin, blurred vision, stomach aches, and shortness of breath were the most common. Burning eyes and shortness of breath were weakly associated with detectable samples of azynphos-methyl, methyl-paration, and phosmet in house and vehicle dust. Azynphos-methyl and phosmet as well as captan (a fungicide) residues have also been found in migrant farmworker homes in Oregon (McCauley et al., 2001).

Villarejo & McCurdy (2008) reported pesticide exposure and illness data from the California Agricultural Workers Health Survey (CAWHS), which was a cross-sectional random household survey of 970 hired farmworkers, including workers in dairy, poultry, and other types of livestock production. Twelve percent of males and 7% of females self-reported direct contact with pesticides from being sprayed or drifted upon in the previous 12 months. Direct contact with pesticides from being sprayed or drifted upon among both males and females was associated with multiple self-reported work-related health conditions such as irritated, itchy, or watery eyes; blurry or clouded vision; skin irritations; and headaches.

Another newly studied but very common chemical exposure for many Asian and Latino workers in the USA is exposure to solvents in nail salons. For example, California has over 300,000 workers licensed to perform nail care services. Nail care products may contain methylene chloride, benzene, formaldehyde (which can cause cancer), toluene, and dibutyl phthalates (endocrine disruptors). A study with a sample of mostly female Vietnamese nail salon workers in California found that 47% reported symptoms that may be associated with solvent exposures, such as skin irritation, breathing problems, numbness, and eye and throat irritation. Most of these symptoms began after they started working in the industry (Quach et al., 2008).

A similar study in Boston surveyed 71 Vietnamese nail technicians exposed to nail polishers, nail polish removers, artificial nail products, nail tip adhesives, artificial nail removers, and disinfectants. It found that almost one-third of those surveyed reported a respiratory symptom that got better when they were away from work; 43% of these reported respiratory irritation only, 31% reported skin problems, and 18% experienced difficulty breathing (Roelofs et al., 2008). Though both of the nail salon studies had small samples and design limitations, they suggest that there are potentially serious health problems emerging in urban, small service sector businesses owned and staffed by recent immigrants.

Vietnamese hardwood floor finishing workers are exposed to flammable liquids such as lacquer sealers and organic solvents. There were 11 fatal injuries of workers in the floor laying/other floor work business in the USA resulting from fire and explosions between 1992 and 2001; five of them occurred in wood floor sanding. In September 2004, two Vietnamese floor finishers burned to death in a Somerville, Massachusetts, house fire when refinishing wood floors. In July 2005, another Vietnamese floor finisher died in another house fire in Massachusetts (Azaroff et al., 2006).

Immigrant janitors and housecleaners are routinely exposed to a variety of toxic chemicals such as chlorine, ammonia, alkylphenol ethoxylates, and 2 butoxyethanol diethylene glycol monoethyl ether, among others (Gute et al., 2010; Pechter et al., 2009). Exposures to toxic cleaning agents at work may cause respiratory problems, such as asthma; irritation of throat, nose, and eyes; dermatitis; and allergies from sensitizing ingredients.

The meat and poultry industry is a good example of a manufacturing industry where immigrant workers are exposed to a variety of chemical hazards. In 2003, 42% of workers in this industry were Hispanic/Latino and about 2% were Asians or other Pacific Islanders. About 26% of all workers in the industry were foreign-born noncitizens, while 38% of production and sanitation workers in this industry were foreign-born noncitizens (GAO, 2005). Workers in the industry may be exposed to hazardous chemicals such as nitrogen sulfide gas, carbon dioxide, and methane in manure pits or manure waste "lagoons," liquid ammonia and freon, used to keep production lines cold, and disinfectants.

Exposure to inorganic lead in construction remains a problem for immigrant workers throughout the USA, especially recent immigrants. For example, blood level screenings conducted in Boston, Massachusetts, in 2008 indicate that Brazilian immigrant residential painters were overexposed to lead at work (Siqueira, 2008). Lead poisoning can cause acute and chronic adverse effects in multiple organs, such as reduced sperm counts, memory loss, kidney problems, fatigue, and miscarriages.

Physical Hazards

Immigrant workers who work outdoors are at higher risk of exposure to extreme hot or cold temperatures and ultraviolet (UV) radiation. Extreme heat conditions are usually seen in the summer in the South and Southwest of the United States. Farmworkers in these areas may suffer from heat cramps, heat stroke, heat exhaustion, and heat rash, among other problems. Heat cramps usually occur after workers sweat profusely during arduous activity. Symptoms include muscle spasms in the abdomen, legs, or arms. Heat stroke is the most serious form of heat stress. Symptoms include hot and dry skin, chills, high body temperature, confusion, dizziness, hallucination, and a throbbing headache. Symptoms of heat exhaustion result from loss of water and salt, and include heavy sweating, extreme weakness or fatigue, nausea, clammy or moist skin, dizziness, and confusion. Immigrant workers in the restaurant industry also often complain of hot work environments in kitchens (Restaurant Opportunities Center of New York, 2005).

Extreme cold conditions usually in the Northeast, Midwest, and North may cause frostbite, hypothermia, and other conditions in construction workers at construction worksites without good climate control (for example, road construction). UV radiation may cause skin cancer and sunburn. Laborers and roofers may also be struck by lightning.

Workers in meat and poultry plants may be exposed to very hot temperatures, used to cook or cure meat, or to very cold temperatures used to preserve meat and facilitate processing. Even colder temperatures are required for production of frozen meat and poultry (GAO, 2005).

Electromagnetic fields (EMFs) produced by power lines, electric wiring, and electric equipment may also be hazardous to immigrant workers, who may be exposed to high magnetic fields if working near electrical systems that use large amounts of electric power, such as large electric motors, generators, or the power supply or electric cables of a building (NIOSH, 1996). There is evidence linking exposures to EMFs and leukemia and other cancers, but no consensus exists regarding EMFs as their cause. Therefore, EMFs are not considered a proven workplace hazard by USA government agencies.

Particulates

Immigrant workers in construction may be exposed to asbestos and dust in demolitions of buildings that contain asbestos, residential and commercial renovations, performance of building maintenance activities, and asbestos abatement projects. Although exposures to asbestos decreased in the last decades due to significant reduction of its use in the USA, immigrant laborers may still be exposed to it as a result of lack of training and compliance with health and safety standards to protect workers. Asbestos-containing materials are usually found in insulation and fireproofing materials, cement and wallboard materials, and automotive breaks and textile products. Exposure to asbestos fibers may cause lung cancer, mesothelioma, and asbestosis. Acute symptoms include shortness of breath, chest or abdominal pain, and irritation of the skin and mucous membranes. Chronic symptoms include reduced pulmonary function, breathing difficulty, and dry cough, among others.

Unusual but important exposures of immigrant workers to particulates and asbestos may also occur. For example, Malievskaya et al. (2002) reported immigrant worker exposure to fiberglass, alkaline concrete dust, crushed glass, and other pulverized construction material during the clean-up of contaminated offices and residential buildings near Ground Zero (the World Trade Center site). Clinical exams were conducted in a nonrandom sample of 418 immigrant building clean-up workers, mostly immigrants from Colombia and Ecuador. Almost all workers examined suffered from either irritation of the airways (cough, sore throat, nasal congestion, and chest tightness) or systemic symptoms, such as headache, fatigue, dizziness, and sleep disturbances.

Exposure to silica dust may occur in construction jobs that involve concrete cutting, surface grinding, tuck-point grinding, sacking and patching concrete, concrete floor sanding, and sandblasting. Diseases caused by exposure to silica include silicosis, lung cancer, pulmonary tuberculosis, and airway diseases (NIOSH, 2010a).

Psychosocial Hazards

Almost all occupational health and safety studies that asked immigrant workers to identify their most important job hazards found stress as one of the major hazards experienced by these workers in the hotel industry (Buchanan et al., 2010), the restaurant industry (Tsai & Salazar, 2007), the health care industry (NIOSH, 2009), the meat and poultry manufacturing industry (GAO, 2005), the textile industry (Lashuay et al., 2002), and the electronics and computer assembly industry (Azaroff et al., 2004), among others. The main reasons for the pervasiveness of high levels of stress in many jobs held by immigrants is that they tend to work in high physical demand and low worker control jobs or in low wage and insecure informal jobs with high turnover, often subject to poor working conditions. In addition, undocumented immigrants may be exposed to racial/ethnic discrimination at work; they may have language barriers, receive poor or no safety and health training, and suffer abuse from employers who have no accountability for failing to protect them against hazardous exposures (AFL-CIO, 2005). Therefore, a broad array of symptoms and diseases has been found in immigrant workers that are associated with stress at work: depression, sleep disorders, neurotic disorders, anxiety, musculoskeletal pain, angina, gastrointestinal disorders, and heart disease, among others.

For example, a survey of 200 Latino workers, almost all immigrants, in poultry processing plants in North Carolina found that management practices, such as poor commitment to safety and abusive supervision, and indicators of job design, such as psychological workload, repetitive movements, frequent awkward posture, task variety, and authority, were associated with risks of self-reported injury/illness, and musculoskeletal and respiratory problems (Marín et al., 2009). de Castro et al. (2006) described how work organization affected immigrant workers in Chicago according to worker rights cases collected by the Chicago Interfaith Workers' Rights Center. This study found that immigrant workers reported racial and ethnic discrimination on the job, as well as discrimination based on immigration status. de Castro et al. (2008) also found that job-related stressors are associated with chronic health outcomes (a composite of a number of chronic conditions such as asthma, diabetes, high blood pressure, back problems, etc.) among Filipino immigrants, and that this association was stronger for recent immigrants.

Infectious Diseases

Immigrant workers are exposed to infectious diseases in a variety of workplaces, such as health care facilities, meat and poultry plants, and farms. There were 1.1 million immigrants employed in health care occupations in 2000, representing 12.9% of the healthcare workforce. They were 25% of all physicians; 17% of nursing, psychiatric, and nursing aides; 16% of all clinical technicians; and 11% of registered nurses (RNs). Asians were the largest immigrant group in the industry, with Filipino nurses the largest immigrant group of RNs and Mexicans the largest immigrant group within nursing aides, followed by Jamaicans and Haitians. Immigrants made up a large proportion of home health aides as well (Lowell & Gerova, 2004). Since there is not much evidence to show disparities in worker exposures in health care settings, one may conclude that immigrant health care workers may be exposed to the same infectious disease hazards faced by the native workforce. Thus, as RNs and nursing or home health aides, they may be exposed to bloodborne pathogens, such as hepatitis B/C and HIV from percutaneous injuries from needlesticks and sharps, mucous membranes, and skin exposures (NIOSH, 2009). Immigrant health care workers may be routinely exposed to common viral respiratory infections, such as the influenza or flu viruses, and also to particular strains of viruses that have caused major epidemics, including the corona virus that caused the epidemic of severe acute respiratory syndrome (SARS) in 2003, and the H1N1 influenza virus that caused the 2009–2010 flu epidemic (NIOSH, 2010b).

In meat and poultry plants immigrant workers may become ill by contact with virus and bacteria in animal tissues and bodily fluids from carcasses, blood and fat, as well as feces. As a result, they may have fever, diarrhea, nausea, or vomiting, all related to acute infections (GAO, 2005). Poultry workers may also be exposed to the avian flu virus (NIOSH, 2010b). Immigrant hired farmworkers may have a high prevalence of parasitic diseases and tuberculosis, and have also been found to have sexually transmitted diseases (e.g., syphilis and AIDS) (Villarejo & McCurdy, 2008).

Ergonomics and Occupational Safety

Musculoskeletal Disorders

Hispanics or Latinos (native and immigrant) accounted in 2008 for 10.5% of all musculoskeletal disorders (MSDs) (Bureau of Labor Statistics, 2009), which included a wide variety of illnesses and injuries such as sprains, strains, carpal tunnel syndrome, and back pain. Asians (native and immigrant) accounted for only 1.5% of MSDs. A qualitative study with a sample of 75 immigrant workers from Latin America and Asia who worked in the restaurant, housecleaning, homecare, apparel, and hotel industries in the Los Angeles area found a high prevalence of self-reported musculoskeletal injuries (Brown et al., 2002). According to a report on workplace injuries experienced by predominantly Chinese immigrant workers in the garment industry in San Francisco, 99% of patients who attended a free clinic for garment workers had one or more diagnosed work-related conditions such as back, neck, or shoulder sprains or strains (Lashuay et al., 2002). A participatory action study conducted with unionized hotel room cleaners in Las Vegas, 85% of whom were immigrants, found that 75% of those surveyed experienced work-related pain, and worked while in pain in the 12 months prior to the survey. Repetitive physical tasks may explain most of the pain reported by such workers (Scherzer et al., 2005).

The meat and poultry industry has one of the highest rates of musculoskeletal injuries compared to other manufacturing industries. These injuries are associated with the meat and poultry production process, such as cutting motions in production lines. In 2001, the carpal tunnel injury rate was 6.8 cases/10,000 full-time workers, while the rate of sprains and strains was 51.9/10,000 and the tendonitis rate was 3.5/10,000. The rate of repetitive motion injuries in the industry in 2002 (22.2/10,000) was fifty percent higher than the rate (14.7/10,000) for all US manufacturing (GAO, 2005).

Hired farm laborers in California reported high levels of musculoskeletal pain: 41% of men and 40% of women surveyed in the California Agricultural Workers Health Survey experienced persistent pain in their backs, necks, knees, shoulders, hands, feet, or multiple parts of the body. The longer the number of years as hired farm workers, the larger the number of body parts which experienced pain (Villarejo & McCurdy, 2008).

Fatal Occupational Injuries and Nonfatal Occupational Injuries and Illnesses

The fatality rate for immigrant workers in 2001 was 5.7 per 100,000 workers, compared to 4.3 per 100,000 workers for all US workers. Analysis of Census of Fatal Occupational Injuries (CFOI) data from 1996 to 2001 shows that foreign-born workers accounted for 13.6% of all fatal occupational injuries recorded in the US. Workers from Latin American countries were responsible for 61% of fatal injuries – two-thirds were

Mexican. Asians were the second largest group, with 21% of foreign-born worker fatalities. Workers born in Europe were the third group, with 12.5% of fatal injuries, followed by workers born in Africa (3.2%) (Loh & Richardson, 2004). The four occupational groups with the largest fatality rates were transportation and material moving occupations; handlers, equipment cleaners, helpers, and laborers; protective services; and construction trades. Private construction, retail trade, and transportation and public utilities were the three most common industries for foreign-born worker fatal injuries. Workplace homicide was responsible for one in four fatal injuries of immigrants, followed by falls to a lower level, and highway incidents. Immigrant workers had a higher fatality rate than native-born workers in retail sales and as handlers, equipment cleaners, helpers, and laborers. The southern region of the USA had the largest share of fatalities, due to its proximity to Mexico and Cuba, while the West had the second largest due to its large share of agricultural, fishing, and forestry immigrant workers.

According to the most recent statistics collected by the Bureau of Labor Statistics, Hispanics or Latinos suffered 13.5% of all nonfatal occupational injuries and illnesses involving one or more days away from work, compared to 1.4% for Asians (Bureau of Labor Statistics, 2009). One study estimated that immigrants have an excess of 16,380 nonfatal injuries involving at least 1 day away from work and an excess of about 61,720 nonfatal injuries annually. It concluded that immigrants work in riskier jobs mainly because of a lack of English literacy and low levels of education (Orrenius & Zavodny, 2009).

Most available literature about immigrant workers' injuries and illnesses focuses on Latino workers, which include a significant proportion of recent immigrants from Mexico and Central America. For example, a national day laborer study with 2,660 day laborers, mostly Mexican and Central American immigrants, found that one in five workers surveyed experienced an injury on the job and two-thirds missed work due to an injury. Although many of these workers were construction workers who worked in a known, dangerous industry, the high rates of injuries reported reflected their poor working conditions, lack of training, and lack of enforcement of safety and health laws and regulations (Seixas et al., 2008; Valenzuela et al., 2006). The poultry processing industry, where many Hispanic/Latino immigrants work, had a nonfatal injury rate of 5.5/100 workers and an illness rate of 2.3/100 workers in 2005 (Marín et al., 2009). A recent study of Occupational Safety and Health Administration (OSHA) 300 logs of injuries in hotel housekeepers, largely females, found that housekeepers had the highest injury rate, 7.9/100 workers. Hispanic (immigrant and nonimmigrant) housekeepers had a higher rate of injuries than other ethnic/racial groups (Buchanan et al., 2010).

Summary

In summary, immigrants are exposed to significant occupational and environmental health risks, resulting in an increased burden of disease and, all too often, mortality. While there are numerous areas noted above that clearly require greater study, it is clear that there are also many hazards that are well documented and affect immigrants disproportionately. The development of culturally and linguistically adapted programs to reduce the burden of these illnesses and injuries in immigrant populations is critically needed. Commensurate with intervention programs there also needs to be better enforcement of existing laws and regulations and, in some cases, development of new policy to provide adequate protections.

Related Topics

- ▶ Air pollution
- ▶ Allergies
- ▶ Asthma
- ▶ Back pain
- ▶ Built environment
- ▶ Chemical exposure
- ▶ Employment
- ▶ Environmental exposure
- ▶ Environmental health
- ▶ Environmental justice
- ▶ Healthy immigrant
- ▶ Heat stroke
- ▶ Homicide
- ▶ Housing
- ▶ Injuries

- ▶ Job stress
- ▶ Labor unions
- ▶ Lead poisoning
- ▶ Migrant farmworkers
- ▶ Occupational health
- ▶ Occupational injury
- ▶ Pesticides
- ▶ Safety
- ▶ Sanitation
- ▶ Stress
- ▶ Tobacco control
- ▶ Water

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Methodological Issues in Immigrant Health Research

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Immigrants have particular health needs and concerns that may not be framed well in the context of the culture from which they left, nor in their new surroundings. The way in which research is conducted with immigrant cultures impacts how effectively the broader community can address significant healthcare needs. The analysis and interpretation of immigrant health research affects our understanding of how to best optimize health for all groups within a population. This chapter highlights some of the most notable methods and methodological issues arising from conducting immigrant health research. Particular attention is given to describing and comparing specific research approaches that have been successfully used in researching issues related to immigrant health.

Special Considerations for Conducting Immigrant Health Research

Role of Language Translation and Cross-Cultural Boundaries

One complicating factor that has the potential to arise while conducting research with immigrant populations is the need for language and cultural translation, be it literal or metaphorical. Healthcare interpreters and translators may be used to facilitate communication across cultural boundaries, and it is important to note translation involves conveying complex ideas and connotations as much as providing a word-for-word conversion between two languages. Most commonly, translators are used for facilitating written communication and interpreters are used for oral communication. Both translators and interpreters may play important roles in assisting the investigator with the design, implementation, and analysis of a research project (de Chesnay, Murphy, Harrison, & Taualii, 2008).

Investigators have previously noted the importance of conducting research requiring translation in the field of immigrant health. Limited representation of non-English-speaking immigrants in health research has been speculated to adversely effect evidence-based health and human services policy (Garrett, Dickson, Whelan, & Whyte, 2010). The language barrier between immigrants and those in the healthcare profession has been shown to adversely affect health services access, health outcomes, and patient satisfaction among immigrant groups, and patient satisfaction with different interpreter methods provides insight into potential applications for research study design (Gany et al., 2007).

Legal and Ethical Protection of the Rights of Human Participants

Several factors may directly contribute to the classification of immigrant groups as vulnerable populations in need of special protections when they are involved in healthcare research. Cultural barriers, language differences, and legal status may all present challenges to effectual communication about – not to mention access to – needed health care. Academic institutions and clinical sites involved in healthcare research most commonly have a designated institutional review board (IRB), sometimes referred to as an independent ethics committee or ethical review board, that is charged with protecting the rights of human subject research participants and evaluating the risks associated with all aspects of a proposed research study.

The IRB is responsible for ensuring an investigator has developed adequate mechanisms for obtaining *informed consent* from all research participants prior to their involvement with the study. Informed consent requires that participants voluntarily agree to participate in the study and that they understand (1) what is

Sana Loue & Martha Sajatovic (eds.), *Encyclopedia of Immigrant Health*, DOI 10.1007/978-1-4419-5659-0,

being asked of them and (2) the purpose of the study and any reasonably foreseeable risks to them associated with their participation (Belmont, 1979). The researcher must disclose any potential conflicts of interest between himself/herself and their role in the project. They must clearly identify to the participants the extent to which their privacy and confidentiality are being protected and maintained. It is of particular note that research participants have the right to withdraw informed consent at before, during, or after the research study has been conducted, and the investigator has an obligation to honor this right at all times, including after data have already been collected (Belmont, 1979).

In the process of conducting immigrant health research, there are numerous ways in which ethical responsibilities and cultural understandings intersect. For example, investigators conducting a recent study on elderly Korean immigrants observed participants were reluctant to answer questions about mental health and depression due, in part, to a cultural predisposition to not share openly what was regarded as a private family matter (Sin, Choe, Kim, Chae, & Jeon, 2010). Another research group conducting qualitative research on cervical cancer screening among diverse groups of immigrant women identified the need to utilize "flexible and innovative approaches," such as including members of the participating cultural groups in the research team, in order to involve multiple cultural groups in their study (Karwalajtys et al., 2010). Developing trust with the immigrant community and individual participants and explaining the extent to which participant confidentiality was to be maintained were essential to the success of these studies.

Selection of Study Designs for Immigrant Health Research

There are many factors to consider in the selection of an appropriate study design that will address issues of immigrant health. The selection of a specific research methodology to be used will be affected by the individual characteristics of the immigrant group to be researched, as well as the nature of any health assessments that may be performed as part of the research process. The purpose and potential applications of the study should be identified to aid in the selection of a beneficial study design. Research that focuses on health needs of immigrants is often used to assist in distribution of aid or resources. If this is an aim, measurable outcomes may be a key factor in the design of the study, and a more comprehensive view of the health needs of the entire community may also need to be addressed. When looking at existing programs in relation to immigrant health issues, taking the participants' self-identified needs into consideration may be one of the most important factors and may encourage a participant-driven type of study. If a deeper understanding of cultural values is desired, the researcher may need to consider how they can build a deeper relationship with persons from that culture. If a large-scale collection of data is needed, the researcher may need to focus efforts on the development of culturally appropriate methods of obtaining sufficient data, while taking a more distant role in the actual collection of data.

Significance of Investigator–Participant Relationship in Immigrant Health Research

What differentiates studies of immigrant health research from other health research is the relationship between the immigrant group and the dominant culture, as there may be a differential in power relationships. In the case that an individual from an immigrant group feels to be of powerless social standing, the role of an interviewer or researcher must be examined for ethical integrity (Green & Thorogood, 2009). When addressing health needs of an immigrant group within a dominant culture, the perspective of the researcher is paramount. A researcher, whether from the immigrant culture being studied or from another cultural group, may choose a research design that respects this potential differential by examining his or her own perspective on the research process. Understanding the desired research relationship between the researcher and the issue or group being studied can aid in selecting the most effective research design. While some immigrant cultures may be celebrated or honored, others may be discriminated against or denied rights. How these cultural groups relate to the dominant culture affects their access to health resources. In a similar manner, the relationship between the researcher and the researched group will impact how data are collected and analyzed. Because each immigrant group differs by culture and country of origin, careful examination of how the researcher relates to the culture being studied and the theoretical issues addressed through the study is useful in order to develop a greater perspective on immigrant health.

Use of Investigator–Participant Relationship to Provide a General Taxonomy to Research Methodologies

The following methods for conducting immigrant health research are organized based on relationships between the researchers and the researched immigrant groups, as illustrated in ➲ *Fig. 1*. This conceptual model represents a nonexclusive taxonomy intended to assist a novice investigator discerning among commonly used approaches to studying immigrant health research.

We describe five approaches to study design, organized according to their population focus.

- Research designs that are *directly focused on the individual or group participants* are subject to limited input or influence by the researcher. An example of this method is a longitudinal study following a specific group of immigrants within the first few years of their arrival in a country.
- Designs may have a *direct focus at the population level*. An example of a study design with this type of focus is the US Census, which collects demographic data for the national population.
- *Participant-generated methods* are studies in which the population being studied plays an active role alongside the researcher in the production of data and the direction of study. An example is

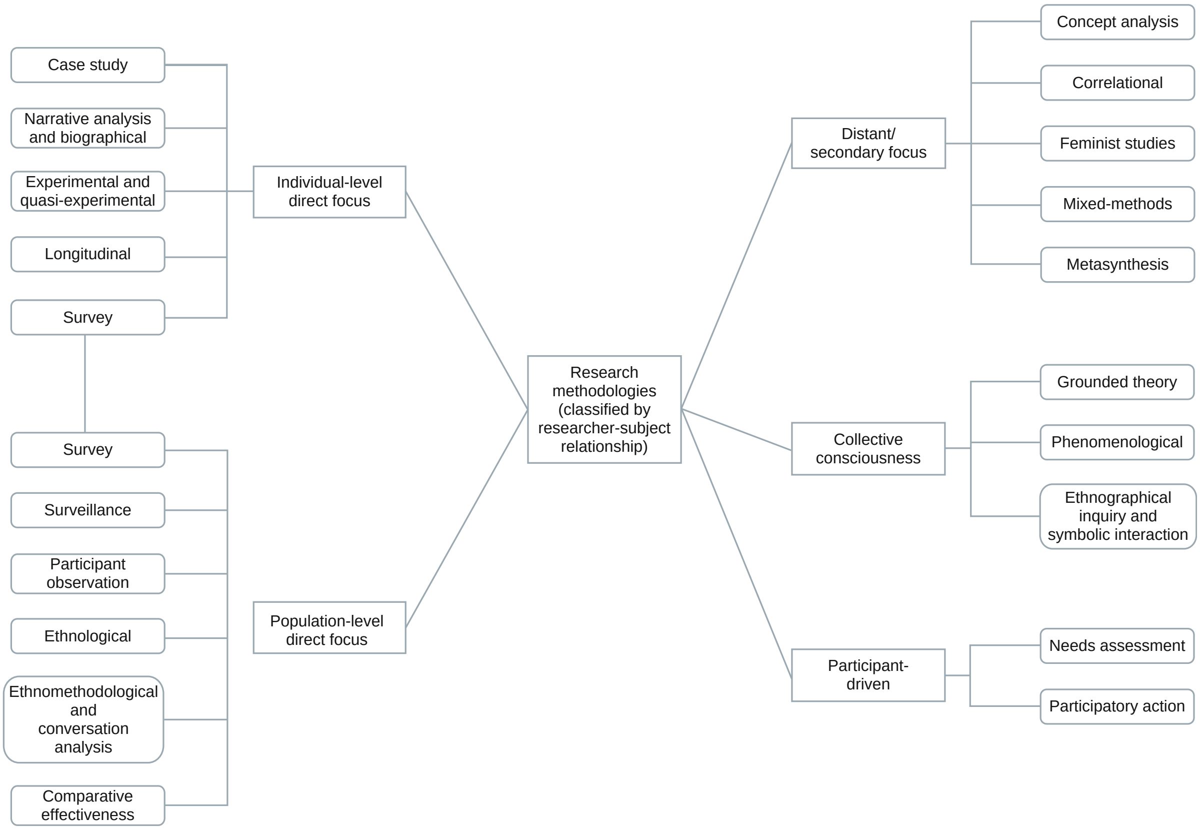

Fig. 1

Illustration of research methodologies commonly used in studying immigrant health, classified by the investigator–participant relationship

a participatory action design to improve healthcare access among immigrant groups in a city, in which community members generate the interventions and outcomes through focus groups, education about resources, and community building training.

- Research methodologies may focus on *defining a collective consciousness* and evaluating theoretical constructs relating to the issue or population studied. An example of this research design is a grounded theory evaluation of the experience and descriptions of depression in an immigrant community in which in-depth interviews are used to synthesize a theory that encapsulates the essence of the experience.
- The research approach may have a *secondary analysis or distant focus* in which previous knowledge is evaluated, revised with a new perspective, or synthesized to generate new knowledge or theories. An example is a systematic review of the experiences of immigrant nurses in Western countries, and barriers they encounter. Through the process of secondary analysis of existing studies, results can be applied to increase understanding as well as establish evidence-based best practice for healthcare managers working with these individuals.

Examples of Research Methodologies Used in the Study of Immigrant Health

Individual-Level Direct Focus Research Methods

Many types of studies have a direct focus on one immigrant group, a collection of individuals, or a specific time frame. These studies tend to allow detailed analysis and insight into a particular group of persons or events, but may not be broadly generalizable. In these studies, the focus is on the person or persons being observed, and the researcher is a discrete variable. Ideally, the same data are collected from each participant, with minimal personal influence or interference from the researcher. If interviews are included in the methodology, the focus is on the participant, rather than the interactive process. These studies also share a common theme in that they may go into depth about an individual or group, but are not broadly generalizable. Studies with a direct focus are useful when the group of participants is limited in scope, or when the health issue is highly specific. These types of research designs include, but are not limited to, biographical and narrative analyzes, case studies, experimental and quasi-experimental designs, longitudinal studies, and surveys.

In choosing a direct focus research relationship for the evaluation of immigrant health issues, some benefits include the ability to generate detailed data on an issue, or to create depth of knowledge relating to a particular group. A direct focus may also promote the minimization of bias or subjective interpretation between the researcher and the group of persons being studied, as the focus is more on the data than on theoretical or subjective analysis. Such types of studies are often foundational, such as a case study that provides an insight to trigger further investigation or a survey that provides accurate numbers with which to evaluate use of health status among immigrant communities. By expanding the direct focus research design to the population level, there is greater potential to use the data for distribution of resources, as well as evaluations and comparisons of ethnic groups within a larger community.

Case Study

A *case study* is an intensive focus on one individual, one group, or a social unit, often over a period of time (Polit & Beck, 2009). Case studies provide detailed observations of a particular program, project, or group of individuals. Case study research asks how and why events occur but does not attempt to control any behaviors, and thus differs from experimental study designs (Yin, 2003). The benefits of case studies include the ability to generate depth of inquiry and observe natural human occurrences (Green & Thorogood, 2009). One potential limitation of conducting case study–based research is that the conclusions from the analysis cannot be generalized well to an ethnic subcommunity, a larger immigrant group, or to the greater population (Green & Thorogood, 2009). A case study may be used to develop a new theory or hypothesis or to find meaning in phenomena that are infrequently seen or poorly understood, and they may lead to new avenues for research.

When using a case study design for immigrant health research, the availability of sources, access to translators, and the desired application of the data are key considerations. There are not specific methodologies for all types of case studies, as the category of research is broad, and may refer more to the sample selected than the method of research (Green & Thorogood, 2009). Documentation and archival records, as well as physical artifacts, such as objective observations and data on a house or apartment building in a case study that relates to housing conditions, can be conducive for accurate documentation of an analysis of data within a case study (Yin, 2003). This information may be difficult to obtain from the country of origin if working with immigrants in a new host country. Interviews and direct observation provide accessible firsthand data, which may have a powerful impact on the reader; however, obtaining this information may become time-consuming for the researcher (Yin, 2003). Using as many sources of data as possible to link and describe phenomena will substantially strengthen the external validity of a case study (Yin, 2003).

Narrative Analysis

Narrative analysis examines how individuals construct and tell stories as a way of making sense of the world and their own existence (Green & Thorogood, 2009). This term does not refer to particular methods for research, but applies to numerous methods that focus on how stories are told (Green & Thorogood, 2009). *Biographical* research may stand alone as a study design, or may serve as the basis of data within the construct of a narrative analysis. In comparison to narrative analysis, biographical studies focus more on content than context. Biographical research methods, which may be done as interviews when the focus is on the life experience of an individual, emphasize the participant's reports of events and experiences in their own life. The emphasis is on the relationship between the experiences and the telling of the experience (Green & Thorogood, 2009). Benefits to narrative analysis are the abilities to include detail and depth about experiences and to promote representation of individuals within a population (Green & Thorogood, 2009). Disadvantages for using narrative analysis for immigrant health research include decreased generalizability and limited ability to examine how human experiences are told in natural social settings, if the data are gathered from interviews (Green & Thorogood, 2009). Applications for biographical and narrative analyzes are focused on understanding and creating the basis for comparison of cultural constructs.

An example of narrative analysis is a study by De Fina (2003) on the accounts of Mexican immigrants living in Maryland, in the northeastern USA. De Fina informed participants of her intent to learn about the life experiences of Mexican immigrants, thus employing a biographical approach to collecting data, but did not reveal that her analysis was on the narrative process itself. Key methods for obtaining data include full transcription of interviews for reference and analysis and building trust with the participants by earning a positive reputation among other members of the community (De Fina, 2003). De Fina's study used a "snowballing method" to recruit subjects, in which new participants for the study are recruited based on referrals from other participants (Polit & Beck, 2009). This method allowed for the collection of narrative accounts from an extended family and social circle within one community. De Fina used her personal identity as an immigrant to America and a previous Mexican resident to build trust and understanding (De Fina, 2003). In this regard, the researchers' personal views and cultural identity are intrinsic to the research process. This helps to create a stronger foundation upon which to develop hypotheses and interpret the narrative discourse, but introduces the possibility of personal or cultural bias in analysis of the data. De Fina's exploration also draws heavily on linguistics and how implicit choices in grammatical and narrative construction reflect on the immigrants' orientation within the society (De Fina, 2003).

Experimental and Quasi-Experiment Design

Experimental studies have an intervention (treatment) with an experimental and a control group based on random assignment (Polit & Beck, 2009). Quasi-experimental studies have similar characteristics as experimental studies but lack a control group based on random assignment. Even if a quasi-experimental study has a control group, that is not based on random assignment that limits causal assumption (Polit & Beck, 2009). The benefits of experimental research study designs include the ability to evaluate new medical treatments or interventions and to control for extrinsic factors that may interfere with the ability to examine cause-and-effect relationships of treatments (Loue, 1999). A disadvantage of attempting experimental designs in an immigrant health context is the difficulty in effectively matching a target population with a control group (Loue, 1999). In a health study of a diverse immigrant or migrant group, it may be difficult or even impractical to control most social variables except through policy or allotment of resources. The benefit of choosing a quasi-experimental design in social settings is the ability to compare multiple groups without the need for randomization (Loue, 1999). Applications of this type of quasi-experimental study may focus on program evaluation, evaluating health effects of a performed intervention, or to test hypotheses on the development and spread of a disease within a community.

As an example of quasi-experimental research design, an immigrant settlement policy in Sweden was evaluated in regard to the success of immigrants relative to where they were placed after arrival (Edin, Fredriksson, & Åslund, 2004). In the context of an experimental design, an independent variable, or proposed cause, has an impact on the dependent variable, or proposed effect. In the study from Sweden, the independent experimental variable was the placement of immigrants away from regions where many immigrants already lived, in accordance with a new policy; the control group consisted of the immigrants placed in cities with existing concentrations of immigrant communities (Edin et al., 2004). Because these experimental and control conditions were not assigned based on randomization, the study is classified as quasi-experimental. Over time, the research showed significant losses in employment and earnings potential for those affected by the new policy, and an increase in welfare dependence (Edin et al.). This indicates that the new policy was not an effective intervention in encouraging successful outcomes for the participants. Further study of these immigrant populations may relate to evaluations of healthcare access and utilization by groups in different geographical locations, and further investigation of the factors that contributed to variable economic success for different immigrant groups.

Longitudinal Studies

Longitudinal studies follow groups of participants for an extended period of time. Examples of these types of inquiries are trend studies, cohort studies, panel studies, and follow-up studies. The benefits of longitudinal study designs include the evaluation of trends over time and the ability to follow up with a particular subset of individuals. Potential drawbacks of conducting longitudinal studies with immigrant populations include high attrition rates if participants are lost to follow-up contact attempts, and an investment of resources to collect data at multiple points in time (Polit & Beck, 2009). The benefit of a large-scale longitudinal study in immigrant health research is the ability to see progress and trends of information over a key period in time, such as the first few years after immigrants' arrival. Results can be used for future policy development and to create more successful programs for new immigrants.

One example of a longitudinal study is the Longitudinal Survey of Immigrants to Canada (Statistics Canada, 2004). The Longitudinal Survey of Immigrants to Canada was established in 2000 as a large-scale evaluation of new arrivals and their process of adjustment. Participants were interviewed at set intervals over the course of four years, through face-to-face or telephone interviews, using a standard questionnaire (Statistics Canada, 2004). Nearly 20,000 participants were initially selected for the survey, and data were collected and analyzed by governmental employees. Though the participants were a randomized sample, governmental data on immigrants were limited to those who were legally registered and thus likely missed workers who were in the country without documentation. Follow-up of participants is a concern with longitudinal studies and of particular concern for newly arrived immigrants, who may change addresses and jobs between interviews. This study used access to national registries to trace individuals who changed their location, in order to reduce attrition rates of the original participants (Statistics Canada, 2004). This particular study was large in scope, but other studies may direct their focus on a much smaller group of immigrants. The applications from the data collected can be used for further research on healthcare utilization in the initial months after arrival, and how orientation programs for new immigrants can be improved to address needs revealed in this longitudinal study.

Surveys

Surveys rely on self-report of information by participants to examine trends and relationships within a population, either as a sample survey or census (Polit & Beck, 2009). They are limiting in that they tend to be topical in scope, but have the potential to reach a broad spectrum within a population, such as with a national census. A benefit of obtaining survey data is the ability to determine prevalence, distribution, and relationships of variables among a population, and the potential to evaluate opinions and knowledge across a spectrum of individuals (Polit & Beck, 2009). Potential disadvantages of conducting surveys with immigrant populations include language barriers, cultural misunderstandings relating to questions asked, and intense time commitments if surveys are done in person (Polit & Beck, 2009). For immigrant health research, the need for interpreters for interviews or written translations may affect the choice of data collection methods or the scope of the population targeted.

Some survey collection methods are personal interviews, telephone interviews, mixed-mode methods, or questionnaires (Polit & Beck, 2009). Though postal mail is a simple way to distribute surveys, and e-mail surveys are less costly to create and distribute, return rates are variable for both methods. E-mail surveys are effective when participants have access to the Internet and are computer literate (Kaplowitz, Hadlock, & Levine, 2004). However, computer literacy cannot be assumed when working with diverse groups of immigrants, particularly if groups of persons are coming from less-developed countries. Telephone surveys may not be effective for low-income individuals, possibly including newly arrived immigrants, who may not have telephones (Polit & Beck, 2009). Surveys done with non-English speakers may need to be recorded, translated, or dictated. Some surveys use a mixed-mode strategy, in which multiple methods may be used in an attempt to collect data if one method initially fails, such as for an individual who cannot read a written survey or does not have a telephone for an interview (Polit & Beck, 2009).

The Mexican Migration Project, developed as a partnership between researchers at Princeton University and the University of Guadalajara, utilizes an ethnosurvey method (Durand & Massey, 2004). The ethnosurvey is designed specifically to evaluate experiences of migrants, with attention to multimethod data collection and multisite sampling for the collection of social and demographic data. In addition, the survey includes detailed personal histories, as well as details about all of the participants' experiences with migration between Mexico and the USA (Durand & Massey, 2004). The sampling methods are done with extensive knowledge of how and where particular groups of workers migrate between the USA and Mexico, and these groups are studied over the course of years to generate consistent sources of data on previously undocumented communities (Durand & Massey, 2004). The design of the survey utilizes human migration patterns and sociocultural factors as integral aspects to the survey design. The data from the Mexican Migration Project is used to evaluate use of health resources, to identify migration patterns, and to inform public policy regarding binational migration (Durand & Massey, 2004).

A key survey database that uses survey methods to specifically count foreign-born citizens in the USA is the Current Population Survey, which does not ask participants about their legal status (US Census Bureau, 2009). This survey generates data about the number and distribution of groups of foreign-born residents, as well as evaluating use of welfare funds and work patterns among families across the country.

Population-Level Direct Focus Research Methods

As with the methods outlined in the section above describing individual-level direct focus research, some larger scale studies at the population level also maintain a direct focus with the researcher examining a group, issue, or set of events. Data collection is central, as is the ability of the researcher to analyze and interpret significance from these data. Some methods, like surveys, are easy to administer in small populations but become more labor intensive when applied to a large population. In comparison to the objectives for the study methods involving individual-level studies described above, population-level studies describe more characteristics of an entire ethnic group or subset of a population, and less about personal needs or individual experiences. Larger studies can also be more applicable for purposes of resource allocation as well as evaluations of healthcare accessibility and efficacy. Several studies at the population level, including ethnological and ethnomethodological studies, have a specific focus on ethnicity and cultural identity, and are well suited to research with immigrant groups (Polit & Beck, 2009). These research methods may be useful for gathering demographic data as well as for evaluating immigrant groups compared to a larger population. Types of immigrant health research designs with a direct focus at the population level include surveys, surveillance, participant observation, ethnological design, ethnomethodology and conversation analysis, and comparative effectiveness.

Surveys

As described with individual-level studies, surveys rely on self-report in order to collect information from individuals to represent trends and commonalities. Sample surveys that target smaller subsets or groups of individuals are typically simple to administer and reflect the needs of a subset of the population. A census type of survey attempts to gather information from every individual within a group, and may be conducted at a national population level. Additional benefits of surveys for population-level research include the generation of national statistics and the ability to use collected demographic data to compare with other variables (Green & Thorogood, 2009). Potential disadvantages of conducting surveys with immigrant populations include the potential for exclusion of nonlegal residents from governmental surveys and miscommunication in written or spoken survey formats when working with speakers of other languages (Green & Thorogood, 2009).

One example of population-level direct focus research is the US Census. This survey attempts to count every person living in the USA regardless of legal status. However, it is difficult to ensure that immigrants, migrants, minorities, and non-English speakers are fully represented. According to the National Association of Latino Elected and Appointed Officials (NALEO), undocumented workers and new immigrants are likely to be undercounted in the census or may be unwilling to provide personal data when asked, thus reducing the accuracy of the data (NALEO, 2010). However, there is an increased focus on population-level research methods to include vulnerable persons in national surveys, such as the *Ya Es Hora* ("It's time") campaign to increase mail response to the US Census among Latino communities across the country (NALEO, 2010). Methods to increase participation include media promotion of the benefits of participation, such as allocation of funding to Latino communities so that communities desire to participate (NALEO, 2010). The campaign also promotes participation in surveys by building partnerships between community organizations and Latino media outlets, including Spanish-language television networks. Much of the effort in growing Latino communities, particularly for migrant workers and those newly arrived to the USA, is to provide assurance that there will be no negative ramifications to the person or their family with participation in the census, and that the information will not be used to inform immigration officials about the presence of undocumented workers (NALEO, 2010).

Once data have been collected through a census survey, the data can be used for evaluation and analysis of health trends, particularly between minority and majority groups within the entire population. A study by Oza-Frank and Narayan (2010) used national survey data to evaluate the potential for diabetes prevention programs within different ethnic immigrant groups in the USA. Several populous immigrant groups in the USA were compared in regards to body-mass index and prevalence of diabetes (Oza-Frank & Narayan, 2010). This study required access to a large sample size of nearly 35,000 individuals, which included both immigrants and nonimmigrant control groups. The respondents were surveyed through the National Health Interview Survey, which utilizes data from the US Census. The analysis of survey data showed that immigrants from the Indian subcontinent were more likely to have diabetes than European immigrants regardless of whether they were overweight. In contrast, immigrants from Central America, Mexico, and the Caribbean were more likely to have diabetes as well as be overweight, when compared to European immigrants (Oza-Frank & Narayan, 2010).

Surveillance

Another common tool used in public health research is *surveillance*, in which departments of health or other organizations collect and analyze outcome-specific data continuously. This may include mandated reporting of information on diseases, prevalence of disease within a region, or the utilization of prevention programs. Surveillance methods do not incorporate interventions to improve conditions, but rather monitor and evaluate compilations of data at a population level (CDC, 2010). Passive surveillance methods use data already collected by public health offices, whereas active surveillance methods reach out to community members for evaluation of events such as disease outbreaks. Sentinel surveillance samples a part of the larger population. Special systems surveillance methods are for evaluation of population trends that cannot be monitored by other methods (CDC, 2010).

Benefits of utilizing surveillance tools in research include evaluating disease and wellness trends in subset of the population, by geography, or by other demographic characteristics. Within immigrant populations, surveillance data can be useful for examining the spread of disease and identifying population groups that may be in need of health interventions. Potential disadvantages of utilizing surveillance tools with immigrant populations include limitations of available data for nonlegal residents of a country and a topical focus on health issues. The collected data can be used to improve education about health resources, or may be used for future studies to evaluate community strengths that may contribute to favorable health outcomes among these groups of immigrants. Smaller scale surveillance designs may be used by local public health departments, such as to monitor use of health resources, disease reports, and emergency room visits among newly arrived immigrants.

A Canadian surveillance program used two decades of comprehensive data from national databases to evaluate health resource utilization by immigrants as well as mortality rates (DesMeules et al., 2004). The study found that immigrant populations had a favorably low mortality rate compared to the national rates for most causes of death, with the exception of infectious and parasitic diseases. Surveillance data also showed sharp increases in health utilization resources approximately 3 months after immigrants arrived in Canada (DesMeules et al., 2004). This knowledge can be particularly useful to healthcare providers working with immigrant populations to identify strengths within the patient population, and to be aware of highly prevalent diseases.

Participant Observation

Participant observation involves the researcher's immersion in the culture or group being studied, and his or her development of a role within the order or structure of the group itself. Participant observation is generally unstructured and time-intensive, with the intent of the researcher to observe firsthand how people exist and interact in their natural environment. Though the researcher is engaged in the social group, there is no attempt to perform any interventions (Green & Thorogood, 2009). Participant observation is based on study frameworks pioneered in the early twentieth century, focusing on urban sociology. Benefits of utilizing participant observation include a deeper understanding of cultures, evaluations of cultural norms, and the ability for a researcher to approach an "insider's" perspective (Polit & Beck, 2009). Potential disadvantages of utilizing participant observation with immigrant populations include the potential for observer bias, emotional involvement that reduces objectivity, and influence of the observer on their surroundings (Polit & Beck, 2009). Ethnographical research often uses the same methods as a participant observation study, but ethnography studies also focus on the interplay of the gathered observations and theoretical constructs as part of the analytical process.

A foundational study of participant observation methods in immigrant research, Thomas and Znaniecki's *The Polish Peasant in Europe and America*, was first published in 1918 during a period of mass immigration of Eastern Europeans to the USA (Bulmer, 1984). The book utilized personal documents, data, and theoretical constructs about culture and sociology to create a more holistic portrait of the immigrant experience, as well as set the foundations for empirical research about immigrants (Bulmer, 1984). The style of research from this early study integrated the roles of Thomas, an American, and Znaniecki, a Polish national, as researchers, both participating in participatory observational research on immigrants. They also incorporated evaluations of migration patterns in the USA and Poland (Bulmer, 1984). Observational research was conducted on two continents over the course of two decades with significant funding from private donors (Bulmer, 1984). From such foundational methods in immigrant research, in which theories were developed from observations of immigrant social groups, the researchers involved with this study developed urban sociology constructs that encouraged subsequent research and exploration of vulnerable communities.

Ethnological Inquiry

Ethnological inquiry is used to compare and contrast cultures, particularly in regards to language, origins, social structure, and characteristics. It is an anthropological construct and allows one to make conjectures about different cultures. It is linked to ethnography, which focuses on interpretations of human behaviors in cultural groups (Polit & Beck, 2009). Additional benefits of ethnological inquiry in population-level research include the ability to examine similarities and differences between diverse subsets within a population, and an examination of behaviors that have an effect on health and disease (Polit & Beck, 2009). Potential disadvantages of ethnological inquiry with immigrant populations include a researcher's potential inability to separate his or her own cultural biases in order to create a balanced interpretation (Polit & Beck, 2009).

An example of a use of this type of approach is an Australian ethnological project, the Mothers in a New Country Study (Small, Rice, Yelland, & Lumley, 1999). This study explores views of maternity within three immigrant groups: Turkish, Vietnamese, and Filipino. When dealing with non-English speaking immigrant communities, research considerations include effective sampling, recruitment, retention, and representativeness (Small et al., 1999). The study found that investing in the training and support of the interviewers to increase cultural awareness and sensitivity yielded a more successful process and greater confidence in the study by participants (Small et al.). As ethnology focuses on comparison of different cultures, all of the bicultural interpreters needed assurance of equal training and support in order to improve success within the study and allow for effective comparison between groups. In this respect, the ethnic and cultural identities of the research assistants were incorporated into the evaluation of the efficacy of data collection methods and validity (Small et al.). This increased cultural competence for the research interpreters, and was an effective method to increase the success of data collection.

Ethnomethodology

Another type of inquiry focused on cultural identity, *ethnomethodology*, is the study of methods that individuals use to communicate and make rational decisions within their cultural group, and how individuals comprehend social relationships (Green & Thorogood, 2009). The researcher is aware of methods employed through his or her observation of the study participants, even though the individuals being researched may not be aware of the process. This raises potential ethical concerns due to the power imbalance and level of cultural awareness that may develop between researcher and participants, and ethical safeguards protecting participants of ethnomethodological studies should be established. This theory is often used in sociology and developed from a phenomenological viewpoint. Phenomenology focuses on how humans describe and interpret experiences through the experience of being conscious in the world (Green & Thorogood, 2009).

Within ethnomethodology, two key concepts are indexicality and reflexivity. Indexicality is the assumption that the meaning of words and language relies on the social context in which they are employed (Garfinkel, 1967). Reflexivity is the assumption that researchers, observers, and participants bring their own identity into the social situation, and cannot be separated from the social relationship, regardless of their role in the study (Garfinkel, 1967). In regards to indexicality, ethnomethodological studies should be considered as they happen in a natural environment, with context playing a role in analysis along with the content of what is said. Reflexivity, which is a component of many other types of studies, allows the researcher to actively analyze how his or her own views and human presence may affect data content or the data collection process.

Additional benefits of using ethnomethodology for population-level research include increased comprehension of complex social interactions and an ability to evaluate interpersonal communication within healthcare settings (Green & Thorogood, 2009). Potential disadvantages of using ethnomethodology with immigrant populations include an overt focus on small interactions without attention to greater social structures (Green & Thorogood, 2009). This type of approach within immigrant health research could be used to evaluate how providers interact and communicate in their office with members of an immigrant group who are not English speakers.

A variant of ethnomethodology is *conversation analysis*, in which recorded and transcribed conversations form the data source for processing and evaluation (Polit & Beck, 2009). Benefits of using conversation analysis for population-level research include the ability to evaluate discourse between patients and providers within healthcare settings, and the potential to observe modes of therapeutic and nontherapeutic communication in real settings (Green & Thorogood, 2009). Potential disadvantages of using this technique in immigrant health research include the potential for misinterpretation or altered translations when working with speakers of other languages (Green & Thorogood, 2009). Conversation analysis can be used for evaluation of public opinion within the context of immigration policies, such as in an Australian study of the discourse used by lawmakers. The study evaluated the effects and ramifications of using terms such as “illegals” when referring to asylum seekers, and other language constructs that portray migrants negatively (Every & Augoustinos, 2007). In regards to these findings, other countries may also choose to consider how the language used affects laws and policies relating to immigration, as well as impacting public support or nonsupport for issues.

Comparative Effectiveness

Comparative effectiveness studies examine different treatments or interventions in regards to their advantages and successful outcomes. Through this research, costs and benefits, or benefits and risks, may be weighed in order to educate providers about when and how to recommend particular treatments. It can also be used to incorporate research into practice (AHRQ, 2010). Advantages for utilizing this type of research include the ability to develop guidelines for providers and for determining cost-effective methods of healthcare funding distribution. Applications for use in immigrant healthcare research may include efficacy of preventive and maintenance treatment of diseases for newly arrived immigrants and cost-effective views of insurance coverage for temporary or migrant workers. In the USA, the National Institutes of Health, Agency for Healthcare Research and Quality, and other major governmental agencies consistently utilize this method to evaluate costs and benefits of medical interventions, new treatments, and health assistance programs such as Medicare and Medicaid (ECRI Institute, 2009). Comparative effectiveness can be useful to dispel myths about how medical funds are used, and in particular can shed light on resources used by immigrants compared with permanent residents.

Current attention to comparative effectiveness in the USA addresses costs and benefits of the potential federal healthcare plan, and how it will affect those who are privately insured, those who are uninsured, and those who are currently covered through government programs. A study in 2005 analyzed data from both the Medical Expenditure Panel Survey and the National Health Interview Survey to compare health costs incurred by immigrants and nonimmigrants (Mohanty et al., 2005). The study found that immigrants who were on public assistance or were uninsured utilized half as many federal dollars in health care as US-born residents with the same insurance status (AHRQ, 2010). In addition, immigrants had 55% lower healthcare expenditures than nonimmigrants, despite public opinion surveys that indicated a majority of people believed immigrants to utilize more public healthcare funds than nonimmigrants (AHRQ, 2010). The assessment of health outcomes in immigrant populations as well as the implications of providing healthcare access to legal and illegal immigrants is another issue to be addressed through comparative effectiveness research (AHRQ, 2010).

Participant-Driven Research Methodologies

In comparison to the methods outlined in the sections above describing individual-level and population-level direct focus research, which focus directly on populations and issues, methods outlined in the following section emphasize collaboration between the researchers and participants in the planning of the research process as well as the generation of data and interventions (Polit & Beck, 2004). In these research designs, the goal of the researcher is to act as a facilitator in order to generate response and analysis from a community. For immigrant groups that occupy a unique role within the dominant society, this method can be highly appropriate for assessing health needs and self-reflexively seeking solutions to health disparities. Drawbacks to these participant-driven methods include a decreased ability to produce results on a set timeframe, as well as the risk of participant inaction or incompletion of the project. These types of participatory methods are particularly useful for interdisciplinary studies, for building community programs, and for building relationships between healthcare providers and healthcare researchers (Green & Thorogood, 2009). These participant-driven methods include needs assessments and participatory action research.

Needs Assessment

Needs assessments evaluate the necessity for a particular type of intervention or program within a community (Polit & Beck, 2009). Needs assessments are central to public health evaluations within a community and are often done in the form of surveys. Another method is a key informant approach, in which specific individuals are targeted to illuminate the needs of the community. An indicators approach uses records and statistics to make an assessment (Polit & Beck, 2009). Needs assessment reports may be self-contained, in which the assessment is the only outcome. They may be the first step in a more comprehensive research study such as a participatory action model. Assessments may also be intended for education within a community. However, the most important reason for conducting a needs assessment is for prioritization of needs, so that recommendations for action can be developed and implemented (Polit & Beck, 2009). Additional outcomes of needs assessments are to be used in funding proposals or secondary research. Additional benefits of conducting needs assessments on a population include evaluating the needs of groups that may be powerless or suffer from negative health disparities (Polit & Beck, 2009). Potential disadvantages of conducting assessment surveys with immigrant populations are that the assessments methods alone do not confer action for change.

There are a variety of methods that can be used for needs assessments, including observations, interviews, focus groups, community forums, oral surveys, questionnaires, analyzes of existing data, and community resource inventories (Minnesota DOH, 2010). Other types of needs assessments include the PRECEDE–PROCEED model. PRECEDE (Predisposing, Reinforcing, and Enabling Constructs in Educational/Environmental Diagnosis and Evaluation) is an acronym to represent the assessment phase. PROCEED (Policy, Regulatory, and Organizational Constructs in Educational and Environmental Development) represents the developmental and implementation stages, and may manifest as action research or secondary analysis (Li et al., 2009). By first conducting an assessment, any subsequent interventions using this knowledge will be grounded in evidence about what a community needs most. A needs assessment using this model seeks to identify health issues, behavioral and environmental influences, and community resources for health promotion (Li et al., 2009).

Participatory Action Research

Participatory action is a voice-centered relational method in which researcher and participant act together during all stages. The voices of the participants are central to the development and outcome of the project. The collaborative relationship between the researchers and participants is needed for the development and revision of methods and goals, which may be revised as new perspectives arise. This method is designed for groups that may be subject to control or discrimination by another culture or group (Polit & Beck, 2009). It was developed from action research. Action research was developed in the 1940s as a research method intended to enable change and improve stakeholder practices within the community – rather than have the researcher passively observe or act as a detached bystander (Green & Thorogood, 2009). Participatory action research is more of an approach than a specific type of research methodology, in that it may be framed within qualitative, quantitative, or mixed-methods designs (Khanlou & Peter, 2005). As such, methodological issues and ethical considerations may look different with a participatory action design than in other types of studies. It may be difficult to ascertain approval for the use of human subjects in a standard ethical board review, as the subjects are truly coinvestigators (Khanlou & Peter, 2005). Investigators may also need to focus on a risk-benefit ratio during the planning stages of study, considering that action research with vulnerable populations may create situations of community unrest and real or perceived danger to participants within their communities (Khanlou & Peter, 2005).

Participatory action is well-tailored to address health concerns within immigrant populations that are oppressed by dominant cultures and likely to suffer negatively from health disparities (Khanlou & Peter, 2005). Furthermore, participatory action research encourages a relationship of balance in power and knowledge between the investigators and participants, thus helping to facilitate empowerment and equality (Polit & Beck, 2009). This approach entails four components: participation, the attainment of knowledge, empowerment, and social change.

Through the process of participation, the community members are conducting the research, since they are the ones capable of engendering social change to reduce inequities (Baum, MacDougall, & Smith, 2006). Potential disadvantages of conducting participatory action projects with immigrant groups include limited generalizability between settings and less attention to the development of theoretical knowledge through this research process (Green & Thorogood, 2009).

Reciprocity, also referred to as reciprocal exposure, is an aspect of research that concerns the exchange between the investigators and participants (Harrison, MacGibbon, & Morton, 2001) and is a factor to consider when conducting participatory action research. It also implies the right of the participants to question researchers as an intrinsic component of the research process (Maiter, Simich, Jacobson, & Wise, 2008). This may be especially pertinent in ethno-studies in which the researcher is immersed in a different cultural group, or when participant action is the focus of the discovery process. As an issue of ethics, the process of reciprocal exposure and power sharing in community-based participatory action research is a necessary component (Maiter et al., 2008). An additional benefit of reciprocal exposure includes input about costs and gains for both participants and researchers (Maiter et al.). Potential disadvantages of reciprocal exposure with immigrant populations include investigator maintenance of the role of facilitator while simultaneously maintaining a power-sharing dynamic with participants (Maiter et al.). An example of this approach is provided by an investigation in Canada that was designed to improve the success of participatory action methods among immigrant groups. The investigators focused on improving access to mental health resources among several immigrant communities. The goal was to link community members to existing services and empowering them to promote access to groups and individuals in need within their cultural communities (van der Velde, Williamson, & Ogilvie, 2009).

Participants defined themselves into five ethnocultural groups, which included Chinese, Somali, Southeast Asian, Spanish-speaking, and Vietnamese. Focus group interviews were conducted, with questions relating to perceptions of mental health issues and access to community-based mental health programs. These focus group sessions were transcribed and recorded, and used for thematic analysis. Strong initial participation and maintaining activity by members in the focus groups was a key intervention in the success of the study, as the other components of participatory action research flow from this foundation (van der Velde et al., 2009). An analysis of program efficacy found that a multiethnic approach for developing programs was effective, but the reasons that many individuals chose to participate and continue with the health projects were culturally unique (van der Velde et al.). Reasons for participating included a desire to support community members, to influence healthcare policy, and to learn about health resources in the community. For other immigrant groups involved in participatory action research, an increased understanding of the cultural reasons for participation may increase retention and involvement.

Collective Consciousness Research Methodologies

More theoretical products of health research include the knowledge derived from interpretations of human experiences and the processes by which a group's identity is formed and described (Green & Thorogood, 2009). From these interpretations, theories can be developed about collective consciousness, which implies commonalities that exist in experiences across diverse groups of individuals. The goals of these methods are not to only observe and record, but to understand generalities about experiences particular to the groups being observed. The emphasis of collective consciousness or group identity research is on how the researchers' interpretations of data build on other theories and insights. Examples of research with an emphasis on collective consciousness include grounded theory, phenomenology, and ethnography.

Collective consciousness research designs will be effective in addressing particular study aims, but anticipating the uses and applications for the study will help to determine whether it is an appropriate methodology. For example, if a researcher wanted to collect incidence and prevalence rates of HIV infection in a particular immigrant group, utilizing surveillance data and health records would be an appropriate method for research, but a study of group identity would not be appropriate. If the goal was to understand the experiences of a few individuals with the disease, a case study method with a direct focus on a small group may be used. If the goal was to interpret the meaning of how humans experience the disease, a mode of study such as phenomenology may be most appropriate.

Though the particular data and demographic representation of certain immigrant groups may be vastly different, an evaluation that utilizes a collective consciousness approach emphasizes similarities. The drawbacks to these types of studies are they may be time-intensive, and the results may not be considered to be as useful for cost-benefit analysis or other issues that use outcomes of research for allocation of funding (Green & Thorogood, 2009). However, ethnography and related studies have tangible applications to health research and public health improvement, and are used in government-funded studies in the USA. The US Government Accountability Office (GAO) describes the value of ethnographic studies for the allocation of federal funding, particularly in regards to immigrants and vulnerable populations. The US Census Bureau has used ethnography to uncover why minority subgroups are underrepresented in the national count, and is applying that knowledge to the 2010 count, to increase success (GAO, 2003). The Center for Disease Control and Prevention also applied ethnographic methods in outbreak studies of sexually transmitted diseases, with a focus on the factors that spread disease within communities (GAO, 2003). Research that utilizes theories of collective consciousness produces data that are more subjective, and may seem less tangible in regards to healthcare knowledge or interventions. But, it can create bridges between diverse groups relating to health in vulnerable communities in order to identify similar experiences and needs.

Grounded Theory

Grounded theory focuses on describing social processes that form an essence of a phenomenon or an aspect of human consciousness (Polit & Beck, 2009). Using an inductive process, in which data are gathered through observation, researchers develop theories about behaviors (Green & Thorogood, 2009). The data are initially collected and analyzed, and theories are developed from these data. The theories are tested with newly collected data and continually evaluated in a cyclical fashion until a point of "saturation," when no new interpretations arise from the data (Green & Thorogood, 2009). Additional benefits of grounded theory in immigrant health research include the development of deeply analyzed theories about human experiences through systematic methods (Green & Thorogood, 2009) Potential disadvantages of using grounded theory with immigrant populations include time constraints, as grounded theory is often a time-intensive pursuit, and difficulty predicting when the saturation point will be reached, if at all (Green & Thorogood, 2009).

A study on depression in Vietnamese Americans used a grounded theory approach to discover and interpret trends and commonalities among the experiences of individuals in a shared cultural group (Fancher, Ton, Le Meyer, Ho, & Paterniti, 2010). Common themes of depression were explored within an ethnic group in order to develop culturally appropriate strategies to be used by healthcare providers. Methods particular to this study included employing a native Vietnamese speaker as an interviewer who was trained by mental health professionals for this project. Sampling was completed with a nonrandom snowballing method in which each participant referred potential new participants through their own social contacts. The researchers conducted semi-structured interviews, which followed a guide on the topic being addressed, but did not follow a set script. All interviews were transcribed, and coded, which is a system for categorization in which recurring themes were identified and noted where they occurred in each transcript (Green & Thorogood, 2009). Four common themes were identified from the participants' discussions of depression: the stigma of mental illness, the role of family, views on medications and traditional healing, and issues of culture and language (Fancher et al., 2010). By utilizing the grounded theory approach, the investigators began the research study with knowledge of the nature of the issue, but used the observation process to inform the development of the research process.

Phenomenology

A framework related to grounded theory, phenomenology, uses a similar foundation and research structure to uncover the meaning of human experiences. *Phenomenology* seeks to describe the essence of human experiences and ascribe essential meaning to these experiences (Polit & Beck, 2009). Phenomenological studies are often based on interviews and personal accounts. Methods in a phenomenological study are similar to grounded theory, including the use of personal, semi-structured interviews, and the employment of interpreters as needed when working with diverse cultural groups. Benefits of phenomenology research include the ability to develop a greater understanding of how unique human experiences can be described and interpreted, and attention to concepts of human experience that are not well understood. This approach is well-suited to use in nursing practice. Potential disadvantages of conducting phenomenology research with immigrant populations include the time-intensive nature of interviews and data collection, the need for the researcher to have deep knowledge about the participants' culture and social constructs, and limited generalizability to other groups.

A phenomenological investigation of experiences with depression among Nigerian-born female immigrants to the USA found that the women were unable to distinguish depression from other mental illnesses (Ezeobele, Malecha, Landrum, & Symes, 2009). Furthermore, the essence of the experiences with depression was linked to perceptions of "craziness" or "curses by spirits," with clergy being the preferred care providers for depressive symptoms rather than healthcare providers. Other essential themes surrounding depression related to social isolation, rejection by family members, and relationship problems (Ezeobele et al., 2009). Data for this study were coded and analyzed through stepwise guidelines for phenomenological inquiry, which helped the investigators identify these themes (Ezeobele et al., 2009).

Descriptive phenomenology focuses on the meaning of the experience itself, as was the case in the study with Nigerian-born women and depression, mentioned above. Researchers using this format may follow a sequence of bracketing (examining one's own biases), intuiting, analyzing, and describing, in order to uncover essential meaning (Polit & Beck, 2009). Another variation, *interpretative* phenomenology, based on the philosophical views of Heidegger, is focused on why and how these experiences are understood. Components of lived experience can be divided into themes of spatiality, corporeality, temporality, and relationality, and how individuals' worldview relate to their own relationship with these themes throughout their life (Polit & Beck, 2009). A study with elderly Iranian immigrants in Sweden used an interpretative phenomenological framework to examine perceptions of mental health and wellness in a vulnerable subset of an immigrant population (Emami, Benner, Lipson, & Ekman, 2000). Interviews were not structured, but participants were guided to talk about their impressions of health, illness, and disease. Data analysis included recordings and transcriptions of the interviews, and the interviews were analyzed in their entirety as well as in parts for comparison. Key themes generated by the interviews were evaluated through thematic analysis, and compared with the original interviews. Themes uncovered in this interpretative phenomenological study revolved around the role of social functioning for health, the concept of health and wellness as continuity within one's life, and illness as a type of disruption to that continuity (Emami et al., 2000). Goals with such a study were to build understanding about human experiences within this community, and allow care providers insight for more therapeutic interactions.

Ethnographical Inquiry and Symbolic Interaction

Ethnographical inquiry is a holistic method based on detailed observations derived from immersion or participation in cultural group studied over a period of time (Polit & Beck, 2009). Ethnographical inquiry is commonly used in anthropology, and can be highly relevant to studies of immigrant health. The relationship between researcher and researched group becomes intertwined over time, which places greater responsibility on the researcher to truly understand and respect the immigrant culture being studied. The outcome of research is generally through written text by the researcher, with an emphasis on what can be learned from the relationships of behaviors within the group (Loue, 1999).

Ethnographies may be viewed at the macro level, to examine large populations groups, or at the micro level, to examine a small community or group of individuals. Ethnography is different from an observational study because of the emphasis on understanding both the emic and etic perspectives of the society. An *emic* perspective represents the members' view, and represents how an "insider" describes their social environment. An *etic* perspective represents the view of the observer, or the one doing the analysis (Green & Thorogood, 2009). In ethnography, the interrelationship between the emic and etic viewpoints drives the creation of theory about the culture and how humans understand their world (Green & Thorogood, 2009). Additional benefits of ethnographies include their holistic approach and diversity in techniques for data collection. Potential disadvantages of conducting ethnographies with immigrant populations include the time-intensive nature, and how the role of an observer affects the culture being studied.

A type of study related to ethnography and undertaken from a sociological perspective is *symbolic interaction*. Symbolic interaction assumes that behavior of individuals is a result of human relationships and experiences with one another (Polit & Beck, 2009). Behavior is thus understood only within the context of the community or cultural group. The meaning of social symbols, which includes language, signs that carry information, and objects, are based on the process of interpretation by each individual within their social world (Polit & Beck, 2009). Benefits of symbolic interaction include an increased understanding of how individuals interpret social cues, such as language (Polit & Beck, 2009). Disadvantages of using symbolic interaction with immigrant groups are the potential for misinterpretation if the analysts are working with a culture outside of their own, and the potential for observer bias.

In an exploration of the perceptions of health of adolescent immigrants from Mexico, both ethnography and symbolic interaction frameworks were used to form the structure of the inquiry (Garcia & Saewyc, 2007). Specific methodological techniques in working with this population included waiving written consent by the students or their parents, owing to the possibility that families might not have had legal status to reside in the USA and would be afraid to sign their name for the study process. The Institutional Review Board accepted oral assent from students. Students also chose an alias for the study to further preserve confidentiality (Garcia & Saewyc, 2007). The methods included an initial, guided interview about the adolescents' views on health and access to services in the USA; these initial interviews were followed by both participant photo journaling of their views of health and follow-up interviews (Garcia & Saewyc, 2007). The analysts were actively immersed in the cultural setting, an American high school, for a period of time. Other techniques used for data collection in the study included participant observation, journaling, and field notes.

In the analytic phase of the study, the theories of symbolic interaction influenced how the data were interpreted. The investigators showed through their interpretation how the students' worldviews were inextricably tied to their cultural and ethnic identities. This relationship affected their perceptions of health, as evidenced by the ethnographical analysis and interpretation of data in a symbolic interaction framework.

Distant/Secondary Focus Research Methodologies

A final set of methods takes a more distant perspective, with the researcher using a theoretical approach to research, examining a large set of studies, or using a retrospective approach to examine or reinterpret studies over time. Meta-interpretative studies imply a secondary analysis of existing studies. Other studies with a distant focus seek to describe correlational relationships between factors, such as potential risk factors in the development of a disease. Research studies identified in this section include concept analysis, correlational studies, historical analysis, feminist studies, mixed-methods, and metasynthesis.

Concept Analysis

Concept analysis is an examination of the characteristics associated with a particular set of phenomena. Concept analysis is useful for deeper understanding of abstract terms that may be commonly used but poorly understood, or for exploration of lesser-known, concepts (Polit & Beck, 2009). Examples of concepts that may be analyzed in health research include stress, caring, or health literacy. If concepts are the "building blocks" for the development of theory (Polit & Beck, 2009), then an analysis of these building blocks addresses the foundation upon which all other research is built. Within the field of health care, benefits of applications from concept analysis may include the development of culturally sensitive models of care and the development of new tools for screening or evaluation (Polit & Beck, 2009). It may encourage the development of new theories or challenge existing theories of a concept. A disadvantage of using concept analysis in immigrant health research is the difficulty of translating findings into practice (Polit & Beck, 2009). Concept analysis studies are generally analytical and exploratory, and may share data collection methods with that of a literature review.

Choi (2001) used the conceptual analysis method to explore the idea of "cultural marginality" in an adolescent immigrant population. Using a framework for analysis developed by Walker and Avant (1995), the study examined a specific concept and its attributes, antecedents, and consequences within a particular population. Choi first established the significance of specialized care of this group. The concept "cultural marginality" was defined by the author, with an exploration of the historical development and related terminology, as well as a literature review relating to the concept. Four attributes, or characteristics, were identified from their repeated mention in the relevant literature. Antecedents, which are necessary factors in the development of cultural marginality, included the immersion of an individual in two distinct cultures. Consequences, which are expected outcomes from one's experience with cultural marginality, were identified as the successful and unsuccessful modes of negotiation between cultures (Choi, 2001). Applications from this study include a greater understanding of cultural marginality for care providers of immigrant adolescents, so that they can provide more sensitive care.

Correlational Studies

Correlational research focuses on the relationship between variables, such as potential risk factors in the development of a disease. Unlike experimental designs, the independent variable is not controlled, and no interventions are performed through this type of analysis. These studies are also called *ex post facto* ("after the fact"), as they may use data already collected from existing studies (Polit & Beck, 2009). Correlational studies can be beneficial for finding previously unknown or unstudied relationships, or for strengthening existing theories. Some correlational studies use a cross-sectional method to look at particular variables as they relate to one another at a moment in time. Other studies use a longitudinal approach to view data over a period of time (Polit & Beck, 2009). Benefits to this type of study include the ability to illuminate previously unknown relationships and to develop hypotheses. Disadvantages to its use in immigrant health research include the inability to establish causality between variables and the potential for misinterpretation of relationships.

A systematic review of research on breast cancer used a correlational model to examine possible disease risk factors and protective characteristics across diverse immigrant populations (Andreeva, Unger, & Pentz, 2007). A systematic review method was chosen in order to examine a wide scope of knowledge and research and seek potential commonalities in groups that differed in age, ethnicity, and culture (Andreeva et al., 2007). In addition, the study was designed to challenge an existing theory on migration and disease, the acculturation-based risk transition model. The research encompassed 79 different studies on breast cancer that spanned a period of 35 years; this permitted an examination of historical trends and relationships in research on the disease. For this study, an extensive collection of data sources was used, particularly cancer registries, public health surveillance databases, and catalogues of academic literature. Inclusion and exclusion criteria were established. The data analysis phase focused on identifying modifiable factors exhibited by women in the pre-migration and post-migration phases and creating a model that can be used for interventions. By using a correlational framework for evaluation, the researchers were able to evaluate a range of contributing risk factors and develop a new model that included the diverse interplay of these factors, without attributing causality to any of them. This model was suggested for use in interventions among Eastern European Jewish immigrants, who have the highest breast cancer prevalence rates in the world (Andreeva et al., 2007).

Historical Analysis

Historical analysis studies are to describe, analyze, and interpret past events. The goal in historical studies is accuracy and impartial interpretation of events as they relate to the research topic, such as the role of illness and physical health in a societal history (Green & Thorogood, 2009). Historical research may depend on documents or recorded accounts of those who were alive during the time period of interest. Documents that are publicly available may be easier to procure than those held privately and can also reduce the amount of resources needed to collect data (Green & Thorogood, 2009). Benefits of a historical analysis include the ability to examine how immigrant groups have moved and adjusted to events over time and how health indicators or conditions have changed. Disadvantages to using historical analysis approaches in immigrant health research include potential limitations of sufficient documentation and the inability to control how past data were collected (Green & Thorogood, 2009).

Feminist Studies

Feminist research uses gender as a tool to examine social processes, knowledge, and power, with emphasis on experiences of women within a male-dominated societal hierarchy. An assumption within feminist theory is that knowledge generated from a male-dominated societal sphere is not objective, and therefore only reflects a masculine worldview (Green & Thorogood, 2009). Specific categories may include feminist empiricism, feminist standpoint research, and feminist postmodernism. Each different approach of feminist research will generate different aims and research questions (Green & Thorogood, 2009). Advantages of using feminist approaches include the ability to examine why marginalized groups of persons, such as women within an already-marginalized ethnic group, do not access health services, or why their needs are not as well addressed. Disadvantages in using this approach in immigrant health research include an intense focus on gender and assumptions about the differences in human experiences by men and women.

A feminist study about immigrant women in Canada evaluated how women tell their stories, particularly focusing on their work, health, and perceptions of identity as female immigrants. By using a feminist approach, the researchers evaluated how sociopolitical forces affected each woman's experiences as well as her telling of the experiences (Dyck & McLaren, 2004). An initial stage of this study consisted of focus groups with educators and community leaders, where impressions of immigrants and immigration issues were discussed. Seventeen women, all immigrants to Canada in the past 5 years, were recruited by the community leaders and interviewed in English or through a translator (Dyck & McLaren, 2004). Though the topics of the interviews were set forth as femininity and family, and how they are affected by immigration, the women directed the discussions. They often focused on economic pressures, inability to find work, and the negative effects of immigration on their personal health (Dyck & McLaren, 2004). All interviews were recorded and transcribed and evaluated along with the researchers' field notes (Dyck & McLaren, 2004). How the women felt they are perceived as immigrants, as well as the socioeconomic pressures they encounter, affected their ability to find work, take control of their health, and succeed in their new surroundings. The researchers described how feminism reframing may not just be beneficial, but also necessary in order to improve research and provide more accurate social representations of female immigrants (Dyck & McLaren, 2004).

Mixed Methods

Mixed-methods studies integrate qualitative and quantitative methods of data collection and analysis. A component design keeps the qualitative and quantitative parts separate for the purpose of data collection and analysis (Polit & Beck, 2009). These types of designs may be used to address one research question build on the results of the other design type, or address separate questions (Polit & Beck, 2009). An integrated design uses both qualitative and quantitative aspects throughout the entire process (Polit & Beck, 2009). These designs blend the qualitative and quantitative data sources throughout the research process, and are more useful for developing and testing theories than component designs (Polit & Beck, 2009). Benefits of utilizing mixed-methods designs include the ability to use nearly any combination of research methodologies and to evaluate multiple within the same study. A disadvantage to mixed-method designs in immigrant health research is that some health issues in research are only suited to either qualitative or qualitative inquiry (Polit & Beck, 2009).

An evaluation of acculturation and food acquisition among Somali refugees to the USA used a mixed-methods approach in order to examine five interrelated hypotheses. The study focused on the effects of food and diet, the geography of where refugees were placed, economics, and access to food stamps on immigrants' dietary choices (Patil et al., 2009). The methodology for this study included data analysis, surveys, and interviews of refugees and caseworkers. The mixed-method approach did not permit the identification of causal links between these factors, dietary changes and poor health outcomes, but did permit the description of many facets of the complex issues surrounding diet, nutrition, and food acquisition in refugee populations (Patil, Hadley, & Nahayo, 2009).

Another mixed-methods study of African refugees incorporated multiple data collection strategies to enhance a community-based participatory action program. The researchers focused on female genital cutting within particular ethnic communities in the USA (Johnson, Ali, & Shipp, 2009). Methods for this study included surveys, interviews of individuals from the refugee community as well as healthcare providers, and focus groups. Through the use of a community-based participatory action design, the investigators were able to engage community members throughout the research process. Participatory action was a particularly important methodological approach to use in this situation since the practice being investigated was not commonly seen among nonimmigrant populations in the USA. An intended application from this research approach was to increase the development and utilization of culturally competent care within this population (Johnson et al., 2009).

Metasynthesis

Metasynthesis is a secondary analysis of a comprehensive group of existing studies from which new theories and interpretations can be developed (Polit & Beck, 2009). Rather than a summary, *meta*-studies seek to develop new theories and interpretations about a collection of separate but linked inquiries (Polit & Beck, 2009). For example, meta-ethnographical studies are used to synthesize conclusions from a range of ethnographical studies, using interpretation of existing data rather than newly collected observations. Considerations for metasynthesis designs include the determination and application of inclusion criteria, publication bias, and an emphasis on the quality, rather than the quantity, of studies to be included. Advantages to utilizing metasynthesis include the ability to integrate studies and knowledge from multiple disciplines and the ability to use the findings as the basis of evidence-based practice. Disadvantages include the potential lack of depth in interpretations and overgeneralization (Polit & Beck, 2009).

Researchers conducting a metasynthesis of studies relating to Asian immigrant nurses working in Western countries used a metasynthesis approach in an effort to improve clinical and communication practices, build on nursing knowledge, and develop policy (Xu, 2007). Studies were collected from an extensive literature search of qualitative research, and inclusion criteria were established. The researchers identified four themes relating to the experiences of Asian immigrant nurses: communication as a barrier, clinical practice differentials, discrimination, and differences in culture (Xu, 2007). The process of gathering and interpreting multiple existing data sources both facilitated the development of theories and thematic conclusions and broadened relevant knowledge beyond what would have been possible through a literature review (Xu, 2008).

Conclusions

A wide array of research methodologies are available to assist investigators in the study of immigrant health. The roles of language translation, cross-cultural boundaries, as well as legal and ethical protections must be carefully considered in research study design and implementation. Of equal significance is the consideration of the relationship between the researcher, research participants, and immigrant community being studied. Selection of the most appropriate methodological approach to studying issues of immigrant health increases the scientific validity of the research findings. Careful attention to methodological issues further ensures the investigator's ethical responsibility to accurately represent the research participants and cultures being studied and to clearly disseminate the research findings to the scientific community and beyond. As immigrant health research may illuminate health disparities and call attention to previously unidentified needs of underserved and vulnerable populations, it is reasonable to regard the well-designed research method as not only as a tool for information gathering and critical analysis, but as a vehicle for social justice.

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Ethical Issues in Research with Immigrants and Refugees

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Introduction

Migration has been construed as:

- The physical transition of an individual or a group from one society to another. This transition usually involves abandoning one social setting and entering a different one (Eisenstadt, 1955, p. 1)

  A relatively permanent moving away of ... migrants, from one geographical location to another, preceded by decision-making on the part of the migrants on the basis of a hierarchically ordered set of values or valued ends and resulting in changes in the interactional set of migrants (Mangalam, 1968, p. 8)

  A permanent or semipermanent change of residence (Lee, 1966, p. 49)

  The process of social change whereby an individual moves from one cultural setting to another for the purpose of settling down either permanently or for a prolonged period (Bhugra & Jones, 2001, p. 216).

These varied constructions indicate that the concept of migration encompasses both movement within and across national borders. This includes both internal migrants, such as agricultural workers and persons who have been displaced as the result of natural disasters or civil conflict, and those who cross international borders, regardless of the manner or legality of their entry. Importantly, the concept of migration captures the continuum of time during which movement and transition occur, from the premigration phase, when individuals may be only contemplating movement; through the perimigration phase, during which movement is effectuated from one locale to another; and through the postmigration phase, following the individual's arrival at a place of temporary or permanent refuge or residence (Loue & Galea, 2007).

Approximately 175 million people, or 2.9% of the world's population, live either permanently or temporarily outside of their countries of origin (International Organization for Migration, 2003). In 1990, migrants accounted for 15% of the population of 52 countries (Council of Europe, 2000). The International Organization for Migration has estimated that currently one in every 35 people in the world is an international migrant (International Organization for Migration, 2003) and that by the year 2050, the number of international migrants will approach 250 million (International Labour Office, International Organization for Migration, & the Office of the United Nations High Commissioner for Human Rights [ILO, IOM, OHCHR], 2001). These figures include migrant workers, permanent immigrants, and those who are seeking asylum or refugee status; it does not include individuals who migrate across borders illegally, who are known variously as "illegal," "undocumented," or "irregular" (World Health Organization, 2003). These individuals may migrate themselves; may be trafficked, a process that involves coercion or deception; or be smuggled, meaning that their entry has been facilitated by others for profit (ILO, IOM, & OHCHR, 2001). Consequently, these figures represent underestimates of the magnitude of migration and its demographic impact in various regions of the world (Council of Europe, 2000).

Individuals may migrate from one area to another for any number of reasons. Circumstances at the point of origin that may "push" individuals to leave include poverty, unemployment, persecution, internal civil strife, a change in government or regime, and/or natural disasters, such as a hurricane. Refugees, in particular, migrate due to "push" factors. The 1951 United Nations Convention on Refugees, as modified by the 1967 Protocol Relating to the Status of Refugees, describes a refugee as a person who:

Sana Loue & Martha Sajatovic (eds.), *Encyclopedia of Immigrant Health*, DOI 10.1007/978-1-4419-5659-0,

- owing to 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 his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside of his former habitual residence as a result of such events, is unable, or owing to such fear, is unwilling to return to it.

Individuals may also migrate because they feel a "pull" toward the intended destination as a result of perceived employment prospects, the ability to reunify with other family members, expectations of a better economic and/or political situation, freedom from persecution, and/or a safe haven from the ravages of man-made or natural disasters. Distinctions have accordingly been made between those immigrants who are "voluntary," such as students, tourists, and migrant workers, and those who are "forced" to migrate as the result of displacement due to internal conflict, environmental disaster, famine, or development projects (Loughna, n.d.).

The various circumstances surrounding immigration and, in particular, those involving trafficked persons and refugees fleeing persecution, may leave persons particularly vulnerable, meaning that they "are relatively (or absolutely) incapable of protecting their own interests" due to insufficient power, education resources, strength, or other requisite attributes (Council for International Organizations of Medical Sciences, 2002, Guideline 13). Vulnerabilities may be cumulative, resulting in what is essentially compounded powerlessness. As an example, a minor child who is fleeing from individuals who have bought and sold him or her into prostitution is vulnerable as a function of both age and sex. This chapter explores the ethical issues that arise in the context of conducting health-related research, whether of a biomedical, epidemiological, or social science nature, with such individuals and communities during their experience of such movement.

The Impact of Migration

Asylum Seekers and Refugees

Numerous studies have reported that refugees and asylum seekers may suffer from posttraumatic stress disorder (PTSD) and other mental illness. In order to be diagnosed with PTSD, the individual must have experienced, witnessed, or been confronted with a traumatic event or a series of events that involved actual death or serious injury or the threat of death or serious injury. As a result of these events, the individual experienced feelings of intense fear, horror, and/or helplessness (American Psychiatric Association, 2000). Additionally, for a period of at least 1 month, the individual reexperiences the event (s), avoids stimuli that are associated with the trauma, and experiences numbing of general responsiveness and increased arousal, resulting in clinically significant distress or impairment in one or more important areas of functioning, such as family life or work. Individuals may attempt to avoid any feelings or thoughts associated with the trauma and, consequently, may suffer "emotional anesthesia" and/or experience amnesia with respect to the triggering event(s) (American Psychiatric Association, 2000). Not surprisingly in view of these symptoms, many individuals suffering from PTSD may experience difficulty with one or more important functions of daily living.

Data suggest that two out of every three asylum seekers (the equivalent of a pending application for refugee status) in the European Union have experienced some mental problems (Burnett & Peel, 2001) and that up to 40% of all refugees have been tortured (Steel, Frommer, & Silove, 2004). In a study of ten detained asylum seekers in the United Kingdom, it was found that six had suffered torture, all ten were suffering from depression, four were suicidal, and two had attempted suicide while in detention (Bracken & Gorst-Unsworth, 1991). More than 50% in a sample of 33 asylum seekers in Sydney, Australia, reported having been physically tortured (Sultan & O'Sullivan, 2001). A review of 20 studies providing results for 6,743 adults from 7 countries and 5 surveys of 260 refugee children from 3 countries reported that among the adults, 9% suffered from PTSD, 4% had generalized anxiety disorder, and 5% had major depression, while 11% of the children were diagnosed with PTSD (Fazel, Wheeler, & Danesh, 2005). The authors concluded that refugees are ten times as likely to have PTSD compared to age-matched individuals in the native populations of the countries surveyed.

High rates of PTSD have also been reported among refugee children. Almost all of the children in a sample of internally displaced Bosnian children were diagnosed with PTSD (Goldstein, Wampler, & Wise, 1997). Among children who had experienced war in Cambodia and the former Yugoslavia and had migrated to the United States, almost one-half suffered from symptoms of PTSD (Mollica, Poole, Son, Murray, & Tor, 1997; Sack, Clarke, & Seeley, 1996; Weine et al., 1995). A study of refugee children ages 8–16 in London found that greater severity of PTSD was associated with premigration experiences including the violent death of family members and an unstable or insecure status following migration (Heptinstall, Sethna, & Taylor, 2004). Similar findings were reported from a study involving 87 children and adolescents who sought refuge in the United States from Cuba and had been held in refugee camps for up to 8 months prior to arrival in the United States (Rothe et al., 2002). More than half of the children (57%) evidenced symptoms of PTSD. Age and having witnessed violence in the camps were associated with PTSD. Consistent with findings from other studies (Chung, 1994; Chung & Kagawa-Singer, 1993; Steel, Silove, Phan, & Bauman, 2002), a dose–effect relationship was noted between the number of stressors and the severity of self-reported symptoms.

Exposure to war and/or political unrest may also heighten the risk of PTSD. A study comparing 258 immigrants from Central America and Mexico to the United States and 329 US-born Mexican Americans and Anglo Americans (non-Hispanic Whites) found that 52% of the Central Americans who had migrated because of war and political violence experienced symptoms of PTSD, compared with 49% of Central Americans who had migrated for other reasons and 25% of Mexican immigrants (Cervantes, Salgado de Snyder, & Padilla, 1989).

Refugees who were subjected to torture may also be at increased risk of developing both PTSD and another psychiatric disorder. A study of ethnically Nepalese, religiously Hindu refugees from Bhutan who sought refuge in refugee camps in Nepal found that those who had been tortured were 5 times as likely to develop PTSD as those who had not been tortured, and 1.6 times as likely to have any psychiatric disorder (Van Ommerren et al., 2001). The 12-month prevalence of any psychiatric disorder was 74.4% among those refugees who had been tortured, compared to 48% among those who had not. The impact of torture on mental health may be alleviated by the presence of family and social support from the immigrant community after arrival in the receiving country (Başoğlu & Paker, 1995; Schweitzer, Melville, Steel, & Lacherez, 2006).

Research findings also indicate that individuals who are placed in detention facilities following their arrival at their destination country may suffer both retraumatization and a worsening of their mental health in comparison with those who are not detained (Becker & Silove, 1993; Bracken & Gorts-Unsworth, 1991; Steel & Silove, 2001; Thompson & McGorry, 1998). In the previously mentioned study of 33 asylum seekers in Sydney, Australia, researchers noted a progressive deterioration in the mental health of the asylum seekers, who had been held in detention for an average period of 2 years (Sultan & O'Sullivan, 2001). The research team found that many of these individuals were

> ► dominated by paranoid tendencies, leaving them in a chronic state of fear and apprehension and a feeling that no one, including other detainees, can be trusted. Long periods of time are spent alone and some develop frankly psychotic symptoms, such as delusions, ideas of reference and auditory hallucinations (Sultan & O'Sullivan, 2001, p. 595).

This deterioration of mental status while in detention is also seen in refugee children. Their distress may be exacerbated as a result of observing parental distress and suffering, interviewing by immigration officials, witnessing displays of violence and self-harm, being separated from their parents with or without warning, and experiencing instability due to lengthy delays in processing their claims for refugee status (Zwi, Herzberg, Dossetor, & Field, 2003).

Confronting the New

At a minimum, immigrants to a new country of temporary or permanent residence may experience what is known as "culture shock." The term "culture shock" was introduced by Kalvero Oberg in 1954 to refer to an "abrupt loss of the familiar" or the "shock of the new."

> ► [It] is precipitated by the anxiety that results from losing all familiar signs and symbols of social

> intercourse. These signs are the thousand and one ways in which we orient ourselves to the situations of daily life: when to shake hands, when and how to be gracious and appropriate . . . when to accept invitations, how to take statements seriously . . .. (Oberg, 1954, p. 1).

As a result, individuals may experience feelings of inadequacy, vulnerability, anger, resentment, and irritability. They may find that they are unable to solve even simple problems because of their lack of familiarity with the new environment. As a result, they may lack self-confidence and have a tendency to blame others for any difficulties.

Culture shock occurs in various stages or phases, which have been variously termed incubation, crisis, recovery, and full recovery (Oberg, 1954, 1960); elation, depression, recovery, and acculturation (Richardson, 1974); and contact, disintegration, reintegration, autonomy, and independence (Adler, 1975). The first stage of elation is characterized by feelings of excitement, which may last for hours, days, weeks, or months. These feelings gradually dissipate, as the individual becomes increasingly aware of the differences that exist between her previous and current environments. This second phase of disintegration is marked by practical problems, an increase in misunderstandings and associated feelings of frustration, a sense of loneliness and uneasiness, and a decrease in self-confidence. During the third stage of culture shock, the individual begins to reintegrate into the new environment or reject her new situation, blaming others and adopting negative coping mechanisms, such as substance use and self-isolation. During the final stage of recovery, the individual may gradually adjust and adapt to the new environment, experiencing a greater sense of control, autonomy, and belonging (reintegration).

Significant variation exists between individuals in their experience of culture shock. The sequence and rate through which they pass through the various stages may differ as a function of their mental state, personality, familiarity with language, family and social support system, religious beliefs, level of education, socioeconomic condition, sex and gender, and past experiences with travel. Some individuals may experience great difficulties, depending upon their age, sex, health status, migration experiences, and the nature of their reception in their destination country.

Ethical Issues in the Context of Research

Immigrants as a Vulnerable Population

The ethical principles of respect for persons and beneficence, derived from the Nuremberg Code (1949), demand that we as researchers assess the risks and benefits to prospective participants prior to the initiation of an investigation, in order to determine whether the investigation should even be pursued. In general, special justification is need for the conduct of research with vulnerable participants (CIOMS, 2002, Guideline 13). Accordingly, one must first ask whether immigrants as a group constitute a vulnerable population within the context of research involving human participants.

As indicated previously, vulnerability refers to those persons who are relatively or absolutely unable to protect their own interests because "they have insufficient power, prowess, intelligence, resources, strength, or other needed attributes to protect their own interests through negotiation for informed consent" (Levine, 1988, p. 72). Application of this definition to the situation confronting many immigrants argues in favor of a determination of vulnerability. Many, if not the majority, of immigrants often do not speak the language of the country to which they are relocating. They may have little access to medical care or knowledge of the health care system. At a minimum, they are likely experiencing some degree of culture shock; some individuals, such as refugees and asylees, may also be suffering from the effects of trauma, severe depression, and physical injury. As a politically and often socially and economically marginalized group, individuals may not perceive their participation in research as voluntary (Barsdorf & Wassenaar, 2005).

Although the principles of respect for persons and beneficence would suggest that these circumstances disallow the participation of immigrants in research, the inquiry cannot stop. The exclusion of immigrants from participation based on such factors alone may well constitute a paternalistic overemphasis on the principle of autonomy, which provides for individual decision making, and the principle of justice, which dictates that the benefits and burdens of research be accessible across populations (Beauchamp, Jennings, Kinney, & Levine, 2002; Erlen, Sauder, & Mellors, 1999; cf. Roberts, Geppert, & Brody, 2004; Stanley B., Stanley M., Lautin, Kane, & Schwartz, 1981). Depending upon the health care system of the receiving country, participation in research may represent for many immigrants the only means by which they can obtain needed health information and care; this may be particularly true for undocumented adults and children. As an example, US law provides that even legal immigrants who are residing permanently in the United States are barred in all but very limited circumstances from receiving health care through publicly funded sources (Personal Responsibility and Work Opportunity Reconciliation Act of 1996). Accordingly, immigrants should be provided with the opportunity to participate in research protocols for which the risks and benefits of participation have been carefully assessed and special protections implemented (CIOMS, 2002, Guideline 13).

Funding Source and Participant Risk

Researchers do not generally consider the possibility that the source of their funding for a study may jeopardize in some way the situation of their research participants. Consider, however, the following hypothetical case.

Recently, a US citizen who had emigrated from Pakistan attempted to car bomb an area of Times Square in New York (Moore, 2010). A law enforcement agency might decide to fund research to understand better the circumstances that might compel an individual in his circumstances to engage in acts of terrorism. The researcher owes the participants of his or her research confidentiality to the extent possible. Yet in such circumstances, the law enforcement entity may feel entitled to all of the data based on its national security concerns. The source of the funding has created potential risk for the participants and the larger participant community; as a result of the fact of the study or its findings, the community as a whole may be subject to increased surveillance, or other measures, which may prove later to have been unwarranted. The community may also be stigmatized as a result of the increased attention from law enforcement authorities.

It is critical that in such circumstances, the researcher negotiate with the finding source the extent to which each party will have access to the data and control its use. The outcome of such negotiations must be made clear to prospective participants so that they can knowledgeably consent to or decline to participate.

Sampling and Recruitment

Immigrants and refugees may face particular risks even during the process of research study recruitment, prior to enrollment, which must be balanced against whatever benefits they may derive, if any, from their participation in the proposed research. First, efforts to recruit individuals that are premised on a designation of membership in a particular group or subgroup or disease status may have the unintended effect of focusing increased attention on a group that may be marginalized and/or stigmatized within not only the larger population, but also within the individuals' immediate milieu. As an example, recruitment to research relating to HIV/AIDS or mental illness that is conducted within a refugee camp, which is often characterized by close quarters and a lack of privacy, may inadvertently result in the identification of individuals with the disease or illness and their consequent marginalization and/or victimization within the camp. A similar consequence may result with respect to research related to any number of diseases, depending upon the sensitivities of a particular group or culture (Leaning, 2001). Accordingly, it is incumbent upon the researcher to understand the dynamics and perceptions of the community prior to the initiation of recruitment efforts, in order to fine-tune the recruitment procedures and language so as to minimize such risks.

Genetic research poses unique ethical issues. The meaning of kinship is known to vary widely across cultures; the meaning may determine issues of politics, economics, inheritance, property rights, succession, and access to power (Kissell, 2005). A redefinition of kinship by a research team to examine what are considered by researchers to constitute familial relationships may have the unintended effect of disrupting the individual's sense of his or her place in the world and reorganizing individual and group responsibilities and obligations, leaving individuals feeling – or being – isolated and dislocated. The worst-case scenario may find individuals expelled from their kinship group and community as the result of such redefinition, with attendant emotional, social, psychological, and economic losses.

Second, depending upon how inclusion and exclusion criteria for a particular study are framed, some individuals illegally present in a particular country may be eligible to participate in the study. Targeting a particular geographic area of a city or town may focus unwanted attention on the immigrants' presence, thereby unintentionally increasing both their vulnerability to political processes and their risks of deportation and/or violent victimization by vigilante groups and/or unethical government agents. Additionally, as Loue and Sajatovic (2008) found in their study of the cultural context of HIV risk among Mexican and Puerto Rican women with severe mental illness, an increase in law enforcement efforts that occurs independently of the researchers' recruitment efforts may increase the difficulty of recruiting and retaining study participants.

The conduct of research with immigrants confined to detention centers raises other ethical issues. When official approval is required to conduct such research and the screening and selection of eligible detainees is determined by those in charge of the facility themselves, the possibility of coercion in selection or nonselection remains ever present. Research conducted without official approval or through the use of deception may ultimately place the detainees at risk of harm and threaten the credibility of the investigators and their research (Kirmayer, Rousseau, & Crepeau, 2004). The close quarters that are characteristic of many detention facilities may limit privacy and confidentiality, potentially placing the participating detainees at increased risk from authorities and/or others who are detained. Nevertheless, some scholars have argued that researchers have a moral responsibility "to address actions of violence or neglect, perpetrated by the state on their behalf that brings suffering and hardship to others" (Kirmayer et al., 2004, pp. 85–86). Others have asserted that even when there exists a conflict of interest between researchers and those in authority in a detention situation, there exists "a legitimate moral imperative . . . for clinical researchers to breach the walls of enforced silence and give a voice to those who are afflicted" (Steel & Silove, 2004, p. 93).

Third, the mechanism used for sampling and/or recruitment may potentially subject immigrants to coercion and duress. Snowball sampling and respondent-driven sampling (RDS), both commonly used in conducting research with populations that are considered hard-to-reach, involve the recruitment of individuals to the study by an already-enrolled participant. The researcher may be unaware of the power dynamics that exist within a specific network or community, or the nature of the relationship between the respondent-recruiter and those that he or she recruits to the study. This can potentially lead to the coercive recruitment of individuals when conducting research with immigrants and refugees specifically because of their relative powerlessness as immigrants and refugees.

Recruitment through a gatekeeper or community leader raises similar concerns of coercion and duress. The leader or gatekeeper may be able to exert influence or pressure on community members because of his or her relative power within the group; this may be particularly true where the individual possesses greater education, wealth, or political connections relative to others, or is a member of a subgroup that has historically held greater power. As with recruitment conducted through already-enrolled participants, recruitment of individuals through a perceived leader has the potential to exacerbate intragroup or intergroup tensions of which the researcher may be unaware, and lead to further oppression, humiliation, or persecution of individuals. Where that individual receives resources, such as cash or transport, from the researcher in exchange for their assistance with recruitment, the researcher may unknowingly be legitimizing the individual's presence and authority to the detriment of those who will be participants (Jacobsen & Landau, 2003).

Enrollment and Participation

Informed Consent

The informed consent process is inherently complex, requiring an assessment of the prospective study participant's capacity to provide informed consent, his or her understanding of the information provided about the study, and the extent to which the individual's agreement to participate is voluntary and free of coercion or duress. The complexity of this process may be compounded with immigrants and refugees due to differences in language, lack of familiarity with the new culture generally and with research specifically, power differentials between the researcher and the participant and, in some cases, a history of trauma, and/or a fear of violence and/or discovery.

Language. The language in which information about the study is conveyed to the participant should be the language that he or she understands as, for example, to present the information in Romanian to Romanian-speaking participants. However, the language that is used must be accessible to and understandable by prospective participants if their consent is to be truly informed. It is unlikely, for instance, that individuals with little or no formal education would understand medical terms used by physicians in a case presentation during Grand Rounds.

In addition, the demographic characteristics of the translators (addressing the written transformation from one language to the other) and interpreters (addressing the oral transformation from one language to the other) may affect the translation/interpretation and, consequently, the accuracy of the information provided to the prospective participant and/or the information that the participant wishes to convey to the researcher. In the context of back translation, one translator will translate the consent form from its original language to that of the prospective participants and a second translator will "back translate" the translated version to the original language to maximize accuracy and reduce ambiguity or confusion. Variations between the translators in terms of their age, social standing, level of education, socioeconomic status, and even place of origin may impact on the dynamics between them, leading one to defer to the other out of respect, even where such deference may lead to less-than-optimal results with the translation (Yick & Berthold, 2005). Similarly, the existence of such differences between the prospective participant and the interpreter assisting with the informed consent process may affect the dynamics of the informed consent process, resulting in reticence on the part of the prospective participant to ask questions or to disagree. It is important that the research team consider such possibilities and take steps to minimize them.

Personhood and Self-in-Context. Unlike the cultures of many industrialized countries, many cultures define personhood as a person-in-context, that is, as a function of the many and varied relationships and roles for which the individual may be responsible. A woman, for example, would not be considered an autonomous individual with sole decision-making authority for herself, but would rather be conceived of as a daughter, a wife, and a mother, with obligations to those persons for whom she plays these roles. Accordingly, consent to participate in a study may require consultation with those to whom she is responsible (Loue, Okello, & Kawuma, 1996). In such situations, researchers may wish to provide for a waiting period between the provision of information to the prospective participant and the completion of the informed consent process, in order to allow the participant adequate time to consult with others of their choosing. Ultimately, however, the decision to participate must be an individual one.

In some cultures, consent must be obtained from a tribal chief or community leader prior to seeking consent from individuals for their participation (Dawson & Kass, 2005; Molyneux, Wassenaar, Peshu, & Marsh, 2005). This necessarily raises issues as to who can legitimately speak for the community and the extent to which that individual is respected by and reflective of or distanced and mistrusted by the community (Marshall & Batten, 2004).

Power Differentials. There is inherently a power differential between the research team members and the immigrant participants because of the difference in roles; this may be accentuated due to differences in sex, education level, professional status, or socioeconomic status. Researchers may believe that reliance on research assistants from the same country or area as the research participants may enhance both recruitment efforts and communication with participants because of their similarity to the participants. However, the researcher may inadvertently transgress political, social, or economic fault lines that exist within the group by unknowingly employing individuals who are members of a subgroup that has historically been hated by or has hated and persecuted those of other subgroups within the country (Jacobsen & Landau, 2003).

Discovery. Prospective participants may fear discovery for any number of reasons. A study focusing on family violence may raise fears of prospective participants that they will be subjected to further violence should their abusive family member discover their participation. Individuals who have been persecuted and/or tortured by the governments or agents of their governments from which they fled may be concerned that their disclosure of any information may incur the wrath of some unknown and unidentified "other," who will seek them out for punishment. Trafficked persons may fear that their traffickers may find them, recapture them, and once again subject them to threats or violence. Still others may be concerned that, if discovered, they will face deportation to their country of origin, where they will once again face whatever drove them to leave. As a consequence, individuals may be reluctant to sign any paper signifying their participation in or association with the research (Langford, 2000).

In such circumstances, it may be advisable to implement informed consent procedures that require only oral consent from the participant (Cwikel & Hoban, 2005). This may be supplemented by a statement signed by a second research staff person, confirming that the participant was provided orally with all of the information necessary to make an informed decision regarding participation and that the individual did, indeed, provide consent to participate. Where circumstances permit, a written information sheet describing the study and the requirements of participation can be provided to the participant.

These safety concerns underscore the need to ensure confidentiality (referring to information) and privacy (referring to the individual) even during the enrollment process, before any data are collected. The possibility of breaches of confidentiality may be reduced by putting passwords on computers; limiting access to data linked to individually identifying information, such as names and addresses, to those persons who truly need such information; maintaining any hard copies of the data in locked file cabinets in enclosed and locked offices; and requiring that all personnel involved with the study sign confidentiality agreements that advise them of the severity of a breach and the likelihood that disciplinary action will be taken if a breach were to occur. Mailings should not be sent to the participant or messages left on a voicemail recording without the prior consent of the individual and assurances that his or her safety will not be threatened as a result of the communication. In the United States, data collected within the boundaries of the United States may receive additional protection through the issuance of a certificate of confidentiality from the National Institutes of Health after application by the researcher and his or her institution (United States Department of Health & Human Services, 2009). Privacy may be enhanced by conducting all interviews and telephone conversations in enclosed office space or, where such space is unavailable, conducting the interviews and conversations out of sight and hearing range of others.

Continuing Consent. Circumstances may change during the course of the study which may impact an individual's willingness or ability to continue with his or her participation and, consequently, require the re-consenting of the individual to assure ongoing validity of his or her consent to participate. As one example, an individual suffering from posttraumatic stress disorder may experience an exacerbation of his or her symptoms that may or may not be related to the focus of the study, but that make it increasingly difficult to continue as a participant. Changes in external circumstances may also render it more difficult for an individual to continue participation. An increase in immigration law enforcement activities in the geographic area in which the study is being conducted may cause a shift in the balance of risks and benefits to the individuals participating (Loue & Sajatovic, 2008). The increase in participants' risk of discovery may outweigh any direct benefits that they had identified at the time of their initial consent to participate.

Special Protections

Community Advisory Boards (CABs). CABs consisting of members of the relevant community have been instrumental in the conduct of research with immigrant communities (Kobetz et al., 2009). Importantly, CAB members who are familiar with and connected to the immigrant community can provide advice to the research team regarding culturally sensitive mechanisms to reduce participants' risks and maximize participants' benefits from the research. CAB members may provide critical input in the development of the research protocol, recruitment and enrollment efforts, and the interpretation of the collected data.

The establishment of a CAB and the training of its members is consistent with ethical principle of beneficence (to maximize good) and with the provisions of Guideline 20 of CIOMS' *International Guidelines for Biomedical Research Involving Human Subjects*, which urges researchers to strengthen capacity for ethical and scientific review and biomedical research, including "educating the community from which research subjects will be drawn." The formation and successful operation of a CAB in partnership with the research team may (1) increase the capacity of the community and its members to understand scientific research, (2) increase community knowledge of a particular disease and its prevention and treatment (Morin et al., 2008), (3) increase access to needed resources and services through the development of linkages between community members and biomedical institutions, and (4) increase community members' knowledge and experience with organizational development and management (Cox, Rouff, Svendsen, Markowitz, & Abrams, 1998).

Researcher Intervention and Referral. During the course of the research, members of the research team may witness acts of violence or other abuse perpetrated against the immigrant respondent. This may occur, in particular, in the context of research involving trafficked persons (Cwikel & Hoban, 2005). Intervention without participant consent to do so may actually exacerbate, rather than ameliorate, the participant's situation by bringing about increased violence or abuse, transport of the participant by the traffickers to a less visible and findable location, and/or the individual's deportation.

Some, but not all, immigrant/refugee participants may have suffered trauma, as a result of events leading up to their departures from their countries of origin and/or their experiences in transit to their destination. It is critical that researchers working with immigrant and refugee populations be aware of this possibility and have appropriate resources and/or referrals available to the participants who may be in need of such services. It is also possible that some of the participants may be suffering from severe depression or may be suicidal. In order to reduce the risk of harm to the participants, appropriate protocols to address such situations must be developed and staff trained on their use prior to the commencement of the study.

Close-Out: Post-Study Dilemmas

Access and Abandonment

Guideline 19 of the *International Guidelines for Biomedical Research Involving Human Subjects* advises that investigators should ensure that participants who are injured as a result of their participation receive free medical treatment for any such injury and that they receive appropriate compensation for any resulting impairment, disability, or handicap. In general, this may be problematic for a number of reasons. First, funders of research, such as the National Institutes of Health in the United States, do not provide funding to compensate research participants for such injuries. Consequently, any such payment is at the expense of the investigator, his or her institution, and/or the industry sponsor of the research, if there is one. Second, there is often no existing legal mechanism to facilitate such recovery, such as a legal regulation requiring such compensation as a condition of conducting the research. As a result, individuals who believe that they are so injured must seek compensation through the court system.

Additional barriers confront immigrants and refugees in such situations. If they are in the country illegally, they may not wish to make their presence easily known for fear of deportation. They may also lack sufficient funds to pursue a lawsuit, with all of the costs that attend it, such as court filing fees, attorney's fees, medical evaluations, etc. The exclusion of immigrants and refugees from proposed research that entails risk of injury may contravene the ethical principles of both distributive justice and respect for persons, but their inclusion might violate the principle of beneficence, requiring that the investigator maximize benefit, and nonmaleficence, requiring that the investigator minimize harm.

Commentary to Guideline 21 of CIOMS' *International Guidelines for Biomedical Research Involving Human Subjects* suggests that researchers should provide referrals to study participants for the diagnosis and treatment of diseases not related to the focus of the research or advise the participants to obtain necessary treatment. This raises issues of access for immigrants and refugees, who may be unable to avail themselves of government-funded health care services because of limitations imposed by those governments on the receipt of such services and/or may be unable to access privately funded health care due to insufficient personal funds. Where eligibility screening for inclusion or exclusion from a study reveals the existence of a serious health problem, one must query whether the researcher's ethical obligation does not at least extend to assisting the individual to obtain the necessary care, particularly in circumstances where the immigrant/refugee faces additional barriers due to language, culture, and unfamiliarity with the country's health care system.

Dissemination of Findings

How the data derived from studies of immigrant or refugee groups are interpreted and disseminated may have serious implications for members of that group. First, the theoretical framework utilized for the development of the protocol and the conduct of the study provides the basis for the direction of the research and, often, the interpretation of the findings. However, reliance on a single theory may bring about a situation in which the researchers are able to see – and consequently are able to convey – only a portion of the real picture, much as each blind man in Saxe's poem about the blind men and the elephant was unable to understand the totality of the elephant because he could feel ("see") only one part of the elephant. Because immigration is often a controversial and highly contested political issue, an unintentionally biased portrayal of the immigrants' situations may result in adverse political consequences to that group (cf. Liamputtong, 2007; Schweitzer & Steel, 2008).

Similarly, a less-than-careful interpretation and portrayal of the study findings may subject an entire immigrant community to stigmatization and marginalization. Such was the case, for example, with the labeling of Haitians by the United States Centers for Disease Control and Prevention as a risk group for HIV/AIDS during the early years of the epidemic (Schiller, Crystal, & Lewellen, 1994).

Conclusion

Significant issues may arise in the context of doing research with participants who are immigrants or refugees. Although a number of these issues are common across research endeavors, they are particularly challenging in this context because of immigrants' and refugees' heightened vulnerability as research participants. Foremost among these are issues relating to the source of the study funding; to sampling and recruitment procedures; the informed consent process; the safeguarding of participants' privacy, confidentiality, and safety during the course of and following the cessation of the study; access to and availability of the benefits of the study following its termination; compensation for study related injury; and the content and mechanism for the dissemination of the study findings. Inadequate attention to the development of appropriate safeguards with respect to these issues may inadvertently result in stigmatization, victimization, marginalization, economic hardship, and/or deportation.

Related Topics

- ► Asylum
- ► Council for International Organizations of Medical Sciences
- ► Depression
- ► Detention
- ► Gender-based violence
- ► Illegal immigration
- ► Immigrant visa status
- ► Immigration status
- ► Irregular immigration
- ► Labor migration
- ► Methodological issues in immigrant health research
- ► Posttraumatic stress disorder
- ► Refugees
- ► Refugee camp
- ► Stigma
- ► Torture
- ► Trafficking
- ► Unaccompanied minors
- ► Violence
- ► Vulnerable populations

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Ethical Issues in the Clinical Context

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Introduction

Immigration is not new phenomenon. In recent years, however, it has become more complex as the groups of immigrants became more heterogeneous, with varying determinants of health status, health needs, and levels of vulnerability (World Health Organization, 2010). The importance of migration is highlighted by the 2007 EU Portuguese Presidency identification of the challenges occurring with immigration. In connection with the health of immigrants, the goal was to “develop a common vision for immigration and health, based on common values and principles of the EU.” The conclusion was that a starting point to achieve this goal would be increased funding of research in the field. This would include efforts to develop research techniques, increase collaboration between research centers in Europe, and increase attention to methodological barriers in order to include data on immigrants in health surveys in Europe and at national level.

It is estimated that there are about 200 million international immigrants, consisting of workers, students, illegal immigrants, or immigrants not registered with authorities. About 70% of individuals are migrating from developing to developed countries. The remaining migration is taking place between developing countries or between developed countries (United Nations Development Program, 2009).

In the EU countries, international immigration is increasing, due to economic and social opportunities. This places increasing challenges on the host countries (Herm, 2008). The migration rate in EU countries in 2008 was three times higher than the natural growth of population in these countries (Vasileva, 2009). Currently it is estimated that in Europe there are about 35–40 million immigrants (Mladovsky, 2007). Approximately 75% of these immigrants in the EU live in Germany, Spain, UK, France, and Italy (Vasileva, 2009). In the USA in 2000, there were 28.4 million immigrants, with 43% more than in 1990 and three times more than in 1970. Immigration has become one of the main determinants of US population growth. From 1990 to 2000, 70% of US population growth was immigrants (Camarota, 2001). In New Zealand, it is estimated that one in five citizens of this country is born in another country (Merwood, 2006).

Because of the heterogeneity of immigrant groups, their degree of vulnerability to health problems varies widely. The health of migrants and the health problems associated with migration are important issues for public health and impose difficult challenges for the governments of the host countries, which must find solutions to integrate the particular needs of immigrants in national health policies, taking into account the rights of immigrants, including their right to health (World Health Organization, 2010).

This chapter addresses the ethical issues that may arise in the clinical context of health care provided to immigrants. While far from being the “last word” on ethical issues in immigrant health, the author’s intention is to highlight some of the issues of this sensitive and extremely large subject, and to foster discussion on this topic. I will first discuss health and disease as social constructs that are largely culture dependent and that influence access to formal health services and adherence to treatment. Next I will discuss various aspects of the concept of individual autonomy (typical for western medicine) in the context of multiculturalism. This will include patient preferences for disclosure of information and obtaining informed consent, detailing the communication barriers that create problems in doctor–patient interaction. I will discuss the barriers that stand in the way of accessing health services by immigrants, with a particular focus on how access to health care is reflected in the welfare of immigrants. Finally I will discuss the necessity of providing culturally appropriate healthcare services for

Sana Loue & Martha Sajatovic (eds.), *Encyclopedia of Immigrant Health*, DOI 10.1007/978-1-4419-5659-0,

immigrant populations in order to increase access and quality of healthcare services and further to improve the health of immigrants, whatever their legal status.

Concepts of Health and Illness: A Multicultural Perspective

In Western medicine, physical and mental health concepts have been mainly defined by the medical model of disease (Palmer & Kaufman, 2003) In Western medicine, the concept of health is divided into physical and mental health, these two being located at the extremes of a continuum. Health may, however, be conceptualized differently in other cultures.

As an example, the concept of *holistic health* has been identified among Iranian immigrants. In Iranian culture, health is seen as a sphere formed outside the physical (body) and the inner spirit (*ruh*). Seen in this way, health is equivalent to a state of balance in life, the best combination of physical, mental/emotional, and spiritual, and represented by a social functioning (Martin, 2009). Disease is regarded as lack of balance in diet, social, physical, mental, spiritual, and emotional health, a loss of self-identity and loss of appetite for life. In this culture, pain is described in terms of suffering rather than pain being located in a particular area. Pain thus is a much larger entity, which affects multiple aspects of a patient's life. This conceptualization is consistent with the holistic approach on health and disease (Martin, 2009). Being culture-dependent constructs, the concepts and categories used by immigrants to explain health problems may differ significantly from typical Western understanding (Mladovsky, 2007). For example, in Iranian culture, the disease called *Evil Eye* occurs when an envious person sends negative energy to another person (Martin, 2009).

There are mental or somatic disorders that are recognized in some cultures that have no corollary in Western culture. This makes diagnostic and therapeutic methods characteristic of Western medicine ineffective for treatment. For example, in Japan, *Taijin kyofusho* is a disease characterized by a morbid fear that physical or behavioral abnormality will cause inconvenience, embarrassment, or will offend the others (Palmer & Kaufman, 2003). In India, the Philippines, Taiwan, and Latin America the condition called *Susto* ("sudden fear") is manifested clinically by tremor, sweating, tachycardia, and depression. *Susto* is considered to result from problems with a person's two components: organic and spiritual. The latter can be detached from the body through a traumatic event or an intense fear (Palmer & Kaufman, 2003). Among Latino immigrants (especially Puerto Ricans), *ataques de nervios* represents the clinical manifestation of stress caused by dislocations produced in the family or a social response to a given situation. This condition is manifested clinically by uncontrolled behavior with anger, crying, shaking, heart palpitations, seizures, or unconsciousness. *Ataques de nervios* might be diagnosed by Western medicine as hysteria, psychosis, or suicidal ideation. Because it is not an accepted psychiatric disorder, drugs used in Western medicine are not often helpful for this condition, which can be cured by family, social, and spiritual support (Palmer & Kaufman, 2003).

Perception and acceptance or rejection of certain diseases in society impact on how an individual suffering from a certain disease is seen by the members of society and may affect his/her willingness to seek medical help or support from family or the community. Cultural factors can lead to stigmatization and marginalization of people who suffer from a disease that is considered to bring shame. For this reason, patients from certain cultures may avoid contacting a doctor, fearing that they will be judged for suffering from a certain disease and for violating social norms (e.g., abortion, contraception, sexually transmitted diseases, infertility, and HIV/AIDS).

Tuberculosis is a highly stigmatizing disease in some countries. For instance, in Vietnam women suffering from tuberculosis may be stigmatized in family and society. As a consequence stigma is one of the main barriers to compliance with treatment among Vietnamese women (Johansson et al., 1999).

In a study on Chinese immigrants to Canada who suffered from chronic fatigue and physical weakness, it was found that their main concern about disclosure of their condition to the family and community was related to the risk of stigmatization. According to Chinese culture it is not appropriate to disclose personal failures and disgrace. In addition, disclosure can also be hindered for other reasons, such as fear that others will not understand the real cause of their condition and will consider that their allegations are motivated by laziness or character flaw. Disclosure could decrease marriage opportunities or cause damage to family life. Individuals may fear they will become a burden for their partners or they will not be able to provide for their family. When the family members learn the diagnosis they may try to keep it a family secret, because according to Chinese social values family shame should not be exposed. This may impede the family's reporting of the patient's condition. Patients may thus prefer to seek treatment with traditional Chinese medicine before they seek a Western physician (Lee, Rodin, Devins, & Weiss, 2001).

Some patients may decide not to disclose certain medical symptoms that could be essential for establishing the correct diagnosis and treatment, such as sexually transmitted infections or pain in order to avoid being punished or judged by the physician or because of beliefs about what is appropriate to discuss with the doctor. A number of studies indicate that in certain cultures there are sex-related norms regarding the acceptability of patient complaints related to pain. Nondisclosure of certain symptoms is more common when the patient is treated by a doctor of the opposite sex, but this can also happen if the doctor is the same sex as the patient (Govender & Penn-Kekana, 2007).

Mental health problems are perceived differently in different cultures. In some cultures mental illness places significant stigma on the sick person who may consequently avoid seeking medical help or may avoid divulging psychological or psychiatric symptoms (Lee et al., 2001).

In some countries, there are only a few medical units for treating the mentally ill and the existing ones are associated with significant social stigma. Countries that have traditionally faced the problem of migration have developed models to address mental health problems of migrants and health professionals have been trained with appropriate cultural and linguistic skills. Examples include the Multicultural Mental Health Plan 2008–2012 in New South Wales, Australia, or the centers for "Refugees as Survivors" (RAS) of New Zealand (http://www.portaldasaude.pt).

The quality of healthcare services is assessed by patients according to their expectations, the latter being strongly influenced by specific cultural norms and beliefs. There are patients who primarily value the physician's medical knowledge and experience, while others mostly value the interpersonal relationship established between the physician and patient. For example, Iranian immigrants assess the quality of health care largely depending on the time spent with their doctors as a prerequisite for building trust and proper communication (Martin, 2009). Russian immigrants consider that physicians need to "have soul" in addition to technical knowledge. They frequently complain that Western medicine focuses on examination based on various devices, to the detriment of clinical examination. Part of this expectation may be because they come from a country with limited technical equipment and are consequently accustomed to diagnosis mainly by clinical methods (Dohan & Levintova, 2007).

Iranian immigrants who emphasize holistic patient care consider that a good doctor is one who, in addition to professional knowledge, has the ability to inspire the patient with hope and optimism. Diet plays an important role in the lives of the Iranians mainly by facilitating social interactions. As a consequence, Iranian immigrants consider that a good treatment should combine drug therapy with appropriate dietary prescriptions, criticizing the fact that most times Western medicine ignores the role of diet in treatment (Martin, 2009). Two studies conducted in Oslo in non-Western immigrants (the Oslo Health Study and the Oslo Immigrant Health Study) have found that satisfaction with medical services received may be directly proportional to the degree of integration in the host country (acculturation) (Lien et al., 2008).

Immigrants may exhibit behaviors that do not conform to Western standards of behavior. Some reports note that some Russian immigrants may present to be seen by a doctor without an appointment, request that the examination be conducted by only a senior physician, and display emotional outbursts in emergency waiting rooms. Some of them might complain of certain symptoms that they do not actually have, perhaps due to past experiences of extreme medical shortage and in order to be examined (Dohan & Levintova, 2007).

The Concept of Individual Autonomy in a Multicultural Environment

Disclosure of Information to the Patient

Individual autonomy represents the right of a person to decide for himself/herself, independently of any influence from other people. In Western medicine, respect for the patient's autonomous decision is a mandatory requirement for all the members of the medical staff, while for patients autonomy is a right (Beauchamp & Childress, 2001). Disclosure of health information to the patient is a central element of Western medicine (Palmer & Kaufman, 2003) that allows for an appropriate choice (Beauchamp & Childress, 2001), expressed through informed consent for diagnostic procedures and treatment.

Attitudes toward disclosure of information, the quantity of information that can be provided, and the circumstances of disclosure depend largely on the culture from which the patients come. Studies have shown that immigrants from countries where disclosure to the patient of a severe diagnosis is not common maintain this preference in the host country (Berkman & Ko, 2009). A study of elderly patients of different ethnic backgrounds (Korean-Americans, Mexican-Americans, European-Americans, and African-Americans) found that ethnicity was the main factor correlated with attitudes toward disclosure of diagnosis and prognosis of terminal illness and to decisions to end life. Korean-Americans and Mexican-Americans considered to a lesser extent than European-Americans and African-Americans that a patient should find out the diagnosis of terminal illness and should make decisions on the use of life support, believing that family members should make decisions in this regard. Thus the principle of individual autonomy is not universally accepted (Beauchamp & Childress, 2001; Palmer & Kaufman, 2003). In the Asian cultures, for example, the focus is placed especially on the principles of nonharm and benefit (Berkman & Ko, 2009). There are communities in which the family-centered model for decision making is considered more appropriate based on the idea that the patient is part of a network of family relationships and the smooth functioning of the family is more valuable than the individual autonomy (Beauchamp & Childress, 2001; Palmer & Kaufman, 2003).

Preferences toward disclosure of information to patients can be greatly influenced by cultural beliefs toward disease, causes of illness, and patients' or their families' fear that disclosing a diagnosis of serious disease may harm the patients. Navajo Indians may believe that thinking and language have power to influence reality and control events, and disclosure of negative information can be potentially harmful. Navajo Indians believe that positive language promotes and even allows healing (Beauchamp & Childress, 2001; Palmer & Kaufman, 2003).

Some Latin-American and Hispanic populations consider it inhumane to burden a person with information about disease (Palmer & Kaufman, 2003). Some ethnic groups prefer to learn only the minimum or ambiguous information about the disease they are suffering, such as elderly Koreans, Mexicans, Native Americans, and Bosnian immigrants in the USA and other countries (Berkman & Ko, 2009). In Asian countries, there may be belief that disclosure of a diagnosis of serious disease destroys hope and condemns the patient to death (Berkman & Ko, 2009).

Russian immigrant families may prefer to spare family members knowledge of bad news about their health. This creates dilemmas related to disclosure of diagnosis and prognosis. In the Russian immigrants' opinion, the diagnosis of cancer is interpreted as a "death sentence," especially since Russian therapeutic resources are limited, even nonexistent in comparison with the USA. Disclosure of diagnosis of cancer to the patients, especially elderly, is equivalent to "taking hope and spirit." Following disclosure of the diagnosis of cancer, patients may become depressed with a diminished power and desire to survive. In discussions with these patients even the word "cancer" should be avoided. A possible solution for such a sensitive case is the creation of support groups for Russian immigrants and their families, who can facilitate the use of curative or preventive medical services and can inspire the patient toward an optimistic vision of the possibilities for treatment (Dohan & Levintova, 2007).

A number of studies indicate that preferences of immigrants regarding the disclosure of a serious diagnosis may be influenced by the time spent in the host country and the degree of acculturation. Research suggests that more acculturated Korean immigrants in the USA receive more information about the disease from which they are suffering, compared to those who are less acculturated (Berkman & Ko, 2009). Russian immigrants in the USA are more willing to work with physicians and accept the disclosure of cancer diagnosis, especially after spending more time in the host country, and become more optimistic about the chances of treatment and recovery in this disease (Dohan & Levintova, 2007).

Disclosure of Information to the Patient's Family

The extent to which patients agree to share information about their health status with family members depends largely on their culture of origin, because individual values and cultural norms are closely linked to attitudes toward disclosure of serious illness (Berkman & Ko, 2009). Family involvement in decisions about health care must take into account the negative impact that the disclosure of a certain diagnosis can have on the patient's family and the community in which the patient lives.

As an example, research findings indicate that among Asian immigrants, the main barrier to disclosure to family members of some diagnoses, such as HIV infection, involves the collectivist nature of Asian culture, in which an individual's behavior is seen in the context of his/her entire family. Harmony and the avoidance of conflicts are particularly appreciated values in the Asian culture. Asian cultures generally discourage discussing personal issues or taboo topics such as sexual orientation, in order to avoid embarrassment to the family/community. Homosexuality and bisexuality are considered deviant, contrary to family values, and evidence of moral weakness. Given that many individuals infected with HIV are gay, individuals may assume that the disclosure of HIV infection is also a disclosure of sexual orientation. In these circumstances individuals may choose not to disclose a diagnosis of HIV infection in order to protect their families from stigma and discrimination. Avoiding disclosure also minimizes family material and emotional burdens arising from the obligation to help. Asian immigrants with HIV infection often seek support from friends, especially those with the same sexual orientation who may also be HIV infected. Healthcare professionals must keep in mind that Asian immigrants need support both in the disclosure of HIV diagnosis and after disclosure. To facilitate communication between Asian patients infected with HIV and their families, healthcare facilities should provide written information materials in their preferred language. This will minimize language barriers and misunderstandings or incorrect perceptions about HIV infection. Patients' isolation due to language barrier, fear of intolerance, or of exclusion from family could be minimized with language and culture-specific education (Yoshioka & Schustack, 2001), enabling the patients to receive appropriate medical care and prevention from the spreading of infection among the population at large.

Patients have the right to request not to be informed of their illness. This is accomplished via a *waiver* (Palmer & Kaufman, 2003), indicating the person who should be informed and who is designated to make healthcare decisions on the behalf of the patient. A patient's decision to delegate the right to decide to another person becomes a manifestation of his/her autonomy (Beauchamp & Childress, 2001).

When the patient delegates his/her right to know and to decide, his/her opinion should be respected, provided that there is no reason to suspect coercion, abuse, or neglect (Ho, 2006). Health professionals must be sensitive to cultural values in addition to conducting an assessment of the patient's communication style and relationships with his/her family. The clinician should understand the decision-making process in the patient's family, why the patient wants to delegate the right to be informed, and why the family members want to make decisions for the patient. It is essential that the patient knows that he/she has the right to receive health information, that he/she has freedom of choice, and that family members know the patient's preferences. The patient may be in a subordinate relationship with the rest of the family, may not believe that he/she is entitled to decide, or may fear that the rest of the family or community may ostracize him/her. In this situation, delegation of right to choose is the result of indoctrination or manipulation and is not a real autonomous desire.

Analysis and appropriate communication with the patient and his/her family allow the clinician to understand the patient's family situation. Clinicians should respect the delegation of decision making by families when it is in full harmony with the patient and in accordance with patient values and preferences. If family decisions do not promote the best interest of the patient, the doctor may discuss the issue with the patient or exclude the family members from the decision-making process. If it is not clear that the family is in harmony with the patient, the clinician should respect the patient's expressed wishes, but also monitor the family dynamics. It is important for the clinician to establish good communication with the patient and inform him/her that he/she has the right to decide autonomously (Ho, 2006).

Often, however, it is difficult for clinicians to evaluate the dynamics of the patient's family. This may be due to minimal interaction with the family or because the patient is not willing to discuss his/her family with the clinician. This may be a particular issue when there are language barriers or if the patient feels that the doctor is not sensitive to the values of the culture from which the patient originates (Ho, 2006).

Although specific cultural values may be characteristic of various immigrant populations, and health professionals should be aware of these features to provide patient-centered and culturally sensitive care, they must also recognize that not all immigrants from a particular community adhere to the community's characteristic practices and values. Healthcare professionals should not assume a priori that if the patient belongs to a certain community, he/she shares the values and beliefs of that community (Beauchamp & Childress, 2001; Berkman & Ko, 2009). Therefore, healthcare professionals must determine on the one hand what, how, and when patients wish to be informed, and on the other hand, what, how, and when they wish to disclose to the family members.

Disclosure of information and informed consent process must be flexible, must be adapted to each patient rather than applying a rigidly individualistic or family-centered decision-making model (Berkman & Ko, 2009; Ho, 2006), and be nonviolative of patient autonomy. Again, autonomy may be operationalized in a variety of ways depending upon the specific circumstances, for example, by individual decision, in collaboration with his/her family members, or delegating his/her right to decide to the family.

Although the decision-making model is largely influenced by cultural values, the preferences of patients from the same culture can vary depending on income, education, religious affiliation, and fluency in English while in the host country. Young immigrant patients with a high degree of acculturation and high health education or those who had been patients before often prefer an individualistic model of obtaining informed consent. It is therefore not correct for the medical staff to assume that if a patient comes from a culture where the focus is on family and close family relationships, he/she would prefer family involvement in his/her healthcare decision (Ho, 2006).

Informed Consent in Multicultural Clinical Settings

Informed consent is considered central to Western medicine in providing ethical, safe, legal, and patient-centered care (Schenker, Wang, Selig, Ng, & Fernandez, 2007). The doctrine of informed consent reflects Western beliefs that mind, body, and soul are separate entities, and that man has an intrinsic value and ability to self-update (Palmer & Kaufman, 2003). However, individual autonomy promoted by Western medicine is not universally accepted. Many US immigrants come from non-Western cultures, where emphasis is placed on strong intergenerational family relationships and the family is considered as the basic unit of society (Ho, 2006). Immigrants from Japan, China, Laos, and Pakistan may live together in extended families, often under the same roof or close to each other. They value family harmony and personal identity is not viewed independently, but in the context of relation to family. Family members are typically involved in important decisions. Many immigrants may not accept the individualistic model of decision making, especially when the decisions they make can have great impact on the lives of entire family. They may prefer the model of informed consent based on the inclusion of family ("family-facilitated approach") (Ho, 2006).

Exclusion of family members in treatment decisions may be more difficult with involuntary migrants (those who do not voluntarily choose to leave their culture and whose family is their main support) and elderly immigrants, especially those who do not speak English fluently, and who may prefer family members to communicate with doctors or assume responsibility for decisions (Ho, 2006). Isolation from family members may inadversely affect these individuals' well-being and can induce a state of anxiety (Ho, 2006).

Immigrants coming from countries where medicine is predominantly paternalistic may wrongly interpret the physician's efforts to inform them. For example, Russian immigrants in the USA may interpret a physician's provision of information as hesitation on the part of the physician and may become skeptical about the ability of the physician to treat them (Dohan & Levintova, 2007).

Communication Barriers in Informing the Patient

Barriers in communication between physician and patient can be related to language barriers or to differences in communication of emotions in different cultures. Level of education and limited knowledge of the language of the host country are the most important factors that affect access to health services by immigrants (Mladovsky, 2007; www.portaldasaude.pt). Language barriers hamper the provision of care to patients from different cultures (National School of Public Health, 2010) in several aspects. Language barriers are also an obstacle to adherence to the treatment and treatment referral (www.portaldasaude.pt). Language differences can create problems in physician–patient communication (Dohan & Levintova, 2007) and more time between patient and clinician is needed for the clinician to ensure full and correct understanding of the information provided (Schenker et al., 2007). When accessing medical services, immigrants may have difficulty in communicating symptoms or misunderstand instructions given by the medical team. The situation is often complicated by the lack of familiarity with a formal healthcare system (National School of Public Health, 2010).

Cumbersome and often poor communication due to language barriers has a negative impact on many aspects of patient care including patient satisfaction, interpersonal care processes, comprehension, and length of hospitalization (Schenker et al., 2007). In addition, misunderstanding of symptoms by the clinician may lead to delayed treatment, medical errors, and even death (National School of Public Health, 2010). From the perspective of ethics and human rights, proper communication is essential to obtain informed consent for medical interventions and to ensure confidentiality of medical information (National School of Public Health, 2010). A first step to facilitate communication between physicians and patients in clinical settings and thus to improve the care of immigrants is the provision of an interpreter (Schenker et al., 2007; National School of Public Health, 2010). Written materials should be provided in the preferred language of immigrants (National School of Public Health, 2010).

Often in clinics members of the patient's family are used as interpreters between the physician and the patient. This is not the best option because family members do not know medical terminology (Schenker et al., 2007) and may unintentionally impede the exchange of information between the patient and the clinicians (Patridge & Proano, 2010). Besides the possibility of inadequate interpretation, it may be difficult for family members, placed in the position of translators, to bear the emotional burden of disclosure of a serious diagnosis for their beloved (Schenker et al., 2007). In addition, reliance on family members as interpreters may infringe on the patient's privacy (Mladovsky, 2007). During the communication process between physician and patient, information may be transmitted that the patient might not want to reveal to his/her family.

Ideally, when physician and patient do not speak the same language, they should involve professional interpreters (Schenker et al., 2007). A study on pediatric populations showed that lay interpreters commit more errors than the professional ones (Flores et al., 2003; Patridge & Proano, 2010). Professional interpreters can act both as translators and as cultural facilitators to get the best results in communicating with patients. They can help clinicians in adapting to cultural differences in the disclosure of the diagnosis – especially in case of a serious diagnosis – and to social differences in treatment expectations (Patridge & Proano, 2010). Professional interpreters adapt their way of communication according to cultural norms of the patient. The clinical objectivity that is characteristic of information disclosure in Western medicine is not suitable for all cultures. For example, Russian immigrants have to be approached "like talking to your own parents" (Dohan & Levintova, 2007).

A professional interpreter is accountable for the work he/she does including signing for the translation made (Schenker et al., 2007). Involving professional interpreters in the process of communication between patient and physician has beneficial effects on the utilization of healthcare services, clinical outcomes, and patient satisfaction with medical care received (Patridge & Proano, 2010).

In some cases, standard disclosure practices can create professional and personal dilemmas for professional interpreters, because on the one hand they have to do their job and translate what is being told, and on the other hand they realize that disclosure could harm the patient. Anticipating this kind of dilemma some interpreters prefer to use a milder disclosure ("soft disclosure") or to preemptively inform the physician about the patient's cultural background. Some physicians accept terms of a more gentle translation, while others require interpreters to literally interpret their words irrespective of patient's cultural particularities (Dohan & Levintova, 2007). Given the clear benefits of their activity, an increasing number of hospitals in countries experiencing high migration rates (particularly in the USA and UK) include professional interpreters in the medical teams (National School of Public Health, 2010).

Unfortunately, many physicians and patients who confront the language barrier do not have access to professional interpreters. Even when professional interpreters are available, they are often underutilized (Schenker et al., 2007). This may be because nonprofessional interpreters, such as family members and medical staff members, could be preferred by some patients or clinicians, extra time is needed to work with interpreters, and the costs of professional interpreters are higher (Patridge & Proano, 2010).

A US survey showed that medical training in the use of professional interpreters in clinical settings has lead to their increased involvement. Low use of professional interpreters in healthcare settings may be partly a consequence of lack of physician training in this direction (Schenker et al., 2007). The US Civil Rights Act of 1964 prohibits discrimination based on national origin or because of limited knowledge of English. In 2000, public and private hospitals that receive federal funds were mandated to provide services for professional interpretation (Patridge & Proano, 2010).

Means of Communication of Emotions

People's emotional experiences and expressions are not universal, but are shaped by culture according to construction of the self. In the Euro-American culture, individuals have an independent, autonomous, and auto-limited sense of the self. Emotions are considered in the context of the needs, desires, and goals of the individual. Emotional expression is a way of showing who one is ("ego-focused emotions"). Emotions like anger and frustration may be considered expressions of individual needs. In East Asian cultures, self is not constructed as a separate entity, but is defined in a relational context. The Asian sense of self is "collectivist" or "interdependent." The self is fluid, changing depending on the environment in which individuals live and function. Emotions are focused on the needs and responses of others, making the individual's emotions less important in determining his/her actions ("other focused emotions"). In the East Asian culture, the prevailing collective meaning of the self suggests that people expect to understand each other without expressing emotions and needs. In Chinese culture, for example, "excess" emotion, whether positive or negative, is considered harmful to the health and spirit of the individual. The ability to regulate emotions and maintain a state of harmony with oneself is crucial to the well-being of the individual. East Asian immigrants do not typically openly express emotions, especially happiness, which can challenge interaction with them in the clinical settings. Chinese individuals may express anxiety with repetitive questions or repeated complaints regarding their physical condition or personal dilemmas. It may not be suitable for healthcare professionals to ask Asian immigrants to openly express their emotions (Shibusawa & Chung, 2009). This attitude is totally opposite to Western cultures in which open expression of emotions is encouraged.

Barriers to Access to Health Care for Immigrants: A Coin with Two Faces

Access to health care and providing health care are problematic issues related to migration. Studies indicate that, regardless of cause/barriers (social, structural, financial), immigrants do not use health services in a host country that ideally enables them to maintain optimal health. A study on health and social situation of newborns in two communities of Portuguese emigrants found high levels of morbidity for mothers and children, and extensive use of emergency services instead of primary care. This suggests a need to provide immigrants with information regarding the appropriate and timely use of health services (National School of Public Health, 2010). Availability and access to medical services have a major impact on health (World Health Organization, 2008b).

Limited access to healthcare services may lead to delays in care (Mladovsky, 2007), negative repercussions on health status (Leclere, Jensen, & Biddlecom, 1997), more expensive treatments later, and poorer outcomes (Mladovsky, 2007; World Health Organization, 2008b). A study from the Netherlands showed a higher rate of preventable mortality among immigrants than among native Dutch (Mladovsky, 2007).

Access and appropriate use of medical services by immigrants is limited by a number of specific factors.

Limited financial resources are a significant impediment to accessing healthcare services especially in the period immediately following migration, when immigrants are often faced with economic problems and poverty (Leclere et al., 1997). Availability and appropriate use of healthcare services by immigrants are often hampered by lack of familiarity with the operation of the healthcare system (National School of Public Health, 2010). There is a need to create orientation services and publishing guidance materials for immigrants (Mladovsky, 2007).

Access to health care is also limited by the *lack of cognitive resources* represented by *limited education* and *language barriers*. Lack of fluency in the language of the host country prevents access to healthcare services (Leclere et al., 1997).

Deterrence from treatment by medical staff could limit the access of immigrants to healthcare services (National School of Public Health, 2010). Despite the fact that primary care services should be the first to assist immigrants, they often discourage immigrants from seeking medical help. This is because general practitioners are often unfamiliar with the epidemiological profile of migrant groups and may feel unprepared to address the complex psychosocial issues affecting immigrants. For this reason, immigrants may choose to use the community services that are often provided by NGOs and take into account the cultural particularities of the community (www.portaldasaude.pt).

The social environment in the host country may affect the access of immigrants to information and health services. *Families* of the immigrants are "social bridges" between the individuals and the medical system. Family members or friends who previously immigrated can help immigrants to more readily acquire information on the healthcare system in the host country. At the same time family members and friends can act as substitutes for formal care (Leclere et al., 1997), leading to reduced use of healthcare services in the host country.

Distrust of Western medical system is an important barrier to accessing formal healthcare services by immigrants (Mladovsky, 2007). For example, many elderly Iranian immigrants resort to traditional medicine because they do not trust Western medicine and because they believe that diseases have certain causes that are not recognized and cannot be treated by the Western medicine (Martin, 2009).

Gender/Sex Issues in Patient–Physician Relationship in Multicultural Clinical Settings

Cultural differences between clinicians and patients, and practices that are considered usual in Western medicine may lead to dissatisfaction among some immigrants who interact with the medical system in the host country. For example, for some immigrant women, lack of access to a female physician can be a barrier to accessing health services (Mladovsky, 2007). Sex differences may create problems in the physician–patient relationship, which can range from mistrust and lack of adherence to treatment, to refusal of medical examination. Reasons for this perspective are varied, and often are culturally dependent. Patients themselves and/or their families may find it unacceptable to be examined by physicians of the opposite sex. Refusing to see a physician of the opposite sex is especially common in gynecology for patients coming from strong patriarchal societies, where the social, cultural, and religious norms and practices require a clear demarcation of sex-related social roles and limit the social and physical contact between men and women (Govender & Penn-Kekana, 2007). A study that examined the experiences of women in Cuba, Thailand, Saudi Arabia, and Argentina who sought antenatal care found that women in Saudi Arabia and Thailand prefer female physicians. In Saudi

Arabia women can be examined by male physicians, in the presence of nurses. However, the women felt uncomfortable with the idea of examination by male physicians, especially for pelvic examinations. Thai women preferred to be examined and assisted by midwives, believing that they can more easily relate with them emotionally. Cuban women accepted examination by male physicians but stated that before examination they must cover their bodies in order not to arouse physician curiosity (Nigenda et al., 2003; Govender & Penn-Kekana, 2007).

In some countries, women prefer a female physician for reproductive problems because treatment and examination of a woman by a male physician is seen as dishonoring the woman and her family (World Health Organization, 2008a). In China, women are reluctant to address a male physician for reproductive problems, and follow-up of women who undergo a surgical sterilization by male physicians rarely happens because it is considered inappropriate for a man to visit the wife of another man. A study in the Yunnan province of China found that women are reluctant to discuss physical and contraception issues with male physicians and the latter, in turn, are reluctant to provide medical care for reproductive issues in women (World Health Organization, 2008a). In contrast, women in Western societies display only a slight preference for their physician on the basis of his/her sex and, instead, base their preference on professional performance and communication style (Govender & Penn-Kekana, 2007; Howell, Gardiner, & Concato, 2002; Plunkett, Plunkett, Kohli, & Milad, 2002; Zuckerman, Navizedeh, Feldman, McCalla, & Minkoff, 2002).

The quality of interaction between physician and patient may also be influenced by sex differences, particularly with respect to the patient's trust in the physician's capacity to treat, and the patient's adherence to prescribed treatment. There are patients who do not take seriously the prescriptions made by nurses, who are mostly women, but follow the prescriptions made by male physicians. The reverse situation is also possible (Govender & Penn-Kekana, 2007).

Studies show that immigrants in the period immediately following migration have a better health status than the population in the host country. This may be due to the selective migration of healthier people (Ronellenfitsch & Razum, 2004) that results from legal barriers against immigration in some countries for people with impaired health (Leclere et al., 1997). This phenomenon is called "the healthy migrant effect." The weakness in this argument is that it does not evaluate the health of the population in the immigrants' home country (Ronellenfitsch & Razum, 2004). Putting aside the difference between the initial health status of immigrants and native populations, immigrants may have greater morbidity than natives due to differences in the prevalence of certain diseases in their home countries (Leclere et al., 1997). Immigrants may develop particular health problems such as communicable diseases (National School of Public Health, 2010) or problems caused by psychological and somatic distress related to migration and adaptation to their new physical and social environment in the host country (Leclere et al., 1997). Many immigrants face, at least in the initial period of life in the host country, a number of difficulties such as greater sacrifices than those estimated before migration, lack of training and work experience recognition, and acceptance of a job below their level of training. All of these factors may lead to depletion of emotional, spiritual, and physical resources (Lee et al., 2001).

Currently immigrants from Eastern European countries represent more than 5% of the total population in Germany (Ronellenfitsch & Razum, 2004). A study on health satisfaction among immigrants from Eastern Europe to Germany indicated that satisfaction was less compared to native Germans, despite substantial improvements in indicators related to socioeconomic status. Decline in health satisfaction can be attributed, on the one hand, to adverse health conditions and increased prevalence of risk factors in immigrants from Eastern Europe in their home countries (e.g., increased prevalence of smoking, hypertension, deficits in antioxidants due to low fruit and vegetable consumption, and frequent alcohol consumption) and, on the other hand, to certain issues pertaining to immigrant status (such as discrimination, psychological stress, and lack of informal support networks). Rapid deterioration of health status among Eastern European immigrants in Germany, irrespective of improving their socioeconomic status, is a concern for public health services and health policies in the host country.

Similar results were obtained in two studies on Russian immigrants in Israel, a country that received about 775,000 Jewish immigrants from the former Soviet Union during the period from 1989 to 1998. Russian Jewish immigrants reported less satisfaction with their health compared with native Jews; chronic diseases were most commonly reported. Recent immigrants more frequently reported low satisfaction with their health than those who immigrated previously. Those expressing satisfaction with their health status were younger and healthier and immigrated at the beginning of the wave of migration from former Soviet Union in Israel (Ronellenfitsch & Razum, 2004).

Given the particular dynamics of the immigrants' health status, it is desirable to create mechanisms to facilitate their access to information and healthcare services (National School of Public Health, 2010). The International Organization for Migration (IOM) estimates that in the near future 3–5 million people will migrate from Eastern European countries, indicating the need to identify specific points of vulnerability and to develop public health policies in the host countries (Ronellenfitsch & Razum, 2004).

Particular Problems of Illegal Immigrants

Access to health care becomes more complicated and difficult for illegal immigrants due to both legal and financial barriers, as well as the fear of being referred to the authorities and deported to their home country (Mladovsky, 2007; National School of Public Health, 2010). Studies show that illegal immigrants, regardless of origin, linguistic fluency, and length of residence in the host country, access fewer formal healthcare services than legal immigrants (Leclere et al., 1997). To improve the level of access to health services it becomes mandatory for the host country to ensure that illegal immigrants be given the right to privacy and that healthcare policies be completely separate from immigration policies (Médecins du Monde, 2009).

In September 2009, Médicins du Monde, a nongovernmental organization, published a report on access to health care for illegal immigrants from 11 European countries (Belgium, France, Germany, Greece, Italy, the Netherlands, Portugal, Spain, Sweden, Switzerland, and UK), based on 1,218 interviews. The report shows that access to health care of illegal immigrants is uneven among European countries, but is very restrictive overall (Médecins du Monde, 2009). The report shows that 72% of the health problems of illegal immigrants are inadequately resolved. The status of illegal immigrants represents a significant barrier to access to healthcare services although the need for medical care in illegal immigrants is very high. They suffer most frequently from arthritis, gastrointestinal ulcer, diabetes, hypertension, and psychological disorders (insomnia, anxiety broadcast, and psychosis). It is estimated that in about 16% of the cases the prognosis is unfavorable without treatment (Médecins du Monde, 2009). Illegal immigrants have poor living conditions and are more sick than the native populations. The situation is aggravated by the difficulties encountered by illegal immigrants when they need health care. According to the report, 45% of illegal immigrants who have health problems declare that they are not examined and receive no treatment. Even when the law of the host country provides medical care free of charge, only one third of respondents say that immigrants really have access. Fourteen percent of respondents stated that they were denied medical care when they were sick.

These difficulties also impact the children of illegal immigrants, although the International Convention on Children's Rights obliges signatory states to provide children the best care possible (Médecins du Monde, 2009). Antenatal care, delivery, and postnatal care in illegal immigrant women are also precarious. Only one out of every two pregnant women stated that they received medical care during pregnancy. Many illegal immigrant women give birth in emergency hospitals that were not suitable for this purpose, and were discharged immediately after the birth of their child (Médecins du Monde, 2009).

Culturally Sensitive Practices in Treatment Provided to Immigrants

Before the 1960s, immigrants in host countries were approached in the context of the *assimilation* perspective, which states that newcomers in a culture will comply and integrate into the lifestyle of the dominant culture. At the end of 1960s, following the disastrous results of this approach, immigrants began to be considered with the *multicultural diversity* perspective. Professionals give more importance to culture and its influence on identifying and defining health problems and on the ways to seek medical help in order to solve them. Most care providers now recognize the importance of respecting the values and experiences of all members of society, starting from the premise that diversity and difference means that the views, experiences, and different perspectives deserve to be heard and valued (Maiter, 2009).

McPhatter defined cultural competence in social work as the ability to transform knowledge and cultural awareness in medical or psychosocial interventions that support normal functioning of the client–system relationship in an appropriate cultural context.

In 1999, Barker stated that *culturally sensitive practices* are ways of professional intervention that take into account both the unique and common features of the clients/patients in terms of different racial, ethnic, religious, economic status; age; sex; or sexual orientation. Culturally sensitive practices are based on elements resulting from exploration of the practices and beliefs of patients on symptoms, disease, death, and other human experiences (Palmer & Kaufman, 2003). Culturally sensitive practices recognize that people with different backgrounds may experience different problems, so that social and medical interventions must be appropriate for members of different ethnic groups. Healthcare professionals must take into account cultural factors that might influence immigrants' help seeking behavior and their adherence to medical treatment. For example, Iranian immigrants in the USA prefer to not seek formal medical help because they have a sense of pride and do not want to become a burden to others. They may think that American physicians do not understand them (Martin, 2009).

Understanding cultural values is crucial in providing adequate medical care to populations of diverse cultural and ethnic background (www.portaldasaude.pt). In order to understand cultural norms and values of their patients, healthcare professionals should make a careful assessment of the patients' cultural features, in order to protect the patients from cultural generalization and stereotypes. A solution for the improvement of quality of the medical services provided to the immigrants is the involvement of *cultural brokers.* They are consultants (social worker, community leaders, etc.) from various ethnic populations, who may provide information regarding beliefs about health, appropriate methods of communicating with members of certain communities (e.g., to show respect for the elderly), and problematic aspects in the interaction between the medical system and immigrants. Using cultural brokers is particularly useful when working with elderly immigrants, who have more health problems and rely more on traditional medicine that may not be compatible with norms in the host country (Martin, 2009).

To provide culturally competent/culturally sensitive care, healthcare professionals must take into account their own cultural background, biases, cultural and professional norms, and incorporate relevant knowledge and interpersonal skills related to the care of patients who have a different cultural background. In providing health care to immigrants it is also necessary that health professionals be familiar with their specific health problems and social characteristics and understand that there are many important cultural, religious, social, gender factors that may arise in the negotiation and implementation of a therapeutic plan for various conditions, such as reproductive health, childcare, management of chronic diseases, aging, and end of life (www.portaldasaude.pt).

Healthcare professionals may be confronted by particular issues that affect immigrant populations such as female genital mutilation. Female genital mutilation, also known as genital cutting and female circumcision, was defined by the World Health Organization in 1998 as: "all procedures involving partial or total removal of external female genitalia for cultural, religious or other non-therapeutic reasons." Female genital mutilation currently affects about 130 million girls and women worldwide; the highest prevalence is in some African countries (Little, 2003; Taylor, 2003). Ethical and legal issues raised in the clinical context of patients who are victims of genital mutilation may be serious.

Female genital mutilation has become an issue for healthcare professionals in countries where this practice is culturally, socially, and legally rejected but is practiced by groups of immigrants. This occurs in Europe, America, and Australia (Hopkins, 1999; Thompson Ortiz, 1998). It is estimated that about 7,000 women who are at risk of genital mutilation arrive each year in the USA. Although female genital mutilation is illegal in the UK, it is practiced in some communities of immigrants coming from Eritrea, Somalia, and Yemen (Hopkins, 1999). About 15,000 children in immigrant communities in UK are at risk of being subjected to genital mutilation, due to the desire of parents to maintain their cultural identity (Taylor, 2003). This widely accepted social and cultural practice in some societies often leads to serious short- and long-term complications (Brady, 1999; Little, 2003). Advocates for this practice assert that female genital mutilation is an important cultural tradition with ancient roots and motivations, one that is motivated by the norms and beliefs of certain societies (Little, 2003). Frequently, female genital mutilation is performed under unsanitary conditions, often by older women in the community (Little, 2003). Recent years have seen an increased "medicalization" of female genital mutilation, that is, families of higher economic status seek medical help to practice genital mutilation of their daughters in order to avoid short-term complications. The issue of healthcare professionals performing a surgical intervention that has no medical benefit and may lead to harm raises difficult ethical issues given the fact that the leading principle of practicing medicine all over the world is "do not harm" (World Health Organization, 2001).

The USA, UK, Canada, Sweden, Australia, Belgium, Switzerland, Denmark, France, and the Netherlands prohibit female genital mutilation and reinfibulation after giving birth with or without the consent of the woman (Hopkins, 1999). However, despite these legal prohibitions, female genital mutilation is still practiced. The great danger of passing repressive legislation is that of moving the practice underground and fostering reluctance to seek for medical help in case of complications, which, ultimately, affects the victims of genital mutilation (Hopkins, 1999).

In the context of international human rights, female genital mutilation is considered to be physical and mental abuse of female children. This practice is being banned by several international bodies (World Health Organization, 2001). However, international human rights laws are difficult to apply because of arguments based on cultural relativism. What is considered to be a violation of the rights of individuals in one culture might be considered morally right in another. Rigid imposition of such laws can lead to accusations of racism or attempts to impose Western values on people from other cultures (Hopkins, 1999).

It is now clear that female genital mutilation cannot be eradicated by legal means alone, but extinction of the practice may occur if it is more widely recognized that this practice is harmful to women's health (Taylor, 2003). Healthcare professionals can play an important role by educating men and women from affected communities so that they understand the dangers and short- and long-term disabilities induced by female genital mutilation. In addition, the girls and women who do not undergo genital mutilation should not be ostracized in their communities. For instance, the French government currently supports a multi-pronged strategy designed to reduce the prevalence of female genital mutilation among girls living in France. One of the central elements of this strategy is based on providing culturally sensitive information and discussion with the girls and their families (Wu & Martinez, 2006).

The key factor in building a healthcare system based on cultural competence is community involvement from the outset and during the planning and implementation stages (in the form of focus groups, advisory committees, or board representation). Community involvement facilitates the understanding of patient needs and the effective allocation of resources and establishes a monitoring system for provision of quality healthcare services to the community members. In this way healthcare services can be provided efficiently, leading to increased patient satisfaction and improvement in the quality of care. In addition, good relationships between the community and healthcare facility support the healthcare services provided to the community (Wu & Martinez, 2006).

Studies indicate that the effectiveness of efforts focused on health promotion, illness prevention, and intervention for disease depend on the creation of medical assistance programs consonant with the linguistic and cultural characteristics and education of the population to whom they assist. The most successful programs are those aimed at a specific target population that ensures participation in the program design, implementation, and evaluation. For example, the Innvadiab project, which aims to reduce the development of type 2 diabetes in Pakistani women living in Oslo, Norway, demonstrated that culturally tailored education has the potential to change women's intentions and behavior related to a healthy diet (www.portaldasaude.pt).

Low level of acculturation reduces the addressability of the immigrants to the healthcare system in the host country. Age at time of immigration and acculturation level has an inverse relationship. For example, elderly Iranian immigrants in Sweden, even if they emigrated many years previously, continue to have difficulty speaking and feel isolated and largely dependent on their children (Martin, 2009). In these circumstances, it is essential that immigrants receive adequate care in a culturally sensitive environment. Organizations serving immigrant communities that can provide assistance with immigrants' needs may help in this regard (National School of Public Health, 2010).

An efficient model that directly addresses the linguistic and cultural problems of immigrants is based on using a *team of cultural support*, which works with both medical staff and community members. Members of this team, called intercultural mediators, are appointed as community health workers or patient navigators; they often originate from the immigrant community. In Hamburg, Germany, intercultural mediation teams plan and carry out activities in immigrant communities in order to familiarize their members with the German healthcare system. Belgium has introduced a program of 80 intercultural mediators in 62 hospitals in Brussels, to provide translation services and patient support activities (www.portaldasaude.pt).

A culturally competent approach must be integrated into all aspects and structures of healthcare. This approach eliminates the tendency to abandon efforts to build cultural competence when a healthcare system is faced with problems, such as the financial ones. Changes in the functioning of the healthcare system due to introduction of the cultural competence approach should be assessed regularly and carefully, both in terms of success and limitations (Wu & Martinez, 2006).

Continuous training of staff is essential for the staff members to understand why changes are needed and to accept them. For example, if staff members understand the usefulness of a professional interpreter, then they will not feel uncomfortable when patients require an interpreter and are more likely to facilitate access (Wu & Martinez, 2006). Medical staff should be trained to respond effectively to the sociocultural needs of the immigrants by "Cultural Competence Training." In Qatar, for example, Weill Cornell Medical College, in association with Hamad Medical Corporation, has implemented a program of Cultural Competence Training for medical students. In New Zealand, the Health Professional Competency Assurance Act of 2003 requires that professional organizations establish standards of cultural competence, clinical competence, and ethical standards to approach immigrant populations and ensure that these standards are met. US medical students must demonstrate that they understand health needs, beliefs, and communication needs of diverse populations. Six states already implemented continuing medical education programs in cultural competence (www.portaldasaude.pt).

Besides cultural factors, race and race-related issues faced by some people, especially those of color, are important aspects in interaction with the patient and his/her family in healthcare settings. It is important for healthcare professionals to take into account the racial differences and the consequences that being a member of a particular race has on the patient's family life. In 1998, Dei launched the so-called antiracist approach that takes into account the social effects of race. Significant social effects of race in White-dominated societies are evident in the experiences of minority groups. This framework can be useful in analyzing complex problems faced by families belonging to racial minorities, analyzing the situation of social services, developing clinical intervention strategies, and conducting research on diversity (Maiter, 2009).

Healthcare systems must systematically incorporate all aspects of immigrant health into service delivery. There are several models that illustrate such an approach, from the single-site intervention, up to comprehensive national policy (National School of Public Health, 2010).

In 2008, the World Health Assembly issued a resolution dedicated to health concerns of migrants (Sixty-first World Health Assembly, 2008), which mainly requires Member States to engage in the creation of *migrant-sensitive health policies and practices*, with the purpose of promoting and protecting the health of immigrants (World Health Organization, 2010). The concept of *migrant-sensitive health services* starts from the need to understand and respond effectively to the needs of immigrants and indigenous communities worldwide. Medical models based on this concept respond adequately to linguistic, cultural, social, religious, and health status differences, which affect the ability of immigrants to properly use the formal healthcare system of the host country. Many of the factors influencing the social status of immigrants and the use of healthcare services by immigrants relate to their social circumstances, which is why multiculturalism is linked to social determinants of health (National School of Public Health, 2010).

Immigrant-sensitive health systems are designed to meet the needs of migrants related to medical services, from basic recognition of the right of immigrants to health care to adaptation of healthcare systems and strategies for service delivery according to the needs of immigrants. Such services already exist in countries with historically high rates of immigration, such as Canada, Australia, New Zealand, the USA, and the UK, and are beginning to be implemented in countries recently experiencing high rates of migration (Fortier, 2010).

How health problems are related to immigration status depends largely on the type of immigration in each country, but also on the level of national social care system (Mladovsky, 2007). Between EU countries there is significant variability in the approach to health problems of immigrants. Healthcare politics for immigrants were developed in Italy since the 1990s. However, it is not clear to what extent the Italian government has successfully managed their implementation. Spain has recently developed national and regional plans for integration of immigrants (Mladovsky, 2007). In the Catalan region of Spain, the program *Migrant-Friendly Health Centres* was implemented by a NGO, in partnership with 33 hospitals of the Catalan public health system. Its purpose is to offer intercultural mediation services (www.portaldasaude.pt). Holland pays sustained and systematic attention to the health problems of immigrants (Mladovsky, 2007). In Norway, the *migrant-friendly hospital network* addresses a series of issues including language barriers in the interaction between patients and healthcare professionals, staff education, and multireligious assistance in the hospitals (www.portaldasaude.pt).

In 2000, the United States Department of Health and Human Services developed national standards to ensure culturally and linguistically adequate care (culturally and linguistically appropriate health services – CLAS). These standards address the practices of medical institutions with respect to the interaction between healthcare professionals and patients, the training of team members, community involvement, data collection, and administrative aspects (www.portaldasaude.pt).

Related Topics

- ▶ Access to care
- ▶ Acculturation
- ▶ Communication barriers
- ▶ Cross-cultural health
- ▶ Cross-cultural medicine
- ▶ Cultural background
- ▶ Cultural competence
- ▶ Gender
- ▶ Health barriers
- ▶ Health beliefs
- ▶ Health care utilization
- ▶ Health outcomes
- ▶ Health services utilization
- ▶ Informed consent
- ▶ Language barriers
- ▶ Multiculturalism
- ▶ Physician-patient communication
- ▶ Stigma

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Part 2

Immigrant Health Topics A–Z

Access to Care

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Access to care is defined for an individual or population as the ability to obtain preventive, primary, and tertiary healthcare as needed for optimal health. The US Institute of Medicine Committee on Monitoring Access to medical care defined access as: the timely use of personal health services to achieve the best possible health outcomes. Access to care is measured through population surveys or statistical data that relate actual healthcare use to various need and other personal, health system, and environmental factors that tend to reduce or enhance healthcare seeking behavior.

In understanding access to healthcare and social services, it is useful to consider the variety of different predisposing, enabling, and need factors that act independently and together to influence patterns of use and outcomes. Predisposing factors include environmental and patient characteristics such as age, gender, race/ethnicity, marital status, education, occupation, environmental risk factors, and health attitudes and beliefs. These factors affect a person's healthcare seeking behavior.

Enabling factors refer to individual and healthcare system and service characteristics that affect the means for obtaining healthcare. They include personal characteristics facilitating access to care such as personal income, health insurance coverage, transportation, and language proficiency. They also include healthcare system characteristics such as the availability of resources and the training and practice styles of providers, which may vary on a regional basis or over time. These factors are often targeted by health policies and programs aimed at improving access.

The third component of access is the combination of professional and patient perceptions of need which drive health care demand. Perceived need is based on the recognition and severity of illness, the recognition and severity of comorbidities, and the desire for a high quality of life. Together with enabling factors, need perceptions determine the extent to which an individual will actually obtain healthcare.

Recognizing the diversity of factors that influence access to care is the basis for measuring access as the relationship between the use of healthcare and the environmental, socioeconomic, behavioral, and need characteristics of individuals and populations.

For more than 3 decades, health services researchers have studied these relationships to understand the determinants of access to care for different populations and predict healthcare use. Initially, access models contained only individual-level variables to explain the variation in access to care across populations. Recently, contextual variables reflecting the social, economic, structural, and public policy environment have been added to the access model.

Contextual variables for a defined geographic area (e.g., country, county, metropolitan statistical area, or state) measure the environment or milieu in which access occurs. Community variables capture the social, economic, structural, and public policy environment in which access occurs. Specifically, these variables include the characteristics of the population (insured and uninsured), public policy support for low-income and safety-net populations, and the structure of the health care market and safety-net services within that market. Other contextual variables that can be considered in the framework include the number of hospitals and hospital beds per 1,000 population, the number of physicians per 1,000 population, and economic measures, such as the unemployment rate in a geographic area.

Sana Loue & Martha Sajatovic (eds.), *Encyclopedia of Immigrant Health*, DOI 10.1007/978-1-4419-5659-0,

Access Measures

Population surveys or administrative databases are used to describe potential and actual measures of healthcare access and associated access factors. Potential access is measured by the presence of enabling variables such as having a regular source of medical care or having insurance coverage. Realized access can be measured in positive terms such as regular visits to a physician and early initiation of prenatal care or negative terms such as delays in seeking or obtaining treatment, and late or no prenatal care.

Access outcomes measure the extent to which effective and efficient access is achieved once the individual enters the healthcare system. This measure combines the use of a specific type of healthcare for a specific health condition. Examples include preventable hospitalization rates for ambulatory care sensitive conditions, visits to hospital emergency rooms for non-urgent conditions, and hospital use for high-risk and complicated deliveries.

In countries with limited resources and lack of epidemiologic data, a common measure of access that combines a number of dimensions of the access model is the treatment gap. The treatment gap is used to measure the difference between the number of people with a given medical condition and the number being appropriately diagnosed and receiving treated. Direct measures of the treatment gap involve population surveys using adequate methods of case ascertainment, representative sampling, and a valid screening questionnaire. Information regarding treatment should be recorded with standardized questions that provide sufficient details on the type and quantity of treatments. Indirect methods, which can be applied when data are scarce, involve comparing hypothetical estimates of prevalence based on data from comparable countries to the number of people in treatment. For example, the drug treatment gap could be estimated by dividing the amount of drugs sold in a country by the defined daily dose of the drug and compared to the estimated number of people in the country who need the drug. Such estimates are subject to numerous biases and should only be used as broad indicators of access problems. A major limitation of the treatment gap as a measure of access is that it reveals little about the alternative factors that may be causing a gap. The researcher should also attempt to investigate the possible causes of the treatment gap in order to point to the strategies needed for improving access to care.

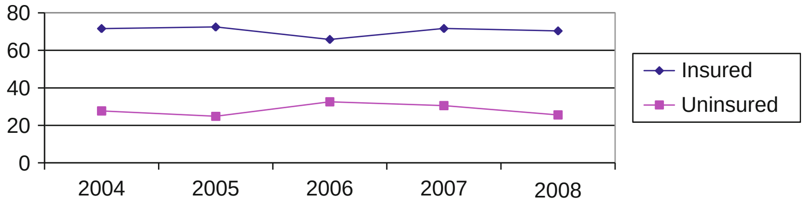
There are two broad approaches used in estimating health care access: empirical and hypothetical. In the former, estimates of the frequency and type of health services, social support services, and family member resources used by individuals with a condition are derived from prospective or retrospective studies of cases. In the latter, the estimates are based on hypothetical information provided by expert panels and/or related literature. Major concerns in both types of studies are the temporal perspective that is adopted (incidence perspective focusing on prognosis of new cases versus prevalence focusing on the current experience of all cases), case definition, the measures of use that are addressed, the generalizability of the estimates, and the attribution of services in patients with comorbid conditions.

Recent Trends in Access to Care in the US State of Texas

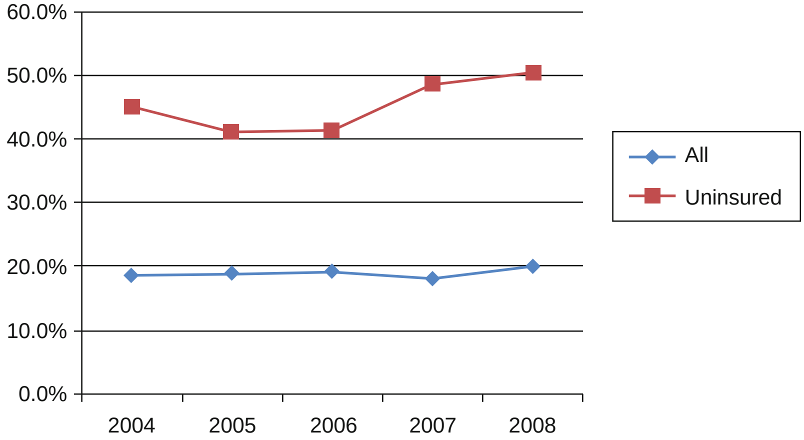
The state of Texas has 3.7 million foreign-born immigrant residents, the third largest number of immigrant residents among the states (after California and New York) and provides a useful example of access issues for immigrants. In Houston, Texas, the largest city in the state, there has been a sharp rise in the percentage of noncitizen residents, many of whom are uninsured. This is a concern because immigrants in the USA, particularly recent immigrants, are much less likely to be insured, and to have a personal source of care than US born individuals. They are also more likely to delay seeking medical care, less likely to receive appropriate care, have a higher rate of disabilities and death, and tend to rely more on Emergency Medicaid funding.

Immigrants in Texas are much more likely to be uninsured than are native-born residents. Well over half (60%) of the 2.6 million foreign-born residents of Texas who are not citizens (legal permanent residents, undocumented, and other foreign-born residents) are uninsured. Compared to other states with similar characteristics, Texas has the largest percentage of children of immigrants (40%) without health insurance.

With respect to potential access, there was a significant gap between the uninsured and the general population in Houston in terms of having a regular source of care (Fig. 1). The uninsured are about half as



Access to Care. Fig. 1 Disparity in potential access: percent with personal doctor or healthcare provider



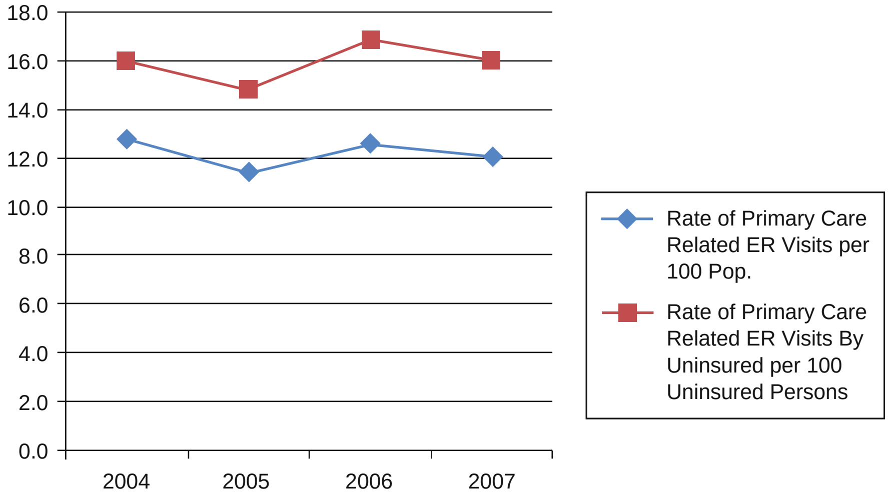
Access to Care. Fig. 2 Disparity in actual access: percent delayed a doctor visit in last 12 months due to cost

likely as the general population to indicate that they have a regular source of care (30% versus 60%). Similarly, with respect to realized access, the uninsured are about twice as likely as the general population to have delayed going to the doctor due to cost (Fig. 2). The gap increased over the last 5 years as the number reported delayed care increased somewhat for the uninsured while remaining constant for the general population. The rate of primary care–related hospital ER visits was between 12 and 13 per 100 population over the last 5 years, but for the uninsured, it ranged from 15 to 17 per 100 (Fig. 3). The gap between the two remained about the same over the period. Similarly, the percentage of total hospitalizations that were preventable was higher for the uninsured than for the general population (about 7% for the general population versus 10–11% for the uninsured) (Fig. 4). The gap between the two increased during the last 5 years.

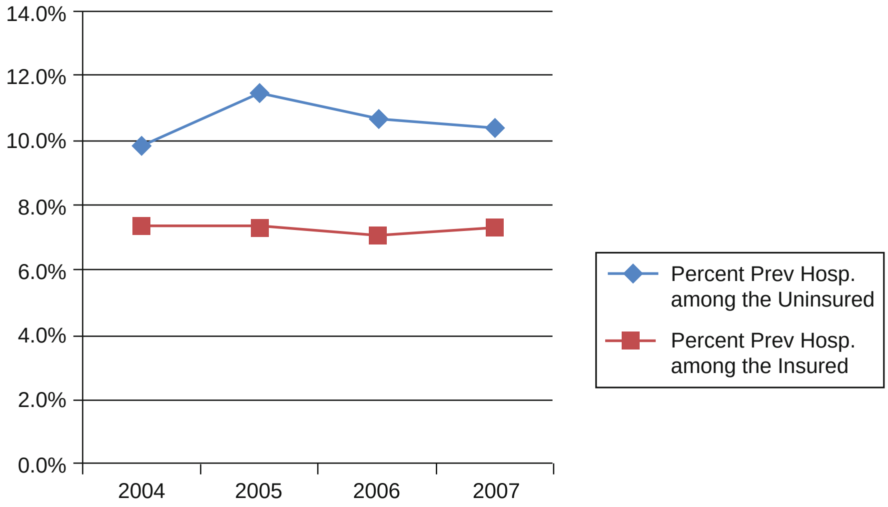
Conclusion

Access to care studies are important in identifying the need for resources, coverage, and or behavioral interventions to improve access and/or reduce the treatment gap. Problems are identified by the extent to which factors other than need determine who gets care or whether there is a significant gap between the need for and availability of care. In order for access studies to be useful, they must provide specific details regarding the barriers to access or the factors that cause the treatment gap. Immigrants in the USA and internationally experience multiple factors that impact their access to appropriate care. Researchers contribute to the understanding of healthcare seeking behavior and health outcomes. Their findings are instrumental in developing programs and policies that insure access for vulnerable populations such as immigrants and address the population-specific nature of access issues.

Immigrant noncitizen adults in Texas have the highest uninsurance rates of any group and face substantial barriers in access to care. In Houston, Texas, they are much less likely than people with health insurance to have a usual source of care, an important facilitator of access to healthcare. They are more likely to delay seeing a doctor because of cost, a measure of



Access to Care. Fig. 3 Disparity in access outcomes: primary care–related emergency room visit rate



Access to Care. Fig. 4 Access outcomes: preventable hospitalizations as percent of all hospitalizations

realized access, and they have higher rates of primary care–related hospital emergency room visits and preventable hospitalizations, both measures of access outcomes.

Related Topics

▶ Health policy

Suggested Readings

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Suggested Resources

Center for American Progress, Washington, DC

Center for Communmity Health Studies, University of Southern California, Washington, DC

Kaiser Family Foundation, Washington, DC

Migration Policy Institute, Washington, DC

Pan-American Health Organization (Organización Panamericana de la Salud), Washington, DC

Acculturation

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The term “acculturation” is used to define a set of changes, both at the psychological and social level, which immigrants usually experience in order to facilitate their own settlement to host societies. At the individual level, the term acculturation denotes a complex series of psychological and interpersonal changes that occur when an immigrant experiences a first-hand encounter with a new culture. These encounters may precipitate psychological adaptations (e.g., changes in behaviors and beliefs, identities, values and attitudes) that are made in order to thrive in the new cultural environment.

Contextual immigration factors may facilitate a healthy and smooth adaptation process at times, while the individual may experience great stress and difficulty in acculturating at other times. As a result, immigrants also appear to have varying levels of health and wellness disparities, which are influenced by the stress involved with the acculturation experience. For new immigrants, access to health care, mental health support, and culturally sensitive services may provide a healthy new beginning and opportunities for growth. On the other hand, immigrants who experience greater disparity in access to services may also suffer from segregation and discrimination. Therefore, they may endure high levels of stress that end up leading to poorer health outcomes and fewer opportunities for a healthy development.

Numerous theoretical perspectives are used by researchers and practitioners to understand how context and acculturation might impact immigrant health. Contemporary bidirectional perspectives on acculturation differ quite dramatically from the early straight-line “assimilation” models that dominated the health and social sciences literature several decades ago. These “assimilation” and “melting-pot” models posited that immigrants can – and should – completely assume the values, customs, identities, languages, and behaviors of the new host country, by leaving their old cultural orientations and traditions behind. Such assimilation into the new host culture was thought to be ideal for promoting rapid social integration into the recipient society through a process that would, in the end, yield optimal social and health outcomes. Despite the popularity of these models before and during the 1960s, the USA’s post-1965 immigration era challenged these views along with the unprecedented diversity of culture, language, and racial origins brought by recent immigrant waves. The new immigrants’ diversity questioned the simplistic models of acculturation as a path toward a predominantly European-based White cultural majority, which has been the mainstream belief until not long ago.

In contrast to simplistic acculturation models, more recent theorists have proposed a multicultural approach to acculturation, in which distinct ethnic milieus can be created and sustained, serving as independent and autonomous cultural living environments. For some immigrant groups in the USA, this may result in the development of ethnic and cultural enclaves, which provide much needed support and security in the new society. Proponents of the multicultural perspective claim that optimal development in the new society might be achieved through immigrants’ immersion in traditional family cultural practices, within a culturally congruent community environment. Individual development within an ethnic enclave may provide stability and support without having to experience interethnic conflict and distress, which may be the case among children who have to navigate both their own cultural system and the one of the host country.

Further, immigrants' introduction to American cultural values and practices may lead to the birth of new "hybrid" cultural groups that hold diverse cultural values, behaviors, and identities. For example, the Latino ethnic group is comprised of individuals of Hispanic or Latin American origin. Many Latino subgroups identify themselves as a distinct aggregate that share both common and distinctive ethnic characteristics. As a result, ethnic, racial, and cultural diversity in today's US communities, schools, and families is more commonplace than exceptional. Importantly, alongside this new cultural diversity came a growing spectrum of theoretical and political perspectives on the ways immigrants and their children could and should "become Americans."

Unfortunately, although multicultural environments can support positive ethnic identities and favorable out-group understanding among minority groups, they may also lead to stereotyping immigrants, thereby placing them and their children at risk for psychological distress and poor developmental outcomes. For immigrants in these situations, there may be greater exposure to discrimination, which can lead to negative mental health outcomes as well as to barriers for receiving adequate and timely health services. Given the shortcomings of either a purely assimilationist or a purely multicultural model, today's research and health practice perspectives emphasize Berry's bidirectional acculturation model, to which we now turn.

The Bidirectional Model and Acculturation Styles

The bidirectional model describes acculturation as a function of the degree to which immigrants strive to maintain their cultural heritage and identity, vis-à-vis the extent to which they become immersed with a new cultural environment. Therefore, immigrants' social and psychological incorporation into a new culture can be understood as a combination of the adaptations made between two cultural frameworks – the culture of origin and the host culture. In examining immigrants' patterns of psychological adaptation, research has found support for four strategies or styles.

The first type of acculturation style, called "assimilation," describes the scenario wherein individuals who do not wish to maintain their original cultural traditions forego them and completely assume the beliefs and practices of the host culture. These individuals learn the new language quickly, usually by making an effort to stop speaking their old language. They are likely to adopt new cultural traditions (e.g., holidays) and practice their household activities (e.g., cooking) according to the new country's cultural norms. The second style, "separation," occurs when an individual strongly adheres to his or her traditional cultural practices, and avoids contact with the cultural institutions of the host country. Immigrants ascribing to the separation style are reticent to adopt new cultural customs, including learning new languages or seeking social relationships outside their communities of belonging.

The acculturation style described as "integrated" refers to immigrants' allegiance to their old ethnic ways, while, at the same time, adopting the new language, values, and traditions prevalent in the host culture. This style, oftentimes is seen as an ideal balance between old and new practices, and is also referred to as biculturalism. "Marginalization" is the final acculturation style stemming from the bidirectional model. This is widely considered as the most deleterious of the four styles, as it indicates a lack of engagement with either culture, and is strongly associated with poor psychological and emotional outcomes (e.g., depression, anxiety).

Acculturation, Context, and Child Development

From a developmental stance, the nuances of the acculturation process are central for understanding its impact on immigrants' overall health throughout the life span. For instance, as the fastest growing segment of the US population, immigrant youth acculturate in ways that usually vary dramatically from their parents or co-ethnic adults. Studies from the last two decades have demonstrated that children adapt to life in the USA differently from their parents', particularly given their different contexts of acculturation (i.e., school vs. work).

Certainly, parents tend to retain more traditional values and practices as they have less exposure to both the majority culture and to the "agents" of cultural change (i.e., teachers and native-born peers). This is especially true if the immigrant family lives and works within an ethnic enclave. Children in these families are more often exposed to mainstream agents, such as schools and native peers, so they will have more opportunities for cross-cultural exploration. As a result, immigrant children appear to acculturate more quickly than their parents, and tend to assume unique family roles during the acculturation process (e.g., translation/interpreter roles for parents). Numerous studies have shown that children and adolescents born in the USA to foreign-born parents have more intercultural social contacts, and are less socially segregated than their parents. Importantly, the implications of these family dynamics are profound. Differential acculturation rates, styles, and strategies between parents and their children have been linked to higher levels of parent–child conflict and distance.

Further, children who immigrate at younger ages (particularly before the age of ten) have been found to experience less stress related to acculturation compared to children who immigrate at older ages, as the first demonstrate less difficulty in acculturating and in adopting the practices and values of the host country. However, these children have also been found to engage in more intergenerational conflict with their families and elders resulting from differences in acculturation rates, amid incongruence of values and behaviors across cultural contexts. In contrast, children who immigrate later may experience greater synergy with their parents, due to the fact that they may be strongly attached to their cultures of origin. However, unlike their peers who immigrated at younger ages, these older children may experience similar acculturative stress as their parents. Furthermore, the acculturation-related struggles taking place within the family are highly influenced by the qualities of the receiving community in which immigrant parents and their children live.

Generally, most immigrants will continue to experience changes in cultural adaptation throughout their lifespan, although their individual responses amid their contexts of belonging will vary. In describing the influence of culture on adjustment, specifically within the school environment, Ogbu proposed three types of cultural discontinuities, which capture the process of how individuals make unique adaptations to new cultural institutions, such as the school system. In the "universal" type of cultural discontinuity, all children must learn to adjust to new school environments, for example, by adapting to novel classroom organization, new social norms, and daily routines. In the "primary" discontinuity model, immigrant children must adapt to new cultural concepts (e.g., American conceptualizations of "liberty" and "rights"), as well as to new learning styles, language, and idiomatic forms, and even basic mathematical concepts such as length and time. Finally, within the "secondary" discontinuity model, populations that are highly stratified and have a long history of social subjugation (e.g., racial minorities) must learn to adapt to the host country's "collective struggles" toward seeking specific religious, political, and legal rights.

Immigrant children are often faced with contradictions between school/peer cultures (which may challenge ideals of upward social mobility), and the beliefs espoused by their parents based on the importance of education as a means for social integration and upward mobility. Additionally, adult immigrants may suffer from the dissonance between their individual expectations and the realities presented to them as either "lower class" individuals or as "minority" members. Particularly with respect to recent immigration policy changes, the psychological and emotional stress experienced by some immigrant groups can be further strained as they fight for their rights, particularly when trying to obtain basic health and social services for their families. Finally, the discontinuity theories discussed in this section highlight the importance of understanding the larger social structures and stratification systems in place during the acculturation process.

Stress and Change

The saliency of the acculturation styles explained earlier can be seen in their association with different health and mental health outcomes. For example, immigrants experiencing either an integrated or a bicultural style of acculturation are also likely to present overall positive health outcomes that include lower levels of worry, stress, and anxiety. At the other end of the continuum, immigrants that ascribe to a marginalized acculturation style are more often exposed to social and structural barriers, such as poverty and racial discrimination. In addition, an internalized feeling of marginalization has been found to result in greater behavioral problems for children, adolescents, and young adults who may also suffer from higher levels of psychological distress.

As a result of the dynamic processes of acculturation, research has found evidence that support a specific psychological outcome, which has been termed as "acculturative stress." Historically linked to "culture shock," acculturative stress refers to the negative emotional reactions that immigrants may suffer during acculturation. As individuals come into contact with a new culture, they may experience fear and emotional threats to their traditional ways of life. They can also suffer from feelings of isolation or discomfort as they try to adapt to a new environment, while being overwhelmed by the challenges presented by the host society (i.e., entering school, finding a job, joining new social networks). Other syndromes that immigrants may experience include anxiety, depression, increased psychosomatic issues, and identity confusion.

Similar to acculturation itself, acculturative stress is a continuous and dynamic process that can be extended over time. Therefore, it is critical to count on services able to help immigrants deal with their physical and psychological difficulties, and which provide coping resources aimed at promoting health and well-being. Immigrants who present higher levels of acculturative stress have been found to experience negative outcomes in the social, emotional, academic, and health realms. Acculturative stress can also have a serious impact on the well-being of immigrants, by increasing their physical health ailments (i.e., chronic pain, heart conditions). Furthermore, recent research has demonstrated the existence of a powerful link between immigrants' experiences of discrimination and marginalization on the one hand, and deleterious health outcomes on the other. Finally, the endurance of acculturative stress increases the likelihood of developing mental health problems, particularly depression and anxiety.

The Immigrant Paradox

There are some acculturation-related health patterns that have been observed among immigrants in the USA, and that are collectively summarized in the notion of the *immigrant paradox*. According to this phenomenon, more highly acculturated groups of individuals will show *less favorable* health and education outcomes than their less-acculturated peers. Particularly among recent immigrant streams (i.e., Latino and Asian groups in the USA), the immigrant paradox suggests that these individuals will have significantly better health and education outcomes than both their native counterparts and those whose families have lived in the USA for generations (i.e., second generation). This troubling health pattern has been documented across a wide array of physical health (e.g., obesity, heart disease, smoking behaviors, sexual health), mental health (e.g., delinquency, internalizing problems), and educational (e.g., high school and college degree attainment) outcomes.

One way to disentangle these seemingly contradictory patterns, is to acknowledge the role structural factors play in shaping immigrants' acculturation experiences. Upon arrival to the USA, immigrants often encounter few upward mobility ladders and meager opportunities for economic advancement. Furthermore, they are typically exposed to grueling living conditions, which along with progressive and deep changes in their life styles can have a negative effect on both their physical and mental health outcomes. Lifestyle changes often include radical modifications in daily eating practices (e.g., drinking alcohol and eating unhealthy foods), working long hours and having little time for resting and socializing with peers. Therefore, it is not surprising to find that the longer immigrants have resided in communities that present high levels of poverty and social marginalization, the worse their physical and mental health outcomes and education possibilities may be. Further research is needed to fully explore the contextual, social, and intrapersonal factors underlying the immigrant paradox.

Final Remarks

The notion of individual acculturation encompasses a diverse set of experiences, which have profound implications for immigrants' health. Importantly, the types of acculturation patterns discussed earlier must be interpreted within the larger social contexts in which immigrants reside. Social barriers, such as poverty and discrimination, greatly influence immigrants' specific acculturation styles which, in the end, will greatly impact their health and developmental outcomes. Furthermore, many immigrant groups may continue to experience stigma and fear when seeking help for both physical and emotional issues.

Finally, less acculturated immigrants may have more difficulty understanding and utilizing Western models of medicine, and may insist on adhering to their healing beliefs. The respect for immigrants' traditional healing methods can actually increase their trust in biomedicine, and may lead to implementing successful multicultural approaches to health care.

Related Topics

▶ Acculturative stress
▶ Adolescent health
▶ Cultural adaptation resources
▶ Culture shock
▶ Depression
▶ Discrimination
▶ Epidemiological paradox
▶ Ethnic enclave
▶ Lifestyle
▶ Marginalization
▶ Multiculturalism
▶ Psychological acculturation
▶ Social integration
▶ Stress

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Acculturative Stress

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The concept of acculturation refers to the cultural and psychological changes that groups and individuals undergo when they come into contact with another culture. Acculturative stress is stress that directly results from and has its source in the acculturative process, often resulting in a particular set of stress behaviors that include anxiety, depression, feelings of marginality and alienation, heightened psychosomatic symptoms, and identity confusion. Acculturative stress may underlie a reduction in the health status of individuals, including physical, psychological, and social health.

People have long been emigrating to better their lives for a variety of reasons, including seeking a safer environment, greater food sources, and personal freedom. In the last few decades, people have migrated more than ever before. Civil wars in Africa, the fall of the Soviet Union, natural disasters, and human-made disasters have instigated the relocation of several million people. While immigrant groups may be seen as having a large number of practical stressors as a result of relocation, such as economic or housing issues, stress related to acculturation also involves problems unique to immigrants, such as difficulties with language and varying customs. The types and intensity of acculturative stress depend on many factors including the similarities and differences between the host culture and that of the immigrants' country of origin, sex, age, language, race, motivation for the relocation, level of education, socioeconomic status, and the host country's political and social attitudes, especially toward immigrant groups.

The influence of gender on the acculturation process and related stressors differs in part due to variation in gender roles ideology across cultures. Females have been reported by a number of researchers to have greater difficulty in adapting to a new culture, with either fewer opportunities to acculturate while remaining in the home, or stressed by demands of employment coupled with a traditional division of labor, resulting in a heavy workload overall. Also, women are often more willing than men to accept low-wage and unskilled positions, sometimes becoming the wage earner in the family and creating stress with their male partners who may be unemployed and feel threatened by power shifts in the relationship and family structure.

Age at the time of immigration often appears to be negatively related to adjustment in the acculturation process. Studies have shown that a younger age at the time of immigration predicted higher levels of acculturation and greater life satisfaction. In addition, elderly people who immigrate with their extended families tend to do more poorly than their younger relatives, due to feelings of isolation being overwhelmed by the differences between the host country and country of origin.

Another factor of acculturative stress is the motivation behind the relocation itself, as it can be voluntary or involuntary. Some individuals have been motivated to move in order to seek educational or occupational opportunities; in other cases, individuals may perceive themselves as having less choice in the decision to leave their home county. Those immigrants with a history of mistreatment, such as refugees, may perceive themselves as threatened or treated unfairly by those in the mainstream group, and thus may feel less inclined to identify with that group.

Other major stressors include changes in socioeconomic status, level of education, and language proficiency in the host country. Immigrants' entry status into the larger society may be lower than their departure status from their country of origin. In addition, the inability to communicate proficiently in the host country's language may result in unemployment or having to accept a position of lower status than the one held in the country of origin.

Provision of social and economical support to immigrants may ease the transition to their new country and may play a vital role in lessening the effects of acculturative stress.

Related Topics

- ► Acculturation
- ► Health perception
- ► Stress

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Acquired Immune Deficiency Syndrome

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Acquired Immune Deficiency Syndrome (AIDS) is a medical diagnosis by a physician of a set of symptoms or conditions based on specific criteria established by the US Centers for Disease Control and Prevention (CDC) and the World Health Organization (WHO). These criteria include infection with Human Immunodeficiency Virus (HIV) *and* either the presence of one or more defined AIDS indicator diseases or other indicators of a suppressed immune system based on certain blood tests (CD4+ counts). The "opportunistic" diseases associated with AIDS occur following the depression of an individual's immune system, allowing susceptibility to unusual infections or malignancies.

AIDS, the end stage of HIV disease, is caused by the infection and spread of HIV within the body. A positive HIV test result alone does not mean that a person has AIDS, only that HIV infection has occurred. HIV destroys CD4+ T blood cells which are crucial to the normal function of the human immune system. Most HIV-infected people carry the virus for years before the immune system is damaged enough for AIDS to develop. There is a direct correlation between the amount of HIV in the blood, the decline in CD4+ T cell numbers, and the onset of AIDS. Progression from initial HIV infection to AIDS may take 10 years or more, but varies greatly depending on many factors, including a person's health status and his or her health-related behaviors. Reducing the amount of virus in the body with anti-HIV drugs can slow down the rate at which HIV weakens and destroys the immune system. The natural history of HIV infection is well documented in the medical literature. Information on HIV transmission, testing, and care and treatment may be found in the entry for "Human immunodeficiency virus (HIV)" in this encyclopedia.

State of the HIV/AIDS Epidemic and the Impact of Migration and Immigration

Worldwide, the United Nations AIDS program (UNAIDS) and WHO estimated that 33.4 million people were living with HIV/AIDS at the end of 2008 (31.3 million adults and 2.1 million children), 20% higher than in 2000 and three times higher than in 1990. During 2008, an estimated 2.7 million people became infected with HIV, and two million individuals died from AIDS. Dramatic advances have been made in understanding the natural history of HIV disease and in development of effective antiretroviral (ARV) therapies that significantly extend survival, allowing many years of healthy life. Nevertheless, the HIV/AIDS epidemic continues to grow with some disturbing trends. ARV drugs remain largely unavailable to many infected individuals in the developing world, and HIV/AIDS morbidity and mortality increasingly impacts the poor, the disenfranchised, and the young.

The International Organization for Migration reported that approximately 191 million people (3% of the world's population) were international migrants in 2005. Migration and immigration, while not HIV risk factors themselves, may create circumstances that increase one's risk of infection. UNAIDS data on HIV transmission and risks indicate that migrant and mobile populations, including labor migrants, refugees, asylum seekers and immigrants, newly arriving or resettling in a new country, are at greater risk for HIV infection than the local general populations in the new country of arrival or resettlement. UNAIDS attributes this to several issues and challenges ranging from financial and environmental conditions to cultural and language barriers, stigma, discrimination, exploitation, and difficulty accessing HIV education, prevention or health services. Patterns of migration are driven by political tensions, war, and economic and environmental crises which exacerbate instability and stress for the population on the move.

The majority of people with HIV/AIDS live in the developing world, two-thirds in Sub-Saharan Africa followed by 14% in East, South, and Southeast Asia. On the other hand, in the developed, high-income regions (United States, Canada, Western and Central Europe and Australia), the number of people living with HIV/AIDS continues to rise due to continued high rates of new HIV infections and widespread access to life-extending ARV therapy. Extended life expectancy with ARV increases the pool of HIV-infected people who are able to transmit the virus to others. HIV prevention activities in some high-income countries are not keeping pace with the spread of HIV or are falling behind, as evidenced by HIV increasing among marginalized groups, including drug users, immigrants, and refugees.

Sub-Saharan Africa contains just over 10% of the world's population and 67% of all people living with HIV/AIDS. Approximately 1.4 million people in this region died from AIDS in 2008. Average survival without treatment is around 10 years after infection. ARV drugs which dramatically extend survival are unavailable to most Africans. In contrast to other regions of the world, Sub-Saharan African women are 1.4 times more likely to be HIV-infected than men, due to both greater effectiveness of male-to-female HIV transmission through sex and the younger age at initial infection. As a generalized epidemic, defined as that in which HIV has spread beyond those engaged in high-risk behaviors to the general population with prevalence rates of 5% or more in urban areas, HIV affects all social and economic groups within Sub-Saharan Africa.

Regional migration, including work-related mobility, within Sub-Saharan Africa is an important factor for HIV transmission in that it encourages increased sexual risk behavior. Examples include increased infection among women who traveled away from home five or more times per year in the United Republic of Tanzania; among individuals residing in close proximity to a primary road in rural KwaZulu-Natal province in South Africa; among long-distance truck drivers and migrant mine workers, who are more likely to engage in high-risk or commercial sex; and among couples in Lesotho separated as a result of labor migration, resulting in a high rate of multiple concurrent partnerships.

In *Eastern Europe and Central Asia*, the HIV/AIDS epidemic is rapidly expanding, with 110,000 people infected with HIV in 2008, bringing the total number of people living with the virus to around 1.5 million. Very few have access to ARV therapy, resulting in around 87,000 deaths from AIDS in 2008, higher than it might otherwise be. Most impacted are the Russian Federation, Ukraine, Estonia, Latvia, and Lithuania. Around 940,000 people are living with HIV in the Russian Federation. Migration in this region has been significantly exacerbated by political tensions, war, economics, disintegration of the former Soviet Union, and recent enlargements of the European Union, all increasing instability with and potential susceptibility to HIV infection.

UNAIDS and WHO estimated approximately 310,000 people living with HIV/AIDs in *North Africa and the Middle East*, with 35,000 new infections and 20,000 deaths from AIDS in 2008. Long believed to have sidestepped the global epidemic possibly due to strict rules governing sexual behavior, the epidemic continues to grow here as well. Timely and reliable epidemiological and behavioral data have been extremely limited for this region, hindering a clear understanding of HIV-related dynamics and trends, including any impact of migration to or within the region.

In 2008, around 4.7 million people were estimated living with HIV/AIDS in *East, South, and Southeast Asia*, with 350,000 new infections and 330,000 AIDS-related deaths in that year. Comprising 60% of the world's population, East, South, and Southeast Asia is second in the number of people living with HIV, with India accounting for roughly half. Other countries with large numbers of people living with HIV include China (700,000), Thailand (610,000), and VietNam (290,000). Although adult prevalence was below 1% in most countries in this region, the national averages may obscure serious epidemics in some smaller provinces and states within larger countries.

Nearly 50 million people in the East, South, Southeast Asia and Pacific region are not living in their country of birth. Even so, this is significantly less than the number of people who migrate internally, particularly within larger countries such as China. Much of the latter is generated by migration for work to urban areas; China's so-called floating population is close to 150 million people. Among these rural-to-urban migrants, frequent substance use, intoxication, and elevated rates of sexually transmitted infections are reported. Cross-border migration among sexual and drug-using networks in some areas, including the India–Nepal border, appears to be contributing to two-way HIV transmission. Migrants are often excluded from basic health services in the areas to which they have migrated and more likely to delay seeking treatment.

UNAIDS and WHO estimated approximately 59,000 people living with HIV/AIDS in *Oceania*, with 3,900 new infections and 2,000 AIDS-related deaths in 2008. Oceania, comprised of Australia, New Zealand, Papua New Guinea, and numerous island nations and dependent territories within the Southern Pacific regions of Melanesia, Micronesia, and Polynesia, generally has a very low HIV prevalence rate compared with other regions, well below 0.1% for the small island nations that make up most countries in the region. Australia, with an estimated HIV prevalence of 0.2%, is also considerably less severely affected than other high-income countries. Monitoring epidemiological trends in the region is limited by weak HIV surveillance systems in many countries. Consequently, the impact of regional migration on epidemiological trends cannot be measured, or whether the epidemic in one country is affecting neighboring countries.

In Australia, the impact of immigration from outside of the region is clearly demonstrated in a per capita rate of HIV diagnosis more than eight times higher among immigrants from Sub-Saharan Africa than among Australian-born persons. Fifty-nine percent of the relatively small percentage of heterosexually acquired cases of HIV infection reported in Australia between 2004 and 2008 were among individuals born in Sub-Saharan Africa or among individuals with sexual partners born in a high-prevalence country.

An estimated 2.24 million people are living with HIV in *Latin America and the Caribbean*, including the estimated 190,000 who became infected during 2008. Around 89,000 people died of AIDS in the same year. Five Latin American countries have an adult HIV prevalence greater than 2%, higher than anywhere outside Sub-Saharan Africa. Although the largest epidemic is in Brazil, with 730,000 people living with HIV, the death rate has fallen there due to widespread access to treatment.

Large-scale migration occurs between countries in Latin America due to civil conflicts, political and socioeconomic conditions, and the high pace of urbanization. Recent studies have linked this movement of people to the spread of HIV in Latin America. Factors which exacerbate risk for HIV infection for immigrants from Latin America include poverty, violence, few available health services, increased risk-taking, rape, loneliness, and contact with large numbers of sex workers. Recent research indicates that the vast majority of migrants do not protect themselves during sexual intercourse, and 10% of female migrants had experienced forced, unprotected sexual intercourse. Migrants sometimes engage in high-risk behaviors, such as sex work, in order to survive day-to-day in a new and unfamiliar area.

Mexico's HIV/AIDS epidemic may be considerably impacted by US/Mexico cross-border migration. According to a survey of more than 1,500 Mexicans who had spent time in the USA, migrants had more sexual partners and used more non-injecting drugs than non-migrants, but migrants also reported higher rates of condom use and HIV testing. More than 20% of individuals with AIDS in the southern Mexican states of Michoacán and Zacatecas had previously resided in the USA. Male injecting drug users (IDUs) in Tijuana who had been deported from the USA were more than four times more likely to be HIV-positive than non-deportee IDUs. Close to 50% of men who have sex with men (MSM) in Tijuana reported having male partners from the USA.

UNAIDS and WHO estimated approximately 2.3 million people living with HIV/AIDs in *North America (north of Mexico) and Western and Central Europe*, with 75,000 new infections in 2008. Within this region, the rate of new HIV infection is highest in the USA. Even with the rate of AIDS-related deaths substantially reduced in this region through access to ARV medicines, AIDS claimed approximately 38,000 lives in the North America and Western and Central Europe region in 2008. In the USA, the CDC estimated that approximately 1,106,400 people were living with HIV or AIDS at the end of 2006, with an estimated 56,300 new HIV infections in that year. The CDC projects that 21% of those infected with HIV are unaware of their status, posing an even higher risk for transmission of HIV to others.

The epidemics in North America and Western and Central Europe are concentrated in higher risk populations, especially MSM, IDUs, and immigrants. Immigrants who acquired HIV infection in their countries of origin before migrating to these areas constitute a sizable share of the epidemic in many of these countries. Migrant populations, particularly from Sub-Saharan Africa, appear to represent a considerable and growing proportion of both HIV infections and AIDS cases reported in the European Union between 1999 and 2006. Individuals who migrated from countries with a generalized epidemic comprised approximately 17% of new HIV diagnoses in Europe in 2007. Several European countries have reported increasing proportions of heterosexually acquired HIV, some associated with migrants from high-prevalence countries; 77% of people newly diagnosed with HIV in the United Kingdom (UK) in 2007 who acquired the virus through heterosexual contact were likely infected outside the UK. The proportion of Sub-Saharan migrants among heterosexual and mother-to-child transmission cases is very high in Europe, and increasingly contributing to the epidemic in Europe, particularly among females. Public health services in North America and Western and Central Europe are challenged to access and provide culturally sensitive HIV prevention programs, care, and treatment to the infusion of immigrants, migrants, and refugees from diverse areas of the world with high HIV infection rates and generalized epidemics.

Cross-border migration between Mexico and the USA creates additional challenges, with concerns that Mexican and other Latin American migrant and recent immigrant populations in the USA are at increased risk for HIV. While relatively little is known about the extent of the HIV/AIDS epidemic among these populations, several factors point to high risk for HIV/AIDS within these populations. These include constant mobility; cultural beliefs; cultural, linguistic, and geographic barriers to HIV testing and health care services; immigration attitudes and legislation, resulting in fear of deportation; change in sexual practices, including higher likelihood to engage in high-risk sexual practices; limited education, including education about HIV transmission and prevention or safer sex; psychosocial factors; isolation; discrimination; poverty; episodic employment and chronic underemployment; and substandard housing. Change in sexual practices can be attributed to a need to seek companionship to compensate for the alienating aspects of migration, fewer restraints or social controls on behavior, exposure to previously unknown or unacceptable sexual, drug-using, or other risky behaviors and practices, or unstable economics that compel some to exchange sexual services for food, lodging, or money.

Future projections of the course and extent of the worldwide HIV/AIDS epidemic cannot be made with any accuracy. Although there are promising signs that the epidemic is abating in some areas, major challenges remain in terms of universal access to prevention, screening, treatment, and care, particularly among many migrant populations. WHO predicts that AIDS will continue to be a leading cause of death throughout the world for the foreseeable future.

Related Topics

- ► Addiction and substance abuse
- ► Asylum
- ► Human immunodeficiency virus
- ► Injection drug use
- ► Labor migration
- ► Refugee
- ► Sex work and sex workers
- ► Sexually transmitted diseases
- ► Trafficking

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Acupressure

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Many Chinese immigrants in the USA have accessed both Western style biomedicine and traditional Chinese medicine (TCM), which includes acupuncture, acupressure, dietary therapy, massage, and therapeutic mind/body practice. Traditional Chinese medicine is a healthcare delivery system that has a professional class of physicians and its own diagnostic system. Individuals may access both TCM and Western conventional medicine.

Acupressure is a form of acupuncture that is performed without the use of needles; it involves only the contact (or touch) of the patient's body through massage. Finger pressure is applied to specific spots known as acupoints; these follow rivers of energy throughout the body that are known as meridians. It is believed that illness occurs when these energies become unbalanced or blocked and that stimulation of the acupoints restores the balance of these energy flows and alleviates illness. Pressure and small circulatory movements with the thumb or index finger are used at the acupoint, and percussion is used along the line of the meridian. Randomized controlled trials suggest that acupressure may be effective in reducing nausea during pregnancy, postoperatively, and following chemotherapy. Its effectiveness in treating motion sickness has not been established.

Studies have found that many Chinese immigrants may prefer Western medicine for acute symptom relief and life-threatening illnesses and prefer TCM for more chronic conditions, especially if they have tried Western medicine and found it to be ineffective or if they have experienced side effects. Conditions such as stress, fatigue, and digestive difficulties are often treated with TCM. TCM may also be utilized because of family traditions or family pressure to do so.

Research also suggests that a decision to use TCM is not influenced by educational level or acculturation level. However, use of TCM may be influenced by socioeconomic status. In the USA, for example, visits to physicians are often covered by health insurance, but visits to TCM providers are generally not covered by insurance. TCM treatment plans may also require more practitioner visits than would be required by Western medical care. As a result, Chinese immigrants may find that TCM care is more expensive than Western-based medical care and that the cost of TCM is prohibitive because of the lack of insurance coverage.

Related Topics

- ► Acupuncture
- ► Alternative and complementary medicine

Suggested Readings

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Acupuncture

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Acupuncture is an ancient healing practice that can trace its history back thousands of years to its apparent origin in China. It eventually spread to Japan, Korea, Vietnam, and East Asia. In the 1970s, the practice finally gained attention in the USA.

Classical Chinese acupuncture is based upon naturalist and Taoist thought. Traditional Chinese Medicine is a form of acupuncture that strives to keep the body in balance. Under Traditional Chinese Medicine, *qi* regulates a person's spiritual, emotional, and physical well-being. A person's *qi* is believed to be affected by two polar compliments: yin and yang. Yin represents negative energy or passive principle. Conversely, yang represents positive energy or active principle.

An imbalance of yin and yang leads to a blockage of the vital energy, or *qi*, along pathways called meridians and results in illness. It is thought there are more than 2,000 points on the human body that connect with 12 main and eight secondary meridians. Through acupuncture, which involves the placement of hair-thin, solid, metal needles at the various points of the body that connect with meridians, the blocked pathways can be cleared. It is believed the use of the needles to manipulate the ability of *qi* to flow allows yin and yang to be brought back into balance.

While Traditional Chinese Medicine is still practiced, another form of acupuncture has emerged: medical acupuncture. Medical acupuncture is often practiced, in Western cultures, by doctors other than health care professionals with medical/health science training. While Traditional Chinese Medicine is highly individualized, medical acupuncture treats the patient's symptoms using a corresponding group of points. Rather than imbalances in the body, it is based more on biomedical diagnoses, anatomy, physiology, and biochemistry.

There are several biomedical theories for how acupuncture works. It has been proposed acupuncture stimulates points that relay electromagnetic signals. This would cause the signals to be sent at a faster rate, triggering the flow of pain killing biochemicals, like endorphins, and sending immune system cells to the injury/diseased site. Another proposition is that acupuncture results in opiates being released into the central nervous system. A third theory is that a patient's brain chemistry may be changed, through acupuncture, due to the release of neurotransmitters and neurohormones in a positive manner.

Acupuncture can be used to treat a variety of conditions. According to the 2007 National Health Interview Survey, 1.4% of respondents, representing approximately 3.1 million US adults and 150,000 children, indicated they had undergone acupuncture the previous year. An earlier National Health Survey Interview revealed pain or musculoskeletal complaints accounted for seven out of the top ten conditions for which people underwent acupuncture. The most common condition was back pain. Other commonly cited conditions included joint pain, neck pain, migraine/ headache, and recurring pain. Acupuncture has also been used to treat conditions like fibromyalgia, menstrual cramps, labor pain, chemotherapy-induced nausea and vomiting, epicondylitis, osteoarthritis, postoperative dental related pain, carpal tunnel syndrome, and myofascial (trigger point) pain.

The Alternative Health/Complementary and Alternative Medicine Supplement portion of the 2002 National Health Interview Survey reported 62.1% of the US population had used some form of complementary and alternative medicine. In 2002, 1.1% of the population had used acupuncture in the prior 12 months. The 2007 National Health Interview Survey revealed the proportion of US citizens that used acupuncture in the prior 12 months increased to 1.4%.

The National Health Interview Survey also examined the ethnicity/race of the respondents. In 2002, of the respondents who used alternative medical systems, which includes acupuncture, 2.4% were Hispanic, 2.8% were White, 1.4% were African-American, and 4.5% were Asian. In 2007, of the respondents who used alternative medical systems 3% were Hispanic, 3.7% were White, 1.4% were African-American, and 5.4% were Asian. Females and those who are between the ages of 40 and 60 were more likely to use treatment like acupuncture. Additionally, individuals in the Western USA as compared to other regions of the USA were more likely to use treatment such as acupuncture.

Asian immigrants to the USA, especially older individuals, may be more familiar and comfortable with treatments like acupuncture and may view these approaches as consistent with their homeland's customs, rituals, cultures, and beliefs. Moreover, language barriers might also prevent immigrants from seeking conventional medical care from physicians.

The effectiveness of acupuncture is subject to debate. As studies use different acupuncture techniques, controls, and outcome measures, the results of the studies can be difficult to compare and draw conclusions from overall. However, there is some evidence that a person's attitude about acupuncture can have an effect on their perceived outcome. While most agree more research is needed, acupuncture is gaining acceptance as a promising alternative for some pain conditions and is covered by some insurance companies.

Potential risks of acupuncture include infection, internal organ injury, soreness, bruising, and bleeding. To lower the risks associated with acupuncture, some countries impose regulations on the practice. In the USA, for example, the Food and Drug Administration regulates acupuncture needle use by licensed practitioners. It is also recommended the patient research the practitioner's qualifications and reputation prior to submitting to treatment.

Acupuncture, like many other types of complementary and alternative medicines, has been growing in popularity and acceptance. Although there is debate as to the effectiveness of acupuncture, it is generally deemed relatively safe when performed by a competently trained professional.

Related Topics

- ► Alternative and complementary medicine
- ► Chinese
- ► Chronic pain

Suggested Readings

Barnes, P. M., Powell-Griner, E., McFann, K., & Nahin, R. L. (2004). *Complementary and alternative medicine use among adults: United States, 2002.* CDC National Health Statistics Report #343. Hyattsville, MD: National Center for Health Statistics.

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Addiction and Substance Abuse

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Discussion of so-called substance abuse and addiction is vexed by ambiguity and disputes over vocabulary, which is caught up in equally vexing disputes about ideology and values. People may distinguish among substance use, misuse, abuse, abuse disorder, dependence, and addiction, but not necessarily in consistent ways.

The American Psychiatric Association defined drug abuse in 1932 as "the illegal, nonmedical use of a limited number of substances, most of them drugs, which have properties of altering the mental state..." Note the oddity that not all drugs are drugs – the second sense meaning therapeutic compounds. This double meaning creates additional confusion. The definition went on to establish as essential conditions violation of cultural acceptability, social norms, or statute; drug abuse was predominantly framed as moral transgression. This moral lens has continued to influence views of substance abuse, but the formulation of addiction or substance dependency as a disease has grown more influential.

As the disease model does not distinguish between licit and illicit behaviors, while the term "drugs" has not generally been understood to include alcohol and tobacco, "substance abuse" is now preferred. Some question the concept of a substance abuse disorder or addiction entirely, claiming that these cannot be distinguished from other categories of voluntary behavior which may have consequences that most people would view as negative. A contrary movement has extended the concepts of behavioral dependence and addiction beyond the use of psychoactive chemicals, to encompass behaviors ranging from gambling to eating to sex to surfing the Internet.

For the disease model of substance use disorders the authoritative texts are the *Diagnostic and Statistical Manual of Mental Disorders IV, Text Revision, (DSM)* issued by the American Psychiatric Association; and the World Health Organization *International Statistical Classification of Diseases and Related Health Problems*, 10th Revision (*ICD10*). Neither uses the term "addiction." The *ICD10* focuses on harm to the individual from overuse of psychoactive substances, with difficulty controlling use and continued use in spite of harm defining "Dependence Syndrome." The *DSM* uses a similar definition for "substance dependence." However, its definition of substance abuse does not focus on damage to health, but rather on psychosocial problems such as failure to fulfill role obligations, and legal consequences. In this respect, the moral lens persists.

In the vernacular, "addiction" may refer to any habitual overindulgence, but in neuropsychiatry it refers specifically to alterations in the brain's dopamine signaling system centering on the nucleus acumbens region. This circuit is believed to provide rewards for behaviors associated with evolutionary success, such as sexual intercourse and eating. Addictive drugs increase the level of dopamine in this system, resulting initially in behavioral reward. Chronic overstimulation of dopamine receptors results in needing the drug in order to feel any behavioral reward and overwhelming other motivations. Note that the "reward" for using the drug is not necessarily euphoria or even pleasure, but merely the relief of craving. Additional accommodations by the body to chronic use of an addictive substance may result in various other physical or mental symptoms when the drug is withdrawn, creating an additional short-term challenge to cessation. However, craving may persist long after these acute withdrawal symptoms have ended.

Chemicals that affect this neural circuit include opioids, nicotine, alcohol, amphetamines, and cocaine, although the effects of these compounds are otherwise dissimilar. Hallucinogens are considered drugs of abuse, but are not habituating. Cannabis (marijuana) targets a different class of neuroreceptors and is less habituating than chemicals that target the dopamine pathway.

Epidemiology of Substance Use Disorders

Any estimate of the prevalence of substance use disorders (SUDs) in any given region or population group depends on how these disorders are defined and ascertained. Some studies count any person who reports having used an illicit drug during some prior period – which could range from the past week to the past year; others require respondents to meet criteria regarding frequency, compulsivity, or social harms. Some count alcohol use exceeding some criteria of frequency and quantity, and/or social harms, usually referred to in this context as "problem drinking," or any tobacco use. Others depend on admissions for treatment for acute complications, or for detoxification or cessation services.

Studies generally find that onset of SUDs peaks sharply at around age 20. Acquiring an SUD in later life is unusual. The World Health Organization estimates there are 76.3 million people worldwide with a diagnosable alcohol use disorder. However, it acknowledges that data from various countries are not readily comparable and not always reliable. WHO finds age adjusted per capita alcohol consumption to be highest in Europe, by a large margin; second highest in the Americas; and lowest in the predominantly Muslim eastern Mediterranean region, and in Southeast Asia. (Islam proscribes any use of alcohol, but alcohol may be legally sold in some predominantly Muslim countries.) However, consumption in Europe has been falling in recent decades. The WHO estimates there are more than one billion smokers in the world – about one-third of the population 15 years of age and older. Use of illicit opioids, notably heroin, has principally been a problem in Europe and North America but is increasingly seen in Afghanistan – the primary producing country – and parts of Southeast Asia and southern China. Cocaine is produced in South America and principally consumed in the USA. (Traditional cocaine use in the Andes, where leaves are chewed rather than refined into pure cocaine, causes little harm.) The WHO publishes detailed reports on substance use and dependence in individual countries, but it is difficult to develop summary comparisons from the diverse forms of available data. (For more information about epidemiology and etiology of SUDs among international migrants, see the entries on "Drug Abuse" and "Substance Use" in this Encyclopedia).

Harm from Substance Use and Abuse

Habitual tobacco use is very harmful to health over the long term, dramatically raising the risk of lung cancer and some other cancers, heart disease, stroke, chronic obstructive pulmonary disease, and associated mortality. Tobacco use is considered the leading preventable cause of death in the USA and most of the wealthy countries. However, as tobacco is fully legal and does not produce acute impairment, other social harms associated with tobacco are minimal.

The example of tobacco supports a plausible argument that the harms associated with opioid dependency principally result from legal prohibition. Dependent users can be maintained with doses that do not produce euphoria but eliminate craving, with minimal consequences to health, and lead fully functional lives. However, as nonprescription opioids are very expensive and their sale and possession is subject to severe legal sanctions, habitual users must devote most of their waking hours to obtaining them or the money with which to buy them, often through illegal activity. They commonly self-inject to obtain maximum effect from small amounts, leading to risk of acquiring HIV and Hepatitis C virus from shared equipment, and injection site infections. They cannot count on the concentration or purity of the product they acquire, and may accidentally overdose or inject dangerous contaminants. They are subject to marginal existence, homelessness, and incarceration.

The harm reduction movement argues for a nonpunitive approach to drug dependence which "Accepts, for better and for worse, that licit and illicit drug use is part of our world and chooses to work to minimize its harmful effects rather than simply ignore or condemn them." Preferred harm reduction policies include providing clean needles, teaching safer injection practices, and mandating users who commit nonviolent crimes to treatment rather than jail.

The harm reduction approach is on weaker ground when it comes to amphetamine and cocaine abuse, as these substances have more profound inherent health and behavioral consequences. There is no medically safe maintenance approach to these chemicals. However, the social harm of prohibition extends beyond the users to the economy of illicit drug trafficking. Since drug traffickers obviously cannot call upon the authorities to enforce contracts and honest trading, the illicit drug industry is controlled by criminal organizations that use violence to control territory and settle disputes.

The case of alcohol is quite different. Alcohol used in moderation – typically defined as no more than two ounces of ethanol per day for men – may have health benefits; whereas excessive consumption and dependency have many negative health and social consequences. Prohibition of alcohol in the USA during the 1920s failed to control alcohol use and abuse, but spawned violent crime syndicates. Most now agree that the social harm associated with alcohol is less under a regime of regulated, legal production and sale than it was under prohibition. In some Islamic countries with no cultural tradition of alcohol use, however, prohibition appears to be successful.

In the USA and Western Europe there is increasing support for decriminalization of cannabis (marijuana), which is held to be at worst comparable to alcohol in potential for harm. Cannabis prohibition is very costly in law enforcement, the incarceration of otherwise law abiding people, and the promotion of criminal activity. However, research in recent decades indicates that cannabis use in adolescence may slightly elevate the risk of later diagnosis with schizophrenia. Cannabis is held by many to have potential benefits for palliation of symptoms of many diseases and side effects of chemotherapy for cancer, so the movement in some states has taken the form of legalizing cannabis for medical use only.

Opioid drugs are a double edged sword of another sort. They are indispensable for relief of pain and are widely prescribed in short courses after dental procedures or surgery. Such use rarely produces dependency. People with chronic pain may be prescribed maintenance regimens of opioids, which can be managed at a level which does not impair functioning. However, some people do develop dependency which continues after their prescription is withdrawn, or crave dosages larger than they are prescribed. This can lead to purchasing illicit supplies, or "doctor shopping" to obtain excessive prescriptions. Furthermore, diversion of prescription opioids to the illicit market is a principal means by which people in the USA are initiated into opioid abuse.

Etiology of Dependency

Nicotine may be the most powerfully addictive substance, which quickly produces dependence and craving in almost anyone who starts to use it. For other potentially addictive substances, some people likely have a genetic predisposition to become dependent. However, the social and cultural environment is important in determining whether use becomes abuse or dependence.

People with limited education who struggle in school and have difficulty getting established in the job market are at elevated risk for dependency. Many college students and young professionals have used illicit drugs, but with enticing life prospects or comparatively rewarding jobs, and a motivation to get to work on Monday morning, this use is less likely to end up as dependency.

But the causal story may not be so simple. In the USA, young African Americans and Latinos are no more likely to use illicit drugs than their White, non-Hispanic counterparts. White youth who come into contact with the police due to illegal drug use or underaged drinking are likely to be diverted into counseling, or simply given a lecture and released. However, minority youth are far more likely to encounter a punitive response, including institutional confinement. This is highly counterproductive, damages their school and career prospects, and immediately labels them as outlaws and failures.

The prison population in the USA overwhelmingly consists of people with substance use disorders – some estimates are as high as 80% – with limited education and erratic work histories, and disproportionately African American and Latino, including Latino immigrants. Most are confined for drug related offenses. They may experience limited access to treatment services while incarcerated, limited support for reentry, and face great difficulty finding jobs or housing. A return to a life of drug abuse and petty crime often results.

Substance abuse disorders have a high prevalence of comorbidity with other diagnosed mental disorders. This probably in part reflects attempts at self-medication, and perhaps also the limited career prospects and social marginalization of people with severe mental illness.

As the onset of substance abuse disorders seldom occurs in adulthood, prevention efforts largely target youth. The evidence base for primary prevention is thin. Many programs continue to receive funding despite limited evidence of effectiveness, and even affirmative evidence that they are ineffective. It is difficult to prove the effectiveness of social programs, but a credible school of thought holds that prevention should not focus excessively on substance abuse per se, but rather take a comprehensive approach to young people's social development including addressing school failure, family problems, self-esteem, and mental health.

Initiation into the use of substances that have potential for abuse and dependency requires a cultural milieu that supports use, and availability of the substance. Where the former exists, restricting the latter has proved to be very difficult.

Substance Abuse Treatment

Chemical dependency is a relapsing/remitting disorder. Many people succeed in long term abstinence only after several attempts. In the USA, "detoxification" means a short-term, inpatient course in which acute withdrawal symptoms are managed. Follow-up services are necessary or relapse is almost inevitable. For people with severe alcoholism, opioid or stimulant dependence, the most effective treatment modality may be a 3–6 month residential program, followed by ongoing outpatient counseling. Residential treatment takes people out of the milieu of dependency and provides a highly structured environment which includes intensive counseling.

Outpatient counseling, without preceding residential treatment, may succeed for people with less severe dependency or who have relatively stable lives and a naturally supportive milieu. Many people participate in so-called "12 Step" peer support programs, Alcoholics Anonymous, and others modeled on it. Although these are very widely accepted, there is little scientific evidence to support them, as participants are largely self-selected.

For people with opioid dependence, maintenance using the long-acting opioids methadone and buprenorphine is standard in some US states and parts of western Europe, but is severely restricted or unavailable in most of the world. Nicotine replacement is used for smoking cessation. Antidepressant medication is sometimes used to facilitate smoking cessation, and there are newer drugs specifically for this purpose. They do have side effects, and seem to have limited effectiveness. Naltrexone blocks the euphoric effects of alcohol and opioids, but its usefulness as a cessation aid is limited since people can simply stop taking it.

People who receive treatment are more likely to remain abstinent, or at least to have shorter periods of relapse and longer periods of remittance, than those who do not. However, health insurance generally provides limited benefits for treatment, if any, and access to publicly funded treatment is greatly insufficient to meet the demand in the USA. The availability of treatment programs, and their underlying philosophy, varies widely around the world. For the most part, the approach to addiction is punitive.

Related Topics

- ► Alcohol use disorders
- ► Drug abuse
- ► Drug use

- ▶ Gambling
- ▶ Injection drug use
- ▶ Mental illness
- ▶ Substance use
- ▶ Tobacco
- ▶ Tobacco control
- ▶ Tobacco use

Suggested Readings

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Suggested Resources

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Adherence

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According to Rhodes and colleagues, is the extent to which a therapeutic regimen is correctly taken. Patients with high adherence take their medication as prescribed by their health care providers; patients with low adherence do not take their medication as prescribed by their health care providers. Adherence is particularly low for immigrants given higher rates of poverty, decreased access to health care, and inexperience with and/or mistrust of the US health care system. The lack of bilingual and bicultural service provision and limited provider knowledge of traditional medicine also lead to reduced adherence among immigrants.

Rates of adherence for individual patients are reported as the percentage of prescribed doses taken by the patient as indicated over a specific time period. Calculating this rate requires assessing whether medications were taken on time and according to the prescribed dosage. Poor adherence to therapeutic regimens accounts for worsened health, more rapid disease progression and even death, increased drug resistance, and higher health care costs. Osterberg and Blaschke reported that of all medication-related hospital admissions in the United States, 33–69% are attributable to poor adherence with the resulting cost of $100 billion per year. Rhodes found that for immigrants, adherence rates are much lower given the added layer of barriers to health screening, care, and treatment.

Generally, adherence is typically higher among patients with acute conditions compared to those with chronic conditions. In fact, adherence rates among patients with chronic conditions may drop dangerously low after the first six months of therapy, jeopardizing medication effectiveness and promoting drug resistance due to suboptimal drug levels. There is no standard for what constitutes "adequate adherence." In fact, adequate adherence may differ by medication. For example, most HIV medications require at least 95% adherence in order to ensure effectiveness, while rates between 50% and 80% may promote drug resistance due to ongoing viral replication.

In addition to adherence to therapeutic regimens, such as taking blood pressure medication, adherence to health-promoting and disease-preventing behaviors also can be challenging for individuals. Maintaining an exercise regimen, using condoms consistently, and seeking regular mammography are examples of behaviors to which some individuals are recommended to adhere. Adherence rates can be calculated for these types of behaviors.

The ability of health care providers to measure and assess adherence is limited. Common measures include directly observed therapy (DOT); measurement of the level of medicine or metabolite, or biologic marker in the blood; patient self-report; counting pills or weighing tubes; rates of prescription refills; patient clinical response (e.g., improved health); electronic medication monitors (e.g., medication bottle cap with an embedded microchip to record bottle openings); daily patient diaries; and caregiver report. Combining approaches may maximize measurement accuracy. However, these approaches require an individual to have access to health care services; immigrants often lack access.

Barriers to adherence to therapeutic regimens among immigrants can be categorized into six major domains. These domains include (1) demographics (e.g., low level of educational attainment, homelessness, unstable housing, and decreased income); (2) cognitive and psychological factors (e.g., little knowledge about how to take prescribed medications or lack of confidence in following guidelines such as condom use, depression, doubting the efficacy of evidence-based medicine, seeing initial positive results of taking medications and thinking that adherence is no longer necessary, and asymptomatic disease); (3) behavioral factors (e.g., alcohol and illicit drug use); (4) provider characteristics (e.g., poor provider–patient relationships, perceived and real prejudice and discrimination by providers, and mistrust of providers and health care system); (5) social factors (e.g., lack of social support, isolation, and stigma associated with illness and disease); and (6) treatment factors (e.g., complexity dosing or behavior, timing, cost, side effects, and food requirements).

Interventions designed to overcome these barriers and improve adherence have had mixed results. Interventions to improve adherence among immigrants may include social marketing to reach and educate them about available services for which they are eligible; reducing fears about eligibility, confidentiality, the privacy of medical records, and costs; patient and family education; improved dosing schedules that are simple and supported by cues to action; increased provider hours and shorter wait times; improved transportation to services; and improved communication between providers and patients.

Low adherence to therapeutic regimens is common, and immigrants are at increased risk of low adherence because of the multi-level barriers they often face. Improving adherence can have a profound impact on reducing disease, death, and health care costs.

Related Topics

- ► Access to care
- ► Behavioral health
- ► Chronic disease
- ► Compliance
- ► Functional health

Suggested Readings

Osterberg, L., & Blaschke, T. (2005). Adherence to medication. *The New England Journal of Medicine, 353*(5), 487–497.

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Administration on Aging

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In 1965, the US Congress passed the Older Americans Act (OAA) (PL. 89–73) in response to a lack of community social services for older persons. The legislation established and granted the Administration on Aging authority for administering grants to States for community planning and social services, research and development projects, and personnel training in the field of aging. The Administration on Aging (AoA) serves as the federal focal point on matters concerning older persons and implements the new provisions contained in the Older Americans Act Amendments of 2006. Currently, the AoA is one of the nation's largest home and community care programs for the elderly and their caregivers.

AoA is an Operating Division of the US Department of Health and Human Services (HHS), reporting to the Assistant Secretary and assisting HHS in all matters pertaining to opportunities and challenges for elderly. Nine regional offices located across the USA provide support to the AoA's mission "to develop a comprehensive, coordinated, and cost-effective system of home and community-based services that help elderly individuals maintain their health and independence in their homes and communities."

AoA Activities

- Advocates for and advises on the characteristics, circumstances, and needs of older persons in program planning and policy development within HHS and with other Federal agencies
- Administers grants to States to establish State and community programs for older persons, including grants for older Native Americans, Alaskan Natives, and Native Hawaiians
- Provides policy and procedural direction, advice and assistance to grantees
- Disseminates consumer information and conducts public education activities, especially surrounding disease and disability prevention and emergency preparedness and response for older people

AoA Funded Services

AoA funds six primary services for elders and their caregivers including nutrition, the National Caregiver Support Program, preventive health services, supportive services, protection of elder rights, and services for Native Americans. Selected examples include:

- The *Aging Services Network* serves over seven million people as it promotes the development of a comprehensive and coordinated system of home and community-based services for older people and their family caregivers.
- The *Alzheimer's Disease Supportive Services Program* supports state efforts to expand the availability of community-level supportive services for persons with Alzheimer's.
- The *Lifespan Respite Care Program* coordinates community-based respite care services for family caregivers.
- The *National Long-Term-Care Ombudsman Program* advocates for the health, safety, welfare, and rights of older residents of long-term-care facilities.
- The *Older American Act Nutrition Program* provides meal service and nutrition education to elders in their communities and homes.
- State *Aging and Disability Resource Center Programs* provide streamlined access to health and long-term-care programs for the elderly.
- The *Hispanic Elders Project* supports community efforts to improve the health of Hispanic elders, especially around prevalent chronic diseases such as diabetes, heart disease, and arthritis.

As the federal focal point for older Americans and their caregivers, the AoA plays a vital role in information exchange on aging issues with other countries, and in collaborating with international organizations to enhance aging programs and policies worldwide. AoA actively supports the United Nations' *Madrid International Plan of Action on Ageing*, and has implemented projects in the areas of work and aging, transportation and aging, housing and aging, advancing health and well-being into old age, and volunteerism for and by the elderly. Aging is a global issue that impacts the global economy, labor force, trade migration, international relations, and national security – and AoA has been a leading supporter of international exchanges, conferences, and publications such as the American Association of Retired Persons' (AARP) Global Aging Program. Information provided by the AoA is helpful in determining what services in their communities are available for immigrant elders, who may be particularly vulnerable and need special services or advocacy.

Related Topics

- ► Access to care
- ► Community programs
- ► Dementia
- ► Disability
- ► Medicare
- ► Vulnerable populations

Suggested Readings

Longest, B. (2006). *Health policymaking in the United States*. Washington, DC: Health Administration Press.

Suggested Resources

www.aoa.gov
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An aging world: 2008. www.census.gov/prod/2009pubs/p95-09-1.pdf
www.eldercare.gov/Eldercare.NET
www.familycaregiving101.org

Adolescent Health

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Approximately 14 million children and adolescents in the United States are immigrants or have immigrant parents. The population of children and adolescents in immigrant families grew by almost 50% during the 1990s, almost seven times faster than the population of children with US-born parents. The majority of adolescents in immigrant families are of Hispanic or Asian origin, but a growing population of immigrant adolescents includes recently arrived refugees from Eastern Europe and Africa. Adolescents in immigrant families are more likely than native-born adolescents to be poor, live in crowded houses, to be uninsured, to lack a usual source for health care, and to be in fair or poor health.

In 2007, 34.3% of the US Latino population was comprised of individuals under the age of 18. Latino immigrant adolescent health is often influenced by factors including language/cultural barriers and lack of access to preventive health care and health insurance. Some of the leading causes of illness and death in the Latino community include cancer, heart disease, stroke, and diabetes. Other health conditions that significantly impact Latinos include asthma, chronic obstructive pulmonary disease (COPD), HIV/AIDS, obesity, suicide, and liver disease.

In 2002, 33% of the Black population in the United States was made up of individuals under the age of 18. The Black community is most affected by the following health-related conditions: heart disease, stroke, cancer, asthma, influenza and pneumonia, diabetes, HIV/AIDS, and homicide.

In 2004, 23% of the Asian community was made up of individuals under the age of 18. Asian immigrant adolescents in the United States contend with many factors which may threaten their health. Some factors that influence health care service utilization in this population include infrequent medical visits due to fear of deportation, language/cultural barriers, and lack of health insurance. Asians are most at risk for diabetes, heart disease, cancer, and stroke. The Asian community also has a high prevalence of chronic obstructive pulmonary disease, smoking, tuberculosis, HIV/AIDS, hepatitis B, and liver disease. While there is notable disease among this population, it is also important to note that Asian American women have the highest life expectancy in the United States (85.8 years).

Immigrant Health Paradox

Immigrant adolescents differ on many health-related outcomes as compared to their native-born counterparts. The degree to which this difference occurs often depends on the generational or acculturative status of the immigrant adolescent. Often, first generation, less-acculturated adolescents demonstrate less risk in health-related behavior than more acculturated or US-born adolescents. This phenomenon is called the "immigrant paradox." This phenomenon is progressive, wherein each generation presents more health-risk than the one before. The immigrant paradox has been documented most abundantly in Latino and Asian immigrant populations, but has also been documented in Black immigrant adolescent populations. The disparity in health-related outcomes remains even when differences in family income and parental education are taken into consideration.

One theory that helps to explain this disparity in health-related outcomes in immigrant adolescent populations is the operant theory of acculturation. According to this theory, behaviors in the adolescent's country of origin that were not reinforced, or were punished, will increase in prevalence during acculturation if the same punishers are not present post-migration. For example, in many Asian countries, healthy eating practices are reinforced, but in the United States, less strict dietary practices are the norm. Therefore, as Asian adolescents acculturate to the United States, it would be expected that their diets would become less healthy. This same theory can be applied to all health-related behaviors to explain why certain health-related behaviors become more problematic as adolescents acculturate to the United States.

Obesity, Diet, and Exercise

Adolescent obesity is a primary public health concern and has health, social, and economic consequences for the adolescent. A study examining the impact of immigrant generation and ethnicity on obesity found that 24.2% of White non-Hispanic adolescents were obese as compared to 30.9% of Black adolescents, 30.4% of Hispanic adolescents, and 20.6% of Asian adolescents. Chinese (15.3%) and Filipino (18.5%) adolescents demonstrated significantly lower obesity rates than White non-Hispanic adolescents. Both Asian and Latino male adolescents showed more obesity than their female counterparts. This was not true for the Black community, in which females demonstrated a higher rate of obesity than males. Important differences by immigrant generation were also found, such that Asian American and Hispanic adolescents born in the United States were more than twice as likely to be obese than first generation Asian and Latino adolescents. Additionally, low levels of physical activity, an important determinant of obesity, tend to be high in US-born Latinos when compared to foreign-born Latinos. There are few data on the dietary practices of Latino immigrants, but data do indicate that foreign-born Latinos generally have healthier diets than US-born Latinos. A study examining the impact of acculturation on dietary practices in Mexican Americans found that first generation Mexican Americans consumed more from the four basic food groups than did US-born Mexican Americans.

Another study examining the difference among Whites, Asians, and Latino adolescents on preventive health behaviors (bicycle helmet use, seat belt use, and sunscreen use), physical activity, time spent watching television or playing video games, and nutrition (fruit, vegetable, milk, and soda consumption) demonstrated interesting trends across immigrant generations. First generation Asian adolescents displayed lower participation in prevention health behaviors, less physical activity, and more television viewing and video game playing that White adolescents. This effect diminished across generations. For the same behaviors, first generation Latino adolescents were similar or worse than Whites, but did not show improvement over successive generations. First generation Asian and Latino adolescents did report having healthier diets than Whites, with higher fruit and vegetable consumption and lower soda consumption. Second and third generation Asian adolescents similarly had better dietary practices than Whites. However, for Latino adolescents, fruit and vegetable consumption decreased across generations and soda consumption increased so that by the third generation, Latinos’ nutrition was poorer than Whites’.

Tobacco and Substance Use

Cigarette smoking is the leading cause of morbidity and mortality in the United States. An estimated 20% of the adolescent population in the United States reports smoking cigarettes regularly. Studies routinely demonstrated that African American adolescents are less likely to smoke regularly than White and Latino adolescents. Studies have indicated that White and Latino adolescents are two to four times more likely to smoke than African American adolescents. Furthermore, studies have consistently demonstrated that White high-school students have significantly higher rates of smoking than African American, Latino, and Asian adolescents.

Studies examining the impact of immigrant generation on substance use have found that native-born adolescents often demonstrate higher levels of substance use than immigrants who were not born in the United States. A study looking at alcohol, marijuana, and illicit drug use indicated that use of alcohol and marijuana over the lifetime, in the past year, and in the last 30 days was higher among native-born adolescents than among immigrants who were not born in the United States. Differences in illicit drug use were not found by immigrant generation. Additionally, native-born adolescents are more likely to report recent alcohol and marijuana use and the intention to use these substances in the coming year than were first- and second generation immigrant adolescents.

Sexual Activity

Although sexual risk behavior is seen in persons of all ages, the 13–19 age group demonstrates the fastest growing group of new HIV cases. Overall, 50% of high-school seniors report having sexual intercourse and 20% report having four or more lifetime sexual partners. Of adolescents who reported having sex in a previous 3-month period, only 58% reported using a condom during sexual intercourse. Latinos appear to be at a heightened risk for contracting HIV overall which is concerning given the growing population of Latino adolescents in the United States. The Latino adolescent population is therefore a concentration of research surrounding sexual risk behavior and immigrant health.

Studies examining the impact of immigrant-generational status on sexual activity provide more mixed findings than those of any other health-related domain. Many studies of adolescent immigrant sexual behavior focus on the reproductive health of Latino adolescents as they have the highest fertility rate of any population in the United States. One such study found that Mexican-born adolescents had their first sexual intercourse at a later age than adolescents born in the United States. Foreign-born Mexican adolescents also had fewer lifetime sexual partners than Mexican Americans born in the United States. The same study found no difference by immigrant generation on age of first sexual intercourse.

In a study examining the impact of immigrant status on sexual activity rates, first generation Latinos were found to be more likely to abstain from sex, followed by second generation Latinos, and then by third generation Latinos. The converse was found to be true for unintended pregnancies, wherein less acculturated Latinas has significantly higher rates of unintended pregnancies compared to more acculturated Latinas.

Other studies have attempted to document the impact of immigrant-generational status on Black, Asian, and Hispanic adolescent immigrants. Findings indicate that overall Asian and Hispanic adolescent females had lower sexual intercourse risk than White adolescents. Black adolescent girls had higher rates of sexual intercourse risk than White adolescent girls. Latino adolescent males had a similar level of sexual intercourse risk to White adolescent males, while Black adolescent males had a higher sexual intercourse risk relative to White adolescent males. Asian adolescent males had a considerably lower level of sexual intercourse risk than did White adolescent males. These overall patterns of sexual risk were found to depend on immigrant generation. The decreased sexual intercourse risk among Asian and Latina adolescent females only applied to second generation adolescents. For adolescent males, third generation Latino males were found to have a sexual intercourse risk level about that of White adolescent males. Asian adolescent males had a lower sexual intercourse risk only if they were first or second generation immigrants.

One of the few studies examining sexual risk behavior in European immigrant adolescents found that levels of sexual risk behavior varied by acculturation status in a group of adolescents girls who were recent immigrants from the former Soviet Union. Results indicated that a higher level of acculturation to American culture was associated with increased risk for unplanned pregnancy of HIV infection.

Sexual behavior varies widely by ethnicity and culture, and therefore displays diverse outcomes for immigrant adolescents corresponding to differences in these factors as well as acculturation. Sexual behavior is influenced by differences in cultural norms and expectations as well as by gender. For this reason, more effort is necessary to develop appropriate prevention and intervention strategies corresponding to sexual health practices in immigrant adolescent populations.

Mental Health

Research suggests that first generation immigrants, overall, have lower rates of mental illness than second- and third generation immigrants. This pattern has been replicated in some studies of immigrant adolescents. In one study, Latino adolescent immigrants were found to have a lower prevalence of mental disorders than US-born adolescents. Similarly, Mexican adolescents born in the United States were found to have higher rates of psychological distress and suicidal ideation than Mexican-born adolescents. In examining depression and psychological well-being in adolescent immigrants, one researcher found that first generation immigrants reported less depression and more positive psychological well-being than their third generation counterparts. Second generation immigrants were found to have similar levels of depression and psychological well-being to third generation immigrant adolescents. Many factors were found to be related to first generation adolescents' heightened level of psychological well-being and decreased level of depression in comparison to their more acculturated counterparts. These factors include parental supervision, reduced parent–child conflict, religious practices, and social support.

Refugees, as a smaller subset of the overall immigrant population, are considered to be at particular risk for psychological distress because of the likelihood of exposure to traumatic events prior to immigrating. Studies of refugees in the United States show increased rates of PTSD, depression, and anxiety. Adolescent refugees in particular, because of the other demands of the adolescent developmental period, should receive targeted prevention efforts to ensure the stability of their mental health as they settle in the United States.

Health Care Access and Utilization

Due to policy in many states surrounding health care coverage for immigrants, many immigrant adolescents are uninsured and therefore have poorer access to medical care. Immigrant children and adolescents are less likely to have a usual source of health care, to see a physician, and to receive dental care than are nonimmigrant adolescents. Immigrant adolescents are also more likely to rely on public or nonprofit health clinics and hospitals that offer uncompensated care for uninsured patients.

Like many other health-related domains, health care utilization rates have also been linked to immigrant-generational status. A study of Latino adolescents demonstrated that 39% of first generation adolescents received routine health care compared to 54.9% of third generation adolescents. The difference in rates of routine health care access decreased after insurance status, parental education, and poverty were taken into consideration. In the same study, 16% of first generation adolescent immigrants reported not seeking health care when they thought they should compared to 22.5% of third generation adolescents.

Role of Context

Contextual factors have been examined to attempt to explain the disparities between immigrant ethnic groups and between generations of individuals of the same ethnic group. Of those factors, many appear to be relevant. Stressful working environments and lack of social support may impact the amount of time that parents can spend with their adolescent children. The lack of parental contact and supervision at home, parental monitoring, has been demonstrated to be related to the levels of health risk behaviors seen in immigrant adolescents. Parental monitoring of adolescent activities has been shown to be protective against adolescents engaging in sexual risk behavior. Language barriers between immigrant parents and adolescents may also lead to marginalization and isolation of immigrant parents from their neighbors. This isolation may further complicate parents' efforts to be involved with their adolescent children's lives due to lack of social support.

Interactions between the parent and the immigrant adolescent may also be related to the level and rate of health-risk behavior seen in various immigrant subgroups. Immigrant adolescents are exposed to American culture at school, through their peers, and through society in general. Parents of immigrant adolescents may hold traditional values which may contradict the American behaviors, attitudes, and values that adolescents are exposed to regularly. This phenomenon is known as *differential acculturation*, wherein parents continue to hold on to traditional values while their adolescent children adopt the values and norms of American culture. Normal parent–child conflict during adolescence may be exacerbated for immigrant adolescents and their parents, further decreasing the likelihood that parents will be able to monitor their children to reduce the chance that they engage in health-risk behaviors.

Other Factors

Many factors that may be precursors to future high risk behavior have been found to be elevated in immigrant adolescent populations as compared to native-born adolescents. Adolescents residing in the United States for less than 6 years reported more peer pressure for substance abuse, sexual activity, and violent behavior and delinquency than did their more acculturated adolescent peers. They also reported less parental disapproval of substance use, sexual activity, and violent behavior than their more acculturated counterparts. Less acculturated immigrant adolescents also reported less self-efficacy and confidence in being able to refuse substances that might be offered by friends.

Immigrant Paradox in Canada and Europe

Although a majority of published work examining the immigrant paradox in adolescent health has studied immigrants in the United States, researchers in Canada and Europe are working to document the immigrant paradox in their immigrant populations. The paradox has been documented in immigrants to Canada as well as in immigrants to European nations, but further research needs to be done in order to determine whether patterns are similar to those found in the United States.

Future of Immigrant Adolescent Health

Because of the increasing size of immigrant adolescent populations in the United States and other nations, it is surprising that little research has been done to examine the impact of immigrant generation and acculturation on health-related behaviors in this population. Many differences have been documented corresponding to ethnicity, but few studies have explicitly examined the differences in health-related domains according to time spent in the United States despite the extant literature which states that acculturation does impact health in adolescent immigrant populations. More research is necessary to document the links between acculturation and health-related behaviors in adolescent immigrant populations around the world.

Related Topics

- ▶ Acculturation
- ▶ Epidemiological paradox
- ▶ Obesity
- ▶ Physical activity
- ▶ Refugee youth
- ▶ Tobacco
- ▶ Tobacco control
- ▶ Tobacco use

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Adoption

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Overview

Adoption is an increasingly familiar phenomenon in many countries with declining birth rates. The 2000 Census estimated that there were over two million adopted children living in the USA, including step-parent, child welfare, private and international adoptees. Since 1990, Americans have adopted roughly 280,000 children from overseas. Although the background of domestically and internationally adopted children may vary greatly, the growing body of literature suggests that children in these two groups have many common characteristics and needs.

Before 1990, children typically came from Korea, India, the Philippines, and Latin America. Since 1990, children have been primarily adopted from China, Korea, Russia, and Guatemala. International adoption is fueled by a variety of social, economic, political, and cultural pressures. Many children originate from countries in transition. As these countries regain equilibrium, they may strengthen child welfare systems, moving from permitting large numbers of children to be adopted internationally to increasing domestic foster care/adoption programs. Government policies limiting family size, cultural values favoring male children, poverty, and natural or manmade disasters may also lead to more intercountry adoptions. The Hague Convention on International Adoption is an international agreement to safeguard and provide standards of practice in intercountry adoptions.

Effects of Deprivation and Neglect Early in Life on Children

Deprivation and neglect early in life delays emotional, social, sensory, and physical development, leading to learning problems, deficits in intellectual function, and various behavior problems. The likelihood that emotional and behavioral problems will persist is directly correlated with length of institutionalization. Similar findings have been described in children within the US child welfare system. Adopted children are at increased risk for psychological and learning disabilities making them eligible for special education services.

Studies show that children's functioning in these domains is positively affected by their adoptive families. Recovery depends heavily on family environment and parents' willingness to devote a significant amount of time to their children. In addition, the quality of resiliency – the ability to recover from adverse experiences – has also been shown to depend partly on genetic factors. It is critical that adoption professionals and mental health practitioners characterize the early history of the adoptee, recognize the potential impact of their experiences, as well as provide appropriate support and resources.

Health and Medical Care

The quality of care received by children prior to adoption varies. Many international adoptees have lived in crowded and resource-poor institutional settings with limited access to medical care. Malnutrition, infectious diseases (i.e., hepatitis, tuberculosis, syphilis, parasites, skin infections), and psychosocial deprivation are often noted. Children in the US child welfare system may also experience undiagnosed illnesses and delays in treatment of chronic conditions due to lapses in medical care. In addition, hearing, vision, and dental problems as well as birth defects are common. Adoption specialty clinics can provide enhanced care for children who have been adopted, and specific practice guidelines are in place to address the many needs of children who are adopted or are in foster care.

Development

During the first half of gestation through the first 3 years of life, brain development occurs that is crucial to focusing attention and inhibition – skills important for planning, problem solving, and sound critical judgment. Adoptees are at risk for exposure to many hazards to early brain development including malnutrition, lead poisoning, hypothyroidism, infectious diseases, and prenatal alcohol and drug exposure. They are also at increased risk of severe abuse and deprivation, which have been linked to poor brain development and decreased cognitive function.

Research suggests that modifications in the quality of care may dramatically improve developmental outcomes. Removal from a deprived and/or neglectful setting has a positive effect on gross and fine motor skills, as well as social and cognitive development. Factors that modify developmental outcomes include the length of deprivation and/or institutionalization, and quality of the pre- and post-adoptive environments.

Attachment and Psychosocial Functioning

Adverse pre-adoptive experiences have a direct impact on the psychosocial development of children.

Challenges in the attachment process and formation of healthy relationships are associated with a higher risk of later behavior problems. Conversely, sensitive responsiveness (the ability to observe and respond to a baby's signals adequately, appropriately, and promptly) is one of the key determinants of a secure attachment relationship. Adopted children who are more securely attached to their parents have been shown to attain better social and cognitive outcomes.

Supporting Adoptive Families

Adoption is a lifelong process. Families adopting internationally and domestically benefit from enhanced pre-adoption preparation, post-adoption supports, and access to professionals aware of the unique needs of these children. To optimize long-term outcomes, families should be prepared for possible challenges and have realistic expectations. While many complicated issues exist, adoption offers a tremendous number of rewards. Most adoptions are successful, most children recover, and the quality of children's lives improve dramatically as a result of gaining a family.

Related Topics

► Access to care
► Adolescent health
► Alcohol use disorders
► Behavioral health
► Birth defects
► Child
► Child abuse
► Child development
► Cognitive testing
► Culture-specific diagnoses
► English as a Second Language
► Ethnic identity
► Family
► Health care
► Immigration in the global context
► Immigration processes and health in the U.S.: A brief history
► Immunization
► Infectious diseases
► International adoption
► Medical examination (for immigration)
► Nutrition
► Pediatrics
► Resilience
► Screening
► Tuberculosis
► Vulnerable populations

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Suggested Resources

American Academy of Pediatrics Children's Health Topics: Adoption. http://www.aap.org/healthtopics/adoption.cfm. Accessed January 15, 2011.

Intercountry Adoption: Office of Children's Issues, US Department of State. http://www.adoption.state.gov/. Accessed January 14, 2011.

Affidavit of Support

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The affidavit of support is provided primarily as part of the permanent resident application process, although occasionally it is used in the nonimmigrant visa context. Its purpose is to overcome the "public charge" exclusion ground contained in Immigration and Nationality Act § 212(a)(4). All temporary visitors and intending immigrants must show that they are not likely to become a public charge while in the United States.

An individual can be considered to be a public charge if he/she relies solely on government-provided benefits in order to live. Individuals can be considered to be public charges if they are institutionalized for a mental or physical health reason and the costs are fully borne by the federal government. Individuals who receive emergency health care, food stamps, unemployment benefits, or medical benefits to pay for prenatal care and the birth of a child do not fall under the public charge provisions.

Prior to 2002, the affidavit of support was an unenforceable promise by an individual to support a foreign visitor or potential immigrant. Form I-134 was completed by any individual who was physically present within the United States who had assets, including a regular salary that could be used to support the foreign visitor or potential immigrant. There was no requirement that the individual be a United States citizen or lawful permanent resident or that the individual provide extensive proof of the asset claimed. In addition, intending immigrants could use their own assets to overcome the public charge provisions. There was no minimum income or asset requirement; in effect, the I-134 was a persuasive, rather than a probative document.

This situation changed with the Family Sponsor Immigration Act of 2002, Act of Mar 13, 2002, Pub. L. No. 107–150, 116 Stat. 74 (2002 Act). The 2002 Act changed the affidavit form and made its use mandatory in many situations. Individuals petitioning for family members are now required to use the new form I-864 even if they are not working and have no assets. In addition, companies whose owners are relatives of an intending immigrant sponsored by the company must also complete an I-864. The new I-864 is intended to be a legally enforceable contract between the individual completing the I-864 (the sponsor) and the United States government. In theory, if a beneficiary of the I-864 uses public benefits, the federal government can request reimbursement from the sponsor. To date, the federal government has not attempted to recover monies spent on beneficiaries from the sponsor. However, some divorce courts are using the existence of an I-864 as evidence to support spousal support determinations.

The I-864 now requires that the sponsor be a United States citizen or lawful permanent resident. The sponsor must be resident in the United States and generally must earn above 125% of the federal poverty guidelines for the household size plus the immigrants to be sponsored (Individuals who are on active duty military service must meet 100% of the poverty guidelines.). For example, a married United States citizen with two children has a household size of four. If she is sponsoring the immigration of a brother who is married and has two children, the sponsor must earn above 125% of the poverty guidelines for a family of eight. Other immigrants sponsored are also counted as part of the household unless the affidavit of support obligation ends. Proof of income and assets must be provided. Individuals are limited to the income reported to the IRS on their federal income tax.

The obligations of the sponsor continue until (1) the sponsor or the beneficiary dies, (2) the beneficiary becomes a United States citizen, (3) the beneficiary formally abandons his/her residence in the United States, or (4) the beneficiary can be credited with 40 quarters of work under Social Security Act. Note that divorce does not end the I-864 obligation, nor does a child reaching adulthood.

If an individual who is required to complete an I-864 does not have the income or assets to satisfy the poverty guideline requirements, a cosponsor willing to accept the I-864 obligations can be used. The cosponsor must meet all requirements independently of the sponsor; the income cannot be commingled.

A sponsor who does not have sufficient income can use the value of an asset to augment the income. Generally, the value of the asset must equal five times the amount lacking. For example, if a sponsor's income as reported to the IRS is $5,000 below the required amount, but the sponsor has a savings account that regularly has $25,000 in it, then the sponsor can use that asset and no cosponsor is required. Assets overseas can be used as long as the government officer reviewing the I-864 is satisfied that the asset could be converted to cash within a reasonable amount of time.

Individuals residing overseas generally cannot complete the I-864. Sponsors must be subject to the jurisdiction of United States courts. The Department of State has allowed an exception for individuals who intend to reside in the United States as soon as the sponsored immigrant receives an immigrant visa. However, evidence of an intent to reside in the United States immediately is required and rigorously enforced.

The I-864 is not required where a child will immediately receive United States citizenship under the Child Citizenship Act of 2000, where an individual is immigrating under the Violence Against Women Act, where the individual can be credited with 40 quarters of work or for certain widows/widowers of United States citizens. Such individuals file the I-864W.

The I-134 affidavit continues to exist and be used. Individuals immigrating through employment use it to show that their accompanying family members will not become a public charge. In addition, individuals wishing to show that a potential visitor will not be a public charge can still use the I-134.

Related Topics

- ► Immigrant visa status
- ► Poverty

Suggested Resources

United States Citizenship and Immigration Services. http://www.uscis.gov

Africa

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Africa and Immigrant Health

Africa is both the second largest and second most populated continent in the world. Recent 2009 figures indicate that the population of the continent has surpassed one billion. Africa is comprised of 54 countries and over 1,000 spoken languages. It is rich in culture and natural resources. However, it remains one of the poorest continents in the world. This poverty is driven in part by ineffective government; despotism (dictatorship or tyranny); frequent military, tribal, political, and religious conflicts and war; as well as natural disasters. Such conditions are inextricably linked to outcomes such as malnutrition, inadequate water supply and sanitation, high prevalence rates of human immunodeficiency virus and acquired immune deficiency syndrome (HIV/AIDS), and infectious and parasitic diseases. These outcomes, in turn, negatively impact health and strain already weak health care systems. The combination of rich culture, abundant natural resources, and high levels of poverty and disease has resulted in both immigration to Africa and emigration from Africa.

Immigration to Africa

Individuals may choose to immigrate to Africa for a variety of reasons. Some may come seeking opportunities for missionary work in impoverished regions, while others come to study disease or conduct other scientific research. Individuals may also choose to immigrate to Africa as a result of job relocation to resource-rich regions such as Nigeria, Ghana, the Ivory Coast, and South Africa, where foreign companies may build affiliate offices. Others may simply immigrate for the sake of the cultural experience. Regardless of the reasons behind relocation to Africa, immigrants to the region will have to deal with many of the same health concerns.

Environmental health issues such as industrial waste, air pollution (indoor and outdoor), and unsafe and insufficient water supplies are issues of immediate concern. In addition, inadequate sanitation (i.e., waste removal and hygiene practices) is directly linked to poor food preparation hygiene and subsequent food and water borne illnesses such as cholera, typhoid, diarrhea, and increased exposure to disease-causing parasites. Diarrhea remains one of the leading causes of death in Africa. Less than half of Sub-Saharan Africa has access to adequate sanitation facilities and roughly half of the region has access to a safe water supply.

Further, food safety issues continue to be a health concern in various rural and urban regions of Africa. Unsafe water, poor food handling, poor refrigeration, and food storage jeopardize food safety. Likewise, failure to disinfect surfaces and utensils that come into contact with animal blood and waste, and the exposure of food to insects (known vectors of disease) jeopardize food safety. This is particularly an issue in areas where street food vendors are popular sources of meals and snacks. Poor handling and preparation of food leads to the spread of Salmonella, *Escherichia coli*, and Hepatitis A virus.

Immigrants to Africa are also at risk for infectious diseases common to the region. HIV/AIDS, tuberculosis, and malaria remain leading causes of death in Africa. According to various reports of the World Health Organization, Africa accounts for an overwhelmingly large portion of the disease burden for HIV/AIDS and malaria. Commercial sex (e.g., sex workers), lack of education, and unsafe practices have helped to accelerate the spread of HIV/AIDS. Examples of unsafe practices include: unprotected sex; sharing knives, razors, or similar implements for traditional ceremonies (i.e., cutting of tribal marks on the face and body, body piercings); and genital mutilation. Immigrants to the region are at risk, should they choose to engage in risky sexual behavior, or come into direct contact with blood, in a region that is known to have one of the highest numbers of HIV/AIDS cases in the world.

Many individuals affected by HIV/AIDS are also coinfected with tuberculosis as a result of weakened immune systems. A shortage of health care workers, underdiagnosis of the disease, unavailability of medication, and poor adherence to treatment regimens continue to serve as obstacles to the management and treatment of tuberculosis. The hot and humid climate of Africa coupled with its geography also help to spread various infectious diseases, including mosquito-borne illnesses such as malaria. An abundance of standing water and drug-resistant malaria parasites, in addition to the use of counterfeit malaria drugs, makes it difficult to reduce the burden of this disease in African nations.

Immigration to Africa has both its risks and benefits. It is important that immigrants to the region are aware of the potential health risks involved with relocation and take necessary measures to minimize such risks, where possible.

Emigration from Africa

The unfavorable conditions found in many regions of Africa have resulted in both voluntary and involuntary emigration from the continent. A large number of voluntary African emigrants are highly skilled workers such as doctors, professors, engineers, and scientists who are seeking higher pay and better working and living conditions for themselves and their families. This departure of highly skilled Africans is often referred to as the “brain drain.” Others leave Africa in pursuit of higher education, reunification with family members, or access to better medical care. Involuntary emigrants such as refugees and asylum seekers leave Africa to escape war, religious persecution, and genocide. Most African emigrants relocate to North American regions (i.e., the United States and Canada) and other developed regions of the world such as Europe (e.g., United Kingdom) and Australia.

African immigrants are a rapidly growing segment of both the immigrant and total Black populations residing in the United States and other developed countries. Most African immigrants come from the Sub-Saharan region of Africa (the region that lies south of the Sahara Desert in the continent of Africa). Historically, immigrants from the Sub-Saharan region have been from West African (i.e., Nigeria and Ghana) and East African (i.e., Ethiopia and Somalia) nations.

Upon relocation to host countries, these immigrants undergo many environmental, lifestyle, and cultural changes; some changes may be positive (e.g., better educational opportunities) while others may be negative (i.e., poor diet or sedentary lifestyle). This process of acculturation can be overwhelming and has the potential to produce negative health outcomes. The stress associated with acculturation is known as acculturative stress. Many immigrants live below the poverty level and are forced to deal with poor living conditions and malnutrition as they struggle to adjust to the culture of their host country. Such factors may compromise their health and safety. Chronic diseases (i.e., diabetes, hypertension, and cancer) are increasing among immigrants.

The increased prevalence of chronic diseases may be partially attributed to the nutritional transition experienced by African immigrants. The drastic change from undernutrition in Africa to an abundance of processed foods, and foods rich in animal fats and sugars in the host countries, may place immigrants at increased risk for diet-related chronic diseases. Further, the low cost and accessibility of fast foods may be especially appealing for immigrants who are living below poverty level.

Untreated infectious and parasitic diseases also continue to pose a problem for immigrants in their host country. The stigma associated with diseases such as HIV/AIDS and/or the lack of experience of health care workers in treating diseases specific to tropical regions such as Africa may hinder proper treatment and management of disease.

Recent African immigrants are less likely to be from English-speaking African countries such as Ghana, Nigeria, and South Africa. Immigrants who are not proficient in the language of their host country face difficulties in accessing health care resources and communicating effectively with health care providers. This problem is further compounded by a lack of culturally competent health care providers and culturally relevant health screening and intervention information for African immigrants.

For example, immigrants may have different cultural beliefs and meanings regarding the causes and treatment of disease and/or may prefer traditional medicine and healing practices (i.e., herbal medicine, native doctors, or special diets), which may not be recognized by health care providers in the host country. In addition, cultural issues related to gender may affect how immigrants interact with health care providers. This is illustrated by situations in which female African immigrants may prefer to be seen only by female health care providers or may not feel comfortable discussing certain symptoms or health issues due to cultural inhibitions.

Further, immigrants may delay coming forward to receive care as a result of language or cultural barriers and possibly fear of deportation. This, in turn, may limit the availability of treatment options if their medical condition is at an advanced stage. Additionally, African immigrants may have difficulty providing necessary medical history to health care workers as a result of language or cultural barriers. For example, diseases may be known by different names or descriptions in an immigrant's host country versus their native country in Africa. In addition, it may be virtually impossible for health care workers to acquire disease history and treatment or family history of disease from African immigrants, simply because such information is not recorded in the immigrant's native country.

Over time, the acculturative stress and the lack of sufficient resources may result in social isolation, depression, and poor lifestyle choices among African immigrants. Refugees and asylum seekers are particularly at risk for negative health outcomes as a result of the psychological stress of involuntary displacement from their native country and the process of acculturation.

Elderly immigrants also represent a vulnerable subpopulation of African immigrants at risk for negative health outcomes. Elderly immigrants may have more difficulty with the acculturation process than younger immigrants for a variety of reasons. First, they have been exposed to their native culture and values for a longer period of time than younger immigrants and therefore may be much slower to adopt the culture and values of another country. Second, age-related physiological changes (i.e., cognitive decline, decreased memory, and limited mobility) may simply prevent them from moving through the process of acculturation at a more rapid pace. Third, they are less likely to be proficient in the language of their host country and may not be willing or able to master a new language. Collectively, these factors may increase the health care barriers they face in their host country.

Relocating to another country does not necessarily mean that African immigrants will invariably face deterioration in their health. African immigrants may be afforded opportunities that were not available to them in their native country. For example, they may have better access to health education and preventive services (i.e., mammograms and prostate cancer screening), which can positively affect health. Likewise, they may have better access to health care and medication, which can result in better treatment and management of disease. Some countries that have socialized medicine or universal health care systems extend health care benefits to immigrants regardless of whether they are legal or permanent residents.

In addition, access to higher paying jobs and better educational opportunities can positively impact health, both directly and indirectly. Increased wages can help immigrants purchase healthy foods and afford living conditions that are better than what was available to them in their native country. Nutrition and living environment both affect health. Higher wages and better education can also enable immigrants to support family members and friends back home in their native country. This in turn can help foster positive mental health outcomes among immigrants who did not have the means necessary to support family members and friends in their native country.

Related Topics

- ▶ Acculturation
- ▶ Acculturative stress
- ▶ Acquired immune deficiency syndrome
- ▶ Asylum
- ▶ Brain drain
- ▶ Cultural competence
- ▶ Emigration
- ▶ Environmental health
- ▶ Explanatory model of illness
- ▶ Food insecurity
- ▶ Health barriers
- ▶ Health beliefs
- ▶ Human immunodeficiency virus
- ▶ Infectious diseases
- ▶ Intestinal parasites
- ▶ Language barriers
- ▶ Malaria
- ▶ Poverty
- ▶ Refugee health and screening
- ▶ Sanitation
- ▶ Tuberculosis
- ▶ Water

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AIDS

▶ Acquired immune deficiency syndrome

AIDS Knowledge

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Acquired immune deficiency syndrome, or AIDS, is the deadly late stage of infection by human immunodeficiency virus (HIV) infection, when a person's immune system is severely damaged and has difficulty in fighting diseases and certain cancers. There is no cure for HIV disease, despite major advances in diagnosis and treatment. HIV is a preventable disease, and widespread understanding of transmission routes, associated high-risk behaviors, and how to protect oneself from contracting the virus is critical to control the spread of HIV/AIDS. Lower levels of HIV/AIDS knowledge are associated with a lower likelihood of safer sex or injection practices. Additionally, individuals who are unaware they are infected with HIV are 3.5 times more likely to transmit the virus to others than those who know about their infection; alarmingly, the proportion of people living with HIV who are estimated to be unaware of their status ranges from over 80% in

Kenya and Burundi to 67% in China to 21% in the USA. Additional information on AIDS, HIV transmission, testing, care and treatment, and the impact of the worldwide HIV/AIDS epidemic can be found in the entries for "Acquired immune deficiency syndrome" and "Human immunodeficiency virus" in this encyclopedia.

The spread of the worldwide HIV/AIDS epidemic has been facilitated in part by internal and international migration in terms of migrants bringing HIV into a host area or country, migrants at greater risk for acquiring HIV and transmitting the virus within the host country or to their home areas or countries upon return, and migrants often being medically underserved with limited access to services and information. As a mechanism for HIV prevention, HIV/AIDS knowledge among migrant and immigrant populations is of particular concern in this regard. Population movement, culture, language, geography, limited education, psychosocial factors, isolation, separation from families, discrimination, and poverty present significant barriers for these groups to accessing HIV/AIDS knowledge. Immigrant status, national origin, conflict situations, family connectedness, provider trust, and various demographic and social characteristics have also been found to be important factors related to HIV/AIDS knowledge.

Knowledge is an important first step to acquiring skills necessary for behavior change to ensure HIV prevention measures. In addition to perception, individuals must be committed to change and taking action. The fact remains that some individuals with high levels of HIV/AIDS knowledge often fail to follow safer sex or injection practices. Several studies among immigrants throughout the world, some of which are highlighted here, have been conducted to gain a better understanding of the level of knowledge of HIV/AIDS and how to tailor education programs to the specific needs of immigrant and migrant populations.

Immigrants from 20 African nations in Houston, Texas reported a high level of HIV/AIDS knowledge, but lower levels of safer sex behaviors and lower levels of perception of risk. Similarly, young migrants with HIV/AIDS in Denmark revealed a high level of understanding of the true ways of HIV transmission, but had knowledge gaps in false ways of transmission and safer sex practices. Another study of Somali and Sudanese immigrants in Denmark indicated low levels of HIV/AIDS knowledge, highlighting the need for targeted, culturally sensitive HIV/AIDS information and counseling. HIV-positive sub-Saharan African refugees in Canada indicated that family separation, continued exposure by family members to violence and fear, financial uncertainty, social isolation due to stigma, and poor nutrition interfered with their ability to engage in health-promoting behaviors. A study of immigrants in Germany concluded that HIV/AIDS educational messages are not reaching immigrants as effectively as German citizens. Within Thailand, 86% of immigrants from Cambodia and Myanmar had become fairly knowledgeable about HIV risk factors. Even so, gaps in knowledge remained for women, persons with less than five years of education, seafarers, and agricultural workers.

Research conducted with South Asian immigrants in the USA indicated a medium level of HIV/AIDS knowledge with some serious gaps, particularly for older immigrants. Both cultural and structural barriers were identified to accessing information. The former included denial, stigma, and patriarchy; the latter encompassed high health care costs, lack of insurance, mistrust of government, and fear that information sharing will negatively impact immigration-related issues. Immigrants of Latino origin, including migrant farmworkers and injection drug users, tend to have misconceptions and a lower level of knowledge of HIV/AIDS than other ethnic groups, frequently associated with low educational attainment and limited bilingual (English/Spanish) language exposure or understanding.

Gender may also play a significant role. Female Mexican, Cambodian, and Myanmar migrants appear to be far less knowledgeable than their male counterparts. Among women in the USA who recently emigrated from Jamaica, most were knowledgeable about HIV/AIDS but religious beliefs and cultural practices created barriers to safer sex behaviors. Many could not be certain their husband or partner was monogamous, yet discussion of sexual issues was considered taboo and the cultural gender imbalance often left women powerless to negotiate condom use or to refuse sex without a condom.

To effectively target information and education programs, public health services must not only know which populations are at risk, but also the gaps in knowledge and barriers to practicing HIV prevention measures for each risk group. Countries must ground their strategies in an understanding of the substantial diversity, inclusive of immigrant and migrant populations, that makes up their local HIV/AIDS epidemics, tailoring and disseminating culturally, linguistically, and educationally appropriate information and other interventions.

Related Topics

- ▶ Acquired immune deficiency syndrome
- ▶ Barriers to care
- ▶ Human immunodeficiency virus
- ▶ Injection drug use
- ▶ Language barriers
- ▶ Stigma

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Air Pollution

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Introduction

Air pollution is produced when chemicals, particulate matter, or gasses are introduced into the air and cause harm or discomfort to humans or other living organisms. The components of air pollution can be divided into primary and secondary pollutants. Primary pollutants are those that are released directly into the air by a process such as combustion. Main primary pollutants include carbon monoxide (CO), nitric oxide (NO) and nitrogen dioxide (NO_2) (jointly they are NO_x), sulfur oxides (SO_x), particulate matter (PM), volatile organic hydrocarbons (VOCs), and metals (such as lead). Secondary pollutants are created by the interaction of primary pollutants through chemical processes or agglomeration. An important secondary pollutant is ground level ozone, which is formed from NO_x and VOCs in the presence of sunlight. Some pollutants, such as NO_2, are both primary and secondary pollutants.

Although there are natural sources of outdoor (ambient) air pollution such as volcanic eruptions and wildfires, the most significant contributions come from human activity. Main sources of air pollution are manufacturing; the burning of fossil fuels for energy production, like coal-burning power plants; gasoline and diesel fuel combustion for vehicles; and methane production from cattle farms and landfills. It is estimated that the majority of ambient air pollution (52%) comes from industry, 27% from transportation, 10% from agriculture, 8% from consumer and commercial products, 1% from commercial and residential heating, and 2% from other sources. Air pollution can also be present indoors. Indoor air pollution is characterized by the presence of particulate matter from cleaning and cooking activities; NO_2 from gas stoves; off-gassing of chemicals from furniture and carpets; CO from wood burning; particulates and chemicals from cigarettes; and biological contaminants such as pet dander, cockroach allergen, and mold spores.

Distribution of Air Pollution

Ambient air pollution is present worldwide, and there is variation in pollutant levels by country, region, and city. Developing nations, including many countries in Asia and sub-Saharan Africa, shoulder a higher proportion of air pollution over industrialized countries. High pollution levels are a product of the complex interconnected processes governed by both economic and political development.

Within countries, there is significant variation in air pollution on a regional scale with urban areas carrying the highest burden of pollutant levels. In the USA, air pollution is higher in the Northeast and Midwest as compared to the South and West, with the exception of California, which has high levels. The regional gradient in pollution level is a function of industrial sources, population density, and meteorological conditions. Predominant westerly winds transport air pollution from industry in the Midwest eastward. Although transport plays a significant role in ambient air pollution, the main source of air pollution in the Northeast and other urban areas is vehicle exhaust. This source is also referred to as mobile emissions, which vary significantly on a local scale based on the location of roadways and public transit. Levels of most primary air pollutants, such as PM, NO, NO_2, and VOCs are higher close to major roadways of highways. However, a small number of secondary pollutants, such as ozone, are lower near highways due to the processes necessary for their development.

Similarly there is a range of indoor air pollution levels that are a function of ambient air pollution, housing type, building condition, behavior (such as secondhand smoke) and the time of year. In developing nations, a significant contributor to indoor air pollution is biomass fuel burning, such as wood, coal, and animal dung. The boundary between the indoor and ambient environments may also be a factor in levels of indoor air pollution. In many developing countries, the design of residential compounds and homes may result in fluid interchange between ambient and indoor air, especially in warm climates. In other countries, such as the USA, the boundary is more defined and the indoor and ambient environments are usually well separated.

Demographic factors regularly govern the distribution and magnitude of air pollution often due to socioeconomic status (a measure of an individual or household's social position based on income, occupation, and education) and race/ethnicity. The siting of polluting facilities has been the subject of environmental justice struggles for almost 30 years in the USA. Research has documented that poor communities and minority neighborhoods have a higher proportion of noxious facilities such as power plants, diesel bus depots, and hazardous waste facilities than higher income or White communities. Many communities comprised of a high proportion of new immigrants fall into one of these categories resulting in similar exposures.

Health Outcomes of Air Pollution Exposure

Exposure to air pollution has been linked to increases in death and illness and is supported by research in the USA, Europe, and other locations across the globe. A study on the global burden of disease estimates that 2.4 million people worldwide die each year from air pollution, a majority of those, 1.6 million, from indoor air pollution. In addition to increased mortality, air pollution has been linked to asthma symptoms, lung cancer, chronic obstructive pulmonary disease, deep vein thrombosis, cardiovascular disease, and an increase in infectious disease in children. The route of exposure to air pollution is the lungs, which explains some of the associations with respiratory illness. However, the majority of deaths from air pollution exposure are due to cardiovascular disease. Increases in air pollution have also been linked to decreases in quality of life.

There are certain subpopulations that are more sensitive to the effects of air pollution than the general population. One of these subpopulations is children because they are generally more active than adults, have higher ventilation rates, and spend more time outdoors. In addition, children's lungs are growing and developing thereby increasing vulnerability to insults from environmental contaminants. The elderly comprise another sensitive subpopulation due in part to the prevalence of comorbidities, which may modify the relationship and possibly heighten the deleterious effects of air pollution. Also, advanced age reduces the ability to repair damage caused by air pollutants.

A third and fourth sensitive subpopulation are low SES communities and racial/ethnic minority groups, many of them immigrants. These groups may be more vulnerable to air pollution due to socially patterned physical conditions such as exposure to multiple environmental contaminants from their residential environment or occupation, inadequate access to health care or poor nutrition. The presence of air pollution may act as a modifying factor increasing the susceptibility for or severity of illnesses with other causes. Or an existing illness may increase the adverse impact of air pollution on the body.

Regulations/Guidelines

Many nations have created laws to control the amount of air pollution emitted in their countries. In the USA, air pollution standards are set by the United States Environmental Protection Agency (USEPA) as well as state and city agencies. The USEPA was established after the enactment of the Clean Air Act (CAA) in 1963 and enforces the National Ambient Air Quality Standards (NAAQS) for criteria air pollutants. The CAA has been amended several times, most recently in 1990. Regulations are focused on controlling emission sources, usually point sources, such as power plants in order to meet NAAQS. The United Kingdom and Canada have also established Clean Air Acts in 1956 and 1970, respectively. The World Health Organization (WHO) has established Air Quality Guidelines (AQG) to help guide countries in reduction of adverse health outcomes of air pollution. The 2005 update of the AQG is designed to assist developing nations with high levels of air pollution by including a tiered set of target concentrations for contaminants, or indicators that are relatively easy to measure and linked to health outcomes.

Related Topics

- ► Asthma
- ► Cardiovascular disease
- ► Environmental health
- ► Environmental justice
- ► Global health

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Alcohol Abuse

► Alcohol use disorders

Alcohol Use Disorders

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An estimated 13% of the US adult population was born outside the United States. As they adapt to life in the United States, they may be differentially exposed to substance use norms and social challenges (i.e., language barriers, unfamiliar customs, and discrimination). One of the consequences of adapting to new circumstances may be an increased rate of substance use. Even among those from the same general regions of the world, there is a significant heterogeneity of immigrant populations which highlights the need to study the factors that may contribute to differential substance use rates. A more comprehensive understanding of the variability among racial/ethnic groups will contribute to the identification of at-risk populations that can be targeted for prevention/early intervention programs.

Conceptual Models for Alcohol Use Problems Among Immigrants and Refugees

Several different models have been developed to explain the use of alcohol and other substances by immigrants and refugees. The *acculturative stress model* states that alcohol and other drug use are resultant reactions to the immigration experience itself because of the stress from cultural conflict, and the lack of social and economic resources for coping.

The *assimilation model* states that, as newcomers adopt the customs of the host country, their patterns of alcohol and other drug use begin to reflect those of their new location. However, it is also possible that immigrants *continue the country-of-origin alcohol use patterns*. A fourth model, known as the *intracultural diversity model*, emphasizes the diversity of alcohol and other drug use patterns that exist within different immigrant and refugee groups. This model recognizes that differences in alcohol consumption exist among individuals within a specific group. It is incorrect to think of a specific drinking pattern as typifying all members of a particular group, and necessary to recognize heterogeneity.

The National Surveys on Drug Use and Health (NSDUH) have been conducted in the United States every year since 1971. Data from the 1999, 2000, and 2001 surveys represent the first nationally representative estimates of substance use among adult immigrants to the United States. Immigrants are defined in this report as US residents born outside the United States.

The rates of alcohol use were lower among immigrants than among US-born adults. This includes past year use (54.3% vs. 67.8%), past month use (39.5% vs. 52.4%), past month binge use (16.9% vs. 22.3%), past month heavy use (3.0% vs. 6.5%), and the average number of drinks per week among current drinkers (6.3 vs. 8.3). Among all foreign-born persons, men had higher rates of use across all alcohol measures than women, and younger age groups (18–49) had higher rates of use than older individuals (50 or older).

Among adult immigrants who were current drinkers, current weekly alcohol consumption was associated with per capita alcohol consumption in the individual's country of birth. Additionally, rates of substance use were associated with the length of time immigrants had been in the United States. Immigrants who had been in the United States for 5 or more years were more likely than immigrants who had been in the United States for fewer than 5 years to use alcohol in the past year or past month and to binge drink.

Estimates of substance use among immigrants from 16 selected countries revealed wide variation across these immigrant subgroups. These differences point out that comparisons based on broad regional groupings of immigrants, such as Latin Americans or Asians, can mask important within-region differences.

It has been hypothesized that among immigrants who were current drinkers, a portion of the variability in alcohol consumption was due to drinking patterns in one's home country. A linear regression model used the following variables as predictors: country-of-origin consumption, gender, age, total family income, marital status, education, and length of time in the United States. Results indicated that drinking in the country of origin was a significant predictor of past month weekly alcohol consumption, as were marital status (unmarried), education (completed less than high school), and sex (male). This model predicts a rise of approximately 4% in the current consumption rate for every liter increase in the country of origin per capita drinking rate.

Per capita alcohol consumption was organized into countries that had rates similar to, higher than, or lower than US rates. Immigrants from countries with per capita rates that were similar to or lower than US rates had significantly lower past month weekly alcohol consumption than US-born persons, 5.7 and 5.9 drinks per week, respectively, when compared with the US-born population (8.4 drinks per week). Past month weekly alcohol consumption was higher for individuals from countries with a higher per capita consumption rate than the US rate, but consumption was still lower than among individuals born in the United States (7.0 vs. 8.4 drinks per week).

Alcohol use patterns were examined among selected Latin American countries with the largest immigrant samples. Immigrants from Mexico, Puerto

Rico, Cuba, El Salvador, Jamaica, and Colombia were examined. A larger percentage of Cuban immigrants reported past month alcohol use (42.4%) than did immigrants from Mexico (34.9%). However, Cuban (9.9%) and Colombian (14.9%) immigrants had lower rates of past month binge drinking when compared with Mexican (22.3%) immigrants. The 9.9% prevalence rate for binge drinking among Cuban immigrants was lower than among Puerto Rican (23.7%) and El Salvadoran (19.7%) immigrants. Cuban immigrants also had lower past month heavy drinking rates (1.3%) than immigrants from Mexico (3.5%). Immigrants from Puerto Rico had prevalence rates similar to Mexican immigrants with respect to binge drinking (23.7% vs. 22.3 %) and heavy drinking rates (3.3% vs. 3.5%).

Mexican, Puerto Rican, and El Salvadoran immigrants had a higher average number of drinks consumed per week (8.1, 6.8, and 7.4 drinks, respectively) than Jamaican immigrants (2.8 drinks) or than immigrants from Cuba (3.3 drinks). In summary, across most drinking measures, immigrants from Mexico, Puerto Rico, and El Salvador had higher prevalence rates than Cuban or Jamaican immigrants. Although a larger percentage of immigrants from Cuba reported drinking in the past month, they had a lower prevalence of both binge and heavy drinking, and they drank fewer drinks per week than most of the other selected Latin American immigrant groups. These differences in alcohol use rates may be partially explained by the older age of immigrants from Cuba, who were on average 53.2 years old compared with immigrants from Mexico (37.3 years), Puerto Rico (46.4 years), and El Salvador (38.6 years).

Immigrants from Mexico, Puerto Rico, and El Salvador had binge drinking prevalence rates (22.3%, 23.7%, and 19.7%, respectively) and past month weekly consumption amounts (8.1, 6.8, and 7.4 drinks, respectively) that were equal to those for US-born adults (22.3% and 8.3 drinks). Immigrants from Cuba, Jamaica, and Colombia had past month weekly consumption rates and binge drinking prevalence rates that were lower than the rates for US-born persons. These differential findings may be due to the age distributions of immigrants from the Latin American region. A higher percentage of immigrants from Mexico and El Salvador were among the younger age groups (18–25, 26–34) compared with immigrants from Cuba, Jamaica, and Colombia.

Alcohol use rates and past month weekly consumption of alcohol were examined for the following individual Asian countries among respondents aged 18 or older: Japan, Korea, the Philippines, China, Vietnam, and India.

Immigrants from Japan (62.1%) and Korea (53.2%) had a higher prevalence of past month alcohol use than immigrants from the Philippines (24.1%), China (28.4%), Vietnam (26.4%), and India (26.6%). Korean and Japanese immigrants also reported a higher prevalence of past month binge drinking (27.9% and 18.6%, respectively) than immigrants from the Philippines (8.9%), China (7.5%), and India (7.8%). Immigrants from Korea had a higher prevalence of past month heavy drinking (3.5%) than immigrants from the Philippines (0.6%), China (0.7%), or Vietnam (0.6%).

A somewhat different pattern was observed for past month weekly alcohol consumption. Although Korean immigrants had the highest level of consumption, consuming on average 7.5 drinks per week, immigrants from Vietnam had the second highest past month weekly consumption rate of 5.1 drinks per week, followed closely by Filipino and Japanese immigrants at 4.6 and 3.5 drinks per week on average, respectively. Past month weekly alcohol consumption was significantly lower for immigrants from China (1.5 drinks) when compared with Korean, Japanese, Vietnamese, and Filipino immigrants. For most Asian immigrant groups, past month weekly alcohol consumption was higher with longer time spent in the United States. China and India had the largest percentages of immigrants who had been in the United States for fewer than 5 years (32.7 and 40.5%, respectively), which may contribute to their lower alcohol use rates.

When comparing rates for persons from individual Asian countries with rates for US-born individuals, Korean and Japanese immigrants had prevalence rates for past month alcohol use that were similar to those for individuals born in the United States. Across all alcohol use measures, rates for immigrants from China, Vietnam, India, and the Philippines were lower than the rates for the US-born population.

Alcohol use rates and past month weekly consumption among current drinkers were examined for three groups of European immigrants aged 18 or older. Immigrants from Germany, the United Kingdom (England, Scotland, Wales, and Ireland), and Poland were compared.

Immigrants from the United Kingdom had higher rates of past month alcohol use (67.5%), past month binge drinking (31.3%), and past month heavy drinking (12.2%) when compared with German immigrants, whose past month alcohol use was significantly lower (49.3%), as were their rates for binge drinking (17.3%) and heavy drinking (5.3%). The past month heavy drinking rate for United Kingdom immigrants exceeded that for Polish immigrants (4.4%). Past month alcohol use (55.9%) and past month binge drinking (23.8%) for immigrants from Poland were similar to those for immigrants from the United Kingdom.

Past month weekly alcohol consumption amounts among current drinkers also were higher among immigrants from the United Kingdom (10.2 drinks) when compared with immigrants from Germany (5.3 drinks) and Poland (4.1 drinks). Immigrants from Germany who had been in the United States for 5 years or more had higher past month weekly consumption rates (5.4 drinks) than those who had been in the United States for fewer than 5 years (3.6 drinks). Immigrants from the United Kingdom who had been in the United States for 5 years or longer had similar past month weekly consumption rates than those who had been in the United States for less time (10.0 vs. 11.5 drinks). Immigrants from Poland showed no differences in past month weekly alcohol consumption amounts whether they had been in the United States for 5 or more or fewer than 5 years (4.0 vs. 4.6 drinks).

Immigrants from the United Kingdom also had alcohol use rates that were higher than those for US-born individuals. Their past month alcohol use (67.5% vs. 52.4%), past month binge drinking (31.3% vs. 22.3%), and past month heavy drinking (12.2% vs. 6.5%) rates all showed a pattern of higher use when compared with US-born persons. Past month weekly consumption amounts were similar for immigrants from the United Kingdom (10.2 drinks) and US-born individuals (8.3 drinks).

Alcohol use rates and past month weekly consumption of alcohol among current drinkers were examined for Canadian immigrants. Immigrants from Canada reported higher rates of past month (64.5%) and past year alcohol use (78.3%) than US-born persons, whose rates were 52.4% and 67.8%. The average past month weekly consumption rate for immigrants from Canada (5.2 drinks) was lower than that for US-born individuals (8.3 drinks). Immigrants from Canada showed a similar pattern of past month binge drinking and past month heavy drinking (19.4% and 5.3%, respectively) as US-born persons (22.3% and 6.5%). Canadian-born persons living in the United States showed no differences in past month weekly alcohol consumption after being in the United States for 5 or more years.

There are several predictors of alcohol use among immigrants aged 18 or older. Younger ages are associated with an increased risk of alcohol use across all measures (i.e., past month use, binge drinking, heavy use, and past year use). Male sex and longer duration of residence in the United States were found to be associated with alcohol use. Being married was associated with lower odds of alcohol use compared with other martial statuses.

Research is limited on the alcohol consumption patterns of immigrant and refugee groups in the United States. Most research has focused on ethnic groups with long histories in the United States, such as Mexican Americans, Japanese-Americans, Chinese-Americans, and Korean Americans. However, much of this research fails to examine the differences that exist within these groups. Brief examples of the research conducted on alcohol use among newer Latino and Southeast Asian immigrant and refugee groups are as follows. These two groups are highlighted because limited empirical research exists on the alcohol use patterns of other more recent immigrant and refugee groups.

Intranational Differences: Mexican Immigrants

Mexican immigrants are an excellent example of the intracultural diversity model. This model recognizes differences in alcohol consumption among individuals within a specific group. Although individuals of Mexican descent have a long history of living in the United States, the immigration of Mexican Indians is a relatively new phenomenon. Mixtecos, Zapotecos, Mixes, Tarahumaras, and other Mexican Indians constitute 10% of the estimated one million persons in California's farm labor force. Alderete, Vega, Kolody, and Aguilar-Gaxiola noted in their 2000 paper that immigrant Mexican Indians are often included with other Mexicans, despite the fact that these very different groups have minimal social contact with each other, either in Mexico or in the United States. In a study of 3,012 Mexican-origin, Spanish- or English-speaking individuals in Fresno County (California), Mexican Indians were found to have higher rates of lifetime alcohol abuse and dependence than non-Indian Mexicans – 5.1% versus 3.3% for alcohol abuse and 17.4% versus 10.7% for alcohol dependence. However, there was no significant difference in lifetime rates for abuse or dependence between these groups after adjusting for sociodemographic factors.

Differences Between National Groups: Central America

In a study conducted by Marin and Posner of 531 immigrants from Central America (primarily El Salvador and Nicaragua), and 391 from Mexico, 64.4% of the Central Americans reported not drinking alcohol in the previous 30 days compared to 56.8% of the Mexicans. The number of days the Central Americans reported drinking in the previous 30 days (mean = 4.5 days) was lower than that reported by the Mexicans (mean = 7.4 days). The Central Americans consumed fewer drinks in the previous 30 days (mean = 5.9 drinks) than the Mexicans (mean = 9.2 drinks).

In a study comparing Dominican and Guatemalan immigrants in New Jersey, differences in the locations chosen for obtaining alcohol treatment were found between the two groups. Dominicans were most likely to seek help for their drinking problem from charismatic groups affiliated with the Catholic Church. In contrast, Guatemalans were more likely to seek help from Spanish-language Alcoholics Anonymous (AA) groups. Neither the Guatemalan nor the Dominican immigrants tended to go to clinics for alcohol problems.

Among Asian groups in California, Vietnamese and Chinese-Vietnamese have been found to report higher alcohol consumption levels in comparison to Japanese, Chinese, Koreans, and Filipinos.

Differences Between Immigrant and US-Born Groups

In a study of 264 young adult immigrants, primarily from Mexico, El Salvador, Nicaragua, and Honduras (mean age 23 years) compared to 188 US-born Mexican Americans, the US-born men and women were found to be heavier drinkers than the immigrants. Approximately 18.3% of the US-born men and 4.2% of US-born women were found to be in the highest drinking category (drinking at least once a week and drinking six or more drinks per usual occasion), in comparison to 9.4% of the immigrant men and 1.0% of the immigrant women. Additionally, US-born women were significantly more likely than their immigrant counterparts to describe alcohol as having social disinhibiting effects, being a mood elevator and tension reducer, and enhancing sociability. No differences were found between the immigrant and US-born males on their beliefs concerning alcohol.

In a study of Vietnamese men living in California, the percentage of drinkers was found to be the same as among men in the general US population. However, binge drinking was twice as common among the Vietnamese men.

Acculturation Differences

One factor that accounts for some differences in alcohol use patterns within specific groups is acculturation. In Alderete et al.'s study of Mexican Indians and non-Indians, both Indian and non-Indian Mexicans who chose to do the interview in English had a statistically significant increased risk for alcohol abuse or dependence compared to those who did the interview in Spanish. This was interpreted as suggesting that acculturation was a risk factor for both populations of Mexican immigrants.

In Marin and Posner's 1995 study of immigrants from Central America and Mexico, greater acculturation was significantly associated with less abstention in the previous 30 days (37.5% for Central Americans, 40.7% for Mexicans) in contrast to individuals who measured lower in acculturation (57.1% for the Central Americans and 68.7% among the Mexicans). The less acculturated Central Americans tended to drink significantly less often in the previous 30 days (mean = 3.9 days) than did their more acculturated counterparts (mean = 5.9 days).

Gender Differences

In a study of young adult immigrants from Mexico, El Salvador, Nicaragua, and Honduras, women had higher rates of abstention than males (59.4% vs. 28.1%). In the same study, US-born Mexican American women also had higher rates of abstention than males (31.6% vs. 21.1%). Both immigrant and US-born women were significantly less likely to be heavy drinkers than men. The immigrant women were also significantly less likely to endorse the belief that alcohol consumption enhances social acceptance, after-work relaxation, freedom from inhibition, global mood elevation, sexual pleasure, tension reduction, social pleasure, and social assertiveness. No association was found between depression and drinking level for either group of women. However, depression was positively associated with alcohol drinking level for both immigrant and US-born men.

Marin and Posner's 1995 study of Central American and Mexican residents found similar gender differences. A lower proportion of men from Central America, compared to women, reported being abstainers in the previous 30 days (51.9% vs. 73.0%, respectively). This finding was replicated among the Mexican men and women (37.7% vs. 72.6%, respectively). Men drank more often during the previous 30 days (mean = 5.3 days among Central Americans, mean = 8.4 days among Mexicans) compared to women (mean = 3.6 days among the Central Americans and mean = 5.8 days among the Mexicans). Men also reported drinking more during the previous 30 days (mean = 10.4 drinks among Central Americans, mean = 15.6 drinks among Mexicans) as compared to the women (mean = 2.8 drinks, among the Central Americans and mean = 4.0 among the Mexicans).

Gender differences in alcohol consumption have also been found among Southeast Asian groups. In a study among Vietnamese immigrants living in the United States for less than 6 months, men were significantly more likely than women to report any alcohol use. Another study in Santa Clara County in California found that 51% of Vietnamese women abstained from alcohol in contrast to only 6% of the men. Additionally 39% of the men were moderate to heavy drinkers in contrast to only 6% of the women.

Reasons for Drinking

In a study of 120 Cambodian refugee women conducted in Long Beach, California and Lowell, Massachusetts, more of the East Coast sample reported using alcohol to cope with nervousness, stress, insomnia, or pain. Cambodian women also described men's drinking as social in contrast to women's drinking which was used to deal with emotional or physical pain. The increasing use of alcohol for the self-treatment of insomnia, pain, and emotional stress has also been reported among the Hmong.

Caetano, Clark, and Tam observed that, among a study of Southeast Asian refugees, 45% reported having problems with alcohol use, and a large proportion found it acceptable to use alcohol to cope with stressful situations. Similarly, in a study of young people of different ethnicities, the recent immigrant Southeast Asian youth reported drinking primarily to forget their pasts, in contrast to the youth of other ethnic groups who reported drinking mostly for social reasons.

Substance use rates also may vary by length of time in the United States. Research findings on substance use patterns among immigrant populations are mixed, with some studies indicating that substance use increased with increased time in the United States. Other studies showed decreased substance use and mental health problems over time and with increased levels of acculturation. One explanation for these discrepant findings is the heterogeneity of immigrant populations. Even within subgroups of immigrants, there is wide variability in substance use patterns.

Makimoto demonstrated differences in drinking patterns among Asian Americans when comparing Chinese-, Japanese-, Korean-, and Filipino-American samples. Among adults, Japanese-Americans had the highest and Chinese-Americans had the lowest lifetime prevalence of drinking and heavy drinking. Alcohol abuse and dependence appear to be significant problems among Southeast Asians resettled in the United States, as a result of contributing factors, such as experiences of trauma during the refugee process and traditional beliefs about alcohol as a health-promoting substance. Other researchers have found that Asian Americans have shown a general increase in substance use patterns with length of time in the United States, and they have attributed the increase to the results of acculturation toward US drinking norms.

The reasons for this variability in drinking patterns are not well understood. Alaniz reported in a 1998 study that alcohol availability and advertising were disproportionately concentrated in low-income racial/ethnic minority communities, with five times more alcohol advertisements in Latino neighborhoods than in predominantly White neighborhoods. Variability in use patterns may arise from differential access to alcohol and other drugs, cultural mores limiting or supporting use, varying degrees of psychological stress, or differences in the use of alcohol in the country of origin. The variability in alcohol use rates could be due to a differential amount of time that immigrant groups have been in the United States or to the younger average age of some of the individuals within the regional groupings.

Clearly, the heterogeneity of the immigrant population of the United States provides a challenge to the substance abuse prevention and treatment community and to early intervention programming. The mixed findings from research with immigrant and minority populations may point to the need for considering cultural values and acculturation in designing interventions. For example, if substance use increases with increased acculturation in some groups of immigrants, it may point to the need to intervene with new immigrants.

Immigrants are faced with multiple socioeconomic, environmental, and cultural factors that increase vulnerability for substance abuse and related problems. Factors that increase the experience of stress include economic insecurity, high levels of poverty that force families to live in deprived neighborhoods, discrimination, experiences of inequality, levels of acculturation, and a pervasive sense of powerlessness. Substance use and abuse can result when attempting to cope with these specific stressors in addition to other daily challenges confronted by immigrants.

The utilization of prevention and treatment programs by immigrants is impacted by many of the same challenges that native-born Americans face. Nevertheless, immigrants also face unique challenges, such as language barriers and cultural barriers, which further hinder their ability to access health care services. Studies have found that immigrants are less likely to utilize medical care than their US-born counterparts regardless of what type of provider – e.g., primary, emergency, or specialized care providers – delivers the services. In order to obtain access to mental health and substance abuse programs, immigrants have to overcome many personal, structural, and financial barriers.

Personal Barriers

Personal cultural beliefs have the greatest impact on the perception of substance use and mental and substance abuse disorders. Culture shapes our beliefs with respect to health and illness, and the causes and remedies of illness. It determines how people understand and deal with substance use and abuse. For example, traditional Asian Indians may avoid substance abuse services due to the fear of stigmatization. For them, substance abuse is a moral problem and a source of family shame. In other cultures, such as in Latin America countries, concepts of *machismo* may promote the use of some substances like alcohol among men. In these cases, heavy drinking is not seen as a problem but as an expected behavior. Even when immigrants are willing to approach substance abuse services, there may be a clash between their health beliefs and the health care providers' beliefs. Western medicine's scientifically based vision of disease tends to compete with some cultures' concepts of illness that include a holistic view where medicine, religion, and cultural practices are intertwined. This disconnect between cultures can contribute to immigrants' mistrust of Western medicine and reluctance to seek help.

Negative past experiences within the health care system can also affect immigrants' willingness to seek services. Experiences of discrimination, alienation, health care providers' biases, as well as communication problems can prevent immigrants from utilizing health services. A survey from the Commonwealth Fund found that 18% of Hispanics felt discriminated against by their physician due to their race/ethnicity, inability to speak English, or to pay for the visit.

Language is one of the strongest barriers to accessing health services. The shortage of trained bilingual service providers in the mental health/substance abuse arena further complicates the problem. This shortage makes it almost impossible for limited-English-proficient immigrants to obtain appropriate services. Only 48% of Spanish-speaking immigrants who required interpreter services during their health care visits said they usually had one. Furthermore, among those receiving interpreter services, only 70% fully understood what the doctor was saying. Language barriers impede access to health at all levels, from primary care to preventive care, as well as specialty services such as substance abuse services.

Immigration status may also constitute a barrier to accessing prevention and treatment services. Undocumented immigrants avoid enrolling in public insurance programs and utilizing health services, due to the fear that data regarding their legal status may be shared with immigration authorities.

Financial Barriers

Lack of insurance is the most significant financial barrier that limits access to substance abuse prevention and treatment services among immigrants. Immigrants are much less likely to be insured than are US-born individuals. The 1997 Current Population Survey found that 34% of immigrants are uninsured compared to only 14% of US-born individuals. Although immigrants are as likely as the US-born to be employed, immigrants are more likely to have low-wage jobs that do not offer health coverage limiting their ability to afford private insurance. In general, uninsured individuals are less likely to have a regular doctor who can refer them to specialty services, are less likely to obtain preventive services, and usually delay obtaining medical care even when they are very sick.

Structural Barriers

In order to access the health care system, it is essential that patients understand how it works. As with many Americans, the majority of immigrants feel overwhelmed by the complicated maze of payments, appointments, multiple levels of service, paperwork, and insurance options that characterize the US medical system. Immigrants may not enroll in preventive and treatment services due to lack of awareness about service availability and/or their eligibility and access to services. When they are able to obtain care, immigrants face longer wait times, limited access to specialists, limited referrals to other services, such as substance abuse services, and less continuity of care.

Conclusion

In general, immigrants to the United States use less alcohol than US natives. At least four different models explain the patterns of alcohol use in immigrant and refugee groups. Among immigrants, alcohol use is highest in young men. There is a wide variation and much heterogeneity among alcohol use patterns seen in different immigrant and refugee groups. Language, financial, and structural barriers complicate the prevention and treatment of alcohol use disorders in immigrant populations.

Related Topics

- ► Acculturative stress
- ► Addiction and substance abuse
- ► Assimilation
- ► Language barriers
- ► Poverty
- ► Trauma exposure

Suggested Readings

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Suggested Resources

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Allergies

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Allergic reactions are caused by the body's immune system overreacting to a substance that is not harmful. Common causes of allergic reactions are certain types of food (e.g., peanuts, soy, dairy, wheat, eggs, and shellfish), seasonal or environmental substances (e.g., dust, mold, pollen, and ragweed), animals (e.g., cat hair, dog dander, insect bites, and cockroaches), and medications (e.g., penicillin, ibuprofen). The substances that cause allergic reactions are called allergens.

An allergic reaction begins when the person with the allergy is exposed to an allergen, usually by swallowing it, inhaling it, or touching it. The person's immune system reacts by creating a type of antibody, called immunoglobulin E (IgE). Antibodies are the weapons the body's defense (immune) system uses to attack substances that may cause harm, such as bacteria and viruses. In the case of an allergy, the IgE attaches to mast cells, which are a type of blood cell that can usually be found in the airways and intestines, as well as other parts of the body. The allergens then bind to the IgE. This binding causes the attached mast cell to release histamine along with some other chemicals into the blood stream.

The symptoms of an allergic reaction are mostly caused by histamine. Symptoms can vary by person and by event. Common symptoms of an allergic reaction are hives, itching, rashes, watery eyes, gastrointestinal disturbances (cramps, vomiting, and diarrhea), sinus and chest congestion, swelling, and anaphylaxis. Anaphylaxis is a severe reaction that affects the whole body and can include any of the above symptoms, as well as difficulty breathing, wheezing, tingling in the extremities, swelling of the tongue or mouth, tightness in the throat, and loss of consciousness. Since anaphylaxis can be life threatening and can progress rapidly, it must be treated quickly by seeking emergency medical treatment at the first signs of the reaction. Individuals who are known to be susceptible to a severe allergic reaction often keep an injectable dose of epinephrine (sometimes called an Epipen or Twinject) on hand to use in the event that they have an anaphylactic reaction.

If an individual suspects that he or she may have an allergy, testing by a medical professional can be done to confirm it and to predict the severity of the allergy. One type of test is a blood test (sometimes referred to as a "RAST" test) to measure the levels of IgE in the blood. Higher levels of IgE indicate more likelihood of an allergy. Other factors (such as medications) may interfere with the results of these blood tests and some individuals may have high IgE levels in their system and yet never experience the symptoms of an allergic reaction. Therefore, if a person has an allergy, the blood test is likely to be positive, but there is also a chance that the test results may be positive even if the individual does not have an allergy. These tests are most helpful when combined with other information such as the details of a reaction to an allergen exposure.

Another type of test is the allergy skin test. In these tests, the individual is exposed to a particular allergen either by pricking the skin after applying a solution containing the allergen, or by injecting the allergen just under the surface of the skin, or by wearing an adhesive patch containing the allergen. The reaction of the skin is evaluated to determine the degree of sensitivity to the allergen. Although the skin test is generally more accurate than the blood test, it is still not always reliable. Just as with the blood test, there is a chance that the skin test may indicate an allergy even if the individual does not actually have one.

In the case of food allergies, if the presence of an allergy is still questionable after combining the results of the blood or skin tests with the individual's history of exposure to the allergen, then a food challenge can be done. A food challenge is a test in which the person is closely observed during a controlled exposure to the allergen and is the most accurate test to determine whether a person has an allergy. During a food challenge, the individual eats increasingly larger amounts of the allergen every 15 min while being observed for an allergic reaction. A food challenge can only be done under the close supervision of a qualified medical professional as there is a risk of experiencing a severe reaction which could require immediate medical intervention.

The scientific literature is inconclusive regarding the risk of immigrants developing allergies in their new country. It is possible that country of origin, age at time of migration, length of stay in the new country, living conditions, and genetic factors may be better predictors of allergies rather than immigration status alone. Health literacy and access to health care are factors that should be evaluated when comparing the prevalence of allergies in immigrants and their native counterparts.

Related Topics

- ► Environmental exposure
- ► Explanatory model of illness
- ► Food
- ► Health literacy

Suggested Resources

The Food Allergy & Anaphylaxis Network: http://www.foodallergy.org/. Accessed June 16, 2011.
Mayo Foundation for Medical Education and Research: http://www.mayoclinic.com/health/allergies/DS01118. Accessed June 16, 2011.
National Institute of Allergy and Infectious Diseases: http://www.niaid.nih.gov. Accessed June 16, 2011.
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Ambiguous Loss

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In a world where immigration and migration are prominent, cultural diversity becomes essential. The United States is known as a cultural "melting pot." Thus, in looking at the cultural diversity each ethnic group brings, there also is an element of cultural ambiguity for the displaced ethnic group. Cultural ambiguity is defined as an unclear culture, or of mixed uncertain cultures. As of 2010, the US Census had 310,233,000 total people living in the US, made up of American Indians, Alaskan Natives, Asians, Blacks, Hispanics, Native Hawaiians, other Pacific Islanders, and Whites. And amongst each of these limited groups are numerous subgroups of individuals that struggle to maintain their ethnic heritage.

Ethnic groups struggle with loss of their native languages, traditions, and traditional roles. For example, Scourby discussed the plight of first, second, and third generation Greeks. Questionnaires were sent out with questions measuring the rate of assimilation. One of the questions asked was if English should replace Greek in Church. Predictably, the individuals in the second and third generations said yes. Interestingly, these individuals were not as liberal-minded in having the liturgy (the devotional part of worship) in English and responded that as this was the sacred, transcendental aspect of the religious experience, it did not need to be verbally understood. This indicates that in younger generations, there are more leniencies to small changes than from the first generation. Another question considered ethnic identity – asking how they identify themselves. The younger generations (3rd) were more apt to identify themselves as Greek-American or American. Ethnic identity is influenced by the judgments and responses from the ethnic group and from the outside of the group. Whether the passing of cultural norms from one generation to the younger generation was a positive or negative experience will also affect the identity of the recipient.

Ambiguity is seen when the ethnic culture and dominant culture have differing expectations. For example, in many Asian communities parents raise male children with the expectation that they will remain at home after marriage and help care for them. This is not a value of the dominant "American" culture. Thus, individuals who are living in these two worlds simultaneously may feel lost and forge their own paths, thus changing the traditional norm. Each small change will eventually lead to a global change resulting in the loss of that ethnic group's traditional identity, moving it closer toward acclimation with the dominant culture.

Related Topics

- ► Acculturation
- ► Cross-cultural medicine
- ► Cultural competence
- ► Ethnic cleansing
- ► Ethnic identity
- ► Individualism
- ► Situational ethnic identity

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Ambulatory Care

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Ambulatory care describes health care services that are provided to patients who are not inpatient nor bedridden. In fact, the very definition of the word "ambulatory" describes someone who is capable of walking and not bedridden. Medical care can include obtaining a diagnosis, observation, treatment, and rehabilitation if care is provided on an outpatient basis and does not involve a hospital stay. Thus, ambulatory care encompasses *any* care that does not involve inpatient treatment in a hospital or medical facility.

Types of Ambulatory Care

Ambulatory care can be divided into two major categories. The first category includes care provided by physicians. The second category involves care that is organized and provided in medical institution.

The care provided by physicians can be provided by a solo practitioner, individual physicians who have organized themselves into a partnership, or physicians who participate in a group practice. There are many different types of physicians that participate in ambulatory care. The care can be provided by primary care physicians and/or specialists. Therefore, physicians that provide ambulatory care include, but are not limited to, general practitioners, family doctors, pediatricians, internists, obstetricians, gynecologists, dentists, cardiologists, ophthalmologists, dermatologists, gastroenterologists, psychiatrists, podiatrists, allergists, neurologists, chiropractors, and orthopedists. Ambulatory care provided by physicians typically occurs at the doctor's office and requires an appointment. It should be noted, however, that when one of these physicians provide treatment to a patient, while they are admitted in a hospital, the care being provided is not deemed "ambulatory care." Additionally, the fee paid to the physician for the inpatient visit is often more expensive than what the same doctor charges for ambulatory care.

Although ambulatory care is provided by physicians, it can also be provided, in an outpatient setting, by other health care professionals. Patients often receive the treatment from physician assistants or nurse practitioners in the outpatient setting. If the patient is only appearing for a service that can be handled by a nurse, such as receiving an injection or bandage changes, the treatment may be provided by a registered nurse or licensed practical nurse.

The second category of ambulatory care involves treatment provided in medical institution–based settings. Such institutions include hospital-based outpatient clinics, walk-in centers, urgent care centers, hospital-sponsored group practices, surgery centers, health department clinics, community health centers, outpatient mental health centers, schools, workplace health services, diagnostic centers laboratories, outpatient rehabilitative and physical therapy centers, pharmacies, imaging centers, correctional health facilities, dialysis centers, laser surgery centers, fertility clinics, military clinics, women's health centers, and sleep centers. Many patients, however, are not admitted and discharged for follow-up care at home or with a health care provider.

Emergency rooms can also provide ambulatory care. However, if the patient is admitted to the hospital, the care is not considered ambulatory. Insurance companies may not include an emergency room visit under ambulatory care, as visits to the emergency often occur without notice and could result in hospitalization.

Growth of Ambulatory Care

In the last three decades, ambulatory care has seen tremendous growth. There are several reasons for this growth. The first reason is advances in technology. As medical science has advanced, the need for inpatient hospitalization and hospital-based services has decreased. For example, surgeries that used to require inpatient observation and care postoperatively can now be performed on an outpatient basis. The surgeries can be performed safely at a freestanding surgery center or a clinic. The development of diagnostic equipment, such as magnetic resonance imaging (MRI) machines, have also led to the development of centers that specialize in providing quality testing in an efficient manner.

The growing cost of health care has spurred the growth of ambulatory care. Often the cost of services at a hospital is greater than at an ambulatory care facility. For example, an imaging center will often charge less for an MRI than a hospital. Additionally, if a patient can undergo surgery and return home the same day, the fact that inpatient care is not needed, alone, serves to reduce the cost related to the surgical treatment.

Finally, patient convenience has contributed to the growth of ambulatory care. The manner in which ambulatory care has grown allows patients to access to health care that is closer to home. A patient who needs to have lab work performed can now find the closest laboratory rather than traveling to the hospital and utilizing its laboratory services. The patient also has more choices in where to obtain care and by whom. By moving certain types of care and testing outside of a hospital setting, hospitals also have the ability to direct more of its resources to patients who do need inpatient testing, observation, or procedures.

With easier access to ambulatory care, the utilization of ambulatory care providers and institutions has steadily grown. By way of illustration, there were 841,204 visits to doctors, emergency rooms, and outpatient departments in the United States in 1994. By 2006, this number had increased to 1,123,354. When examining the different types of ambulatory care used during these years, visits to physicians appear to constitute the largest percentage of the care utilized. In 2006, doctor's visits made up four-fifths of the ambulatory care sought by Americans. It was estimated that 902 million visits were made to physicians in their offices, with 58.3% being made to primary care physicians, 22.0% to medical specialists, and 19.7% to surgical specialists. Thus, on average, there were approximately 306.6 visits for every 100 persons. Similar increases in the use of ambulatory care have been noted in other countries.

Utilization of Ambulatory Care

Studies have shown that ambulatory care services are utilized by more women than men. The higher rate of ambulatory care by women may be explained by the fact that women tend to be more likely to use preventive care, attend regular checkups, be proactive in their care, and comply with all the treatment. Further, ambulatory care is used more by the elderly than the young. As the elderly tend to have more health issues and conditions that require monitoring, an increased use by this population is logical and to be expected.

The amount of access citizens have to health care, including ambulatory care, varies from country to country. In the United States, uninsured citizens have been found to have the lowest rate of utilization of ambulatory services such as physician office visits. Consequentially, illegal immigrants, immigrant groups, and others who cannot afford insurance and do not qualify for governmental assistance appear to have limited access to a majority of the ambulatory care services offered in their area. In countries that offer some form of universal health care, citizens do not face the same barrier and, therefore, may have greater access to ambulatory care.

Choosing Quality Ambulatory Care

As with all health care services, a patient must keep in mind that not all ambulatory care providers are equal. Providers vary in the amount of training received, availability, qualifications, experience, their bedside manner, the amount of staff on hand, accreditation, certification, equipment utilized, and the time they are willing to spend with each patient. As choosing a quality health care provider is an extremely important decision, an individual should research the ambulatory care providers and institutions available before enrolling in care. However, it is worth noting that an individual's choice of ambulatory care provider may be limited by factors such as insurance, provider's acceptance of the individual's insurance, and, in the network insurance programs, which providers are in network and available to the patient.

In circumstances where the patient is searching for a specialist or is considering the use of a medical institution, such as a diagnostic center or surgical center, the patient may be able to start his or her research with their primary care physician. While speaking to family, friends, or other community members may also be helpful, advice from lay sources should be placed in perspective and complemented by other information about the service.

Once the individual has a list of prospective providers, it is recommended that a visit to the facilities, a call, or a meeting with the manager or other staff members about the organization's services, policies, history, and staff credentials be conducted. However, depending on the provider, the amount of time and information the individual may receive could be minimal. Staff members may be unwilling or unable to discuss subjects concerning issues such as their employer's incident rates, infection rates, outdated equipment, or doctors' success rates.

Some physicians and facilities publish information about their qualifications, services, and success stories in brochures or Web pages. Consumer groups, Internet postings, and blogs are other research tools that are available. While publications, consumer groups, and the Internet are additional investigational tools, any such information may be limited and may not include such information as medical malpractice suits filed against them. Dissatisfied patients may also misrepresent information. Likewise, satisfied patients may offer helpful suggestions.

Questions an individual should consider when trying to choose an ambulatory care provider include:

- Will your rights and responsibilities as a patient be properly explained?
- Will you and your family be provided adequate and sufficient information to make appropriate decisions regarding your care?
- Can family members come into the recovery room?
- Does the provider have a license, board certification, hospital privileges, or accreditation?
- Do you have access to information about the provider's experience with the procedures, qualifications, and training?
- Are emergency services, such as cardiopulmonary resuscitation, available by trained personnel? Will you be transferred to a hospital if there is an emergency?
- Do you have access to information regarding how often the provider performs the procedure or treatment at issue and how successful he or she has been with the procedure or treatment?
- If there are complications, is the provider available 24 h a day, 7 days a week?

Conclusion

The majority of today's health care services are ambulatory care. More and more treatment and testing are moving from a hospital-based setting to doctor's offices and medical institution–based settings. By doing so, patients can usually receive quality care that is less costly, more convenient, and they have the opportunity to choose from a larger pool of providers. Despite this, ambulatory care tends to still be less accessible to certain segments of the population.

Underutilization of ambulatory care by immigrants could place them in a position where their health may be compromised. Immigrants often do not receive regular preventive care or treat diseases until the condition has become serious. By making care easier to receive and less expensive, however, immigrants, who may have refrained from obtaining care due to cost or an inability to fully understand the health care/insurance system, should be better able to receive care. Additionally, access to a larger pool of providers allows immigrants the opportunity to search for, and use, doctors and facilities that are aware of, and perhaps even cater to, their particular cultural needs and concerns. Additionally, education concerning ambulatory care, its availability, and its importance should be made widely available for both immigrants and the public at large.

Related Topics

- ► Access to care
- ► Disease prevention
- ► Health care utilization

Suggested Readings

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Ambulatory Care Utilization

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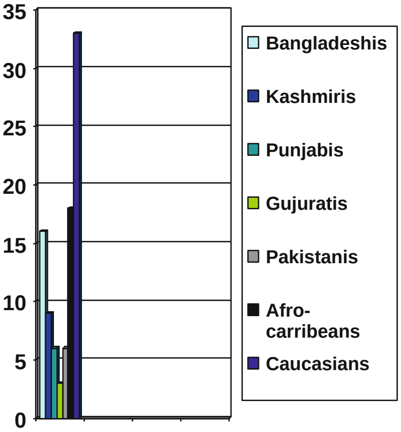
Most health services are accessed through primary care services. These are generally General Medical Practitioners or Family Doctors located in surgeries or other clinics distributed in the local community. Surgeries and clinics that often provide maternal and child health and family planning clinics are usually run by local health authorities, and in some countries may be called Health Centers or polyclinics. If patients are too ill to be served by primary care clinics, but not ill enough to need admission to hospital, or if they need more complex examination, then they will be referred to hospital outpatient departments. All of these services, including primary care and outpatient services, are referred to as ambulatory services, from the Italian "ambulare" – to walk, because these patients walk to the clinics to be seen by doctors and other clinicians, and do not have to be admitted to "lie in a hospital bed."

It will be clear from the above that most care from specialists in developed countries is given in outpatient "ambulatory" clinics, rather than within hospitals; the maintenance of hospital buildings makes care for hospital inpatients extremely expensive. Therefore, patients are only admitted to hospital for short periods of time for specific procedures. However, it is also true that different ethnic groups may have different perceptions of the need to attend outpatients; the figure (Fig. 1) below shows different rates of non-attendance at outpatient appointments for different ethnic groups in an ambulatory service for patients with an episode of Psychosis in Luton, Bedfordshire, and this clearly demonstrates different choices in terms of attending outpatient appointments.

Immigrants who do not access and utilize appropriate health services may realize consequences for themselves and their communities. Immigrants with serious illnesses such as infectious diseases may receive inadequate treatment if they do not seek care at clinics

- Bangladeshis have more missed outpatient appointments than the other Asian subgroups.
- The second largest number of missed appointments is found in the Kashmiri Population.
- In general however, Afro-Caribbeans and Caucasians have more missed appointments than any of the Asian subgroups.
- Only 1 Bangladeshi patient kept all his appointments.One Pakistani and 1 Punjabi patient kept all their appointments. All the other Asian patients did miss appointments.
- By contrast, 1 Afro-Caribbean and 15 Caucasian Patients attended all their appointments.
- There are 40 missed appointments in all Asian groups together.
- Missed appointments appear to be an important problem in the Asian Community and may lead to disengagement from services.



Ambulatory Care Utilization. Fig. 1 Missed appointments in different ethnic groups

where they are entitled to receive care and where the appropriate care is available. An immigrant entering a new country suffering from tuberculosis, for example, will continue to deteriorate and pose a risk to others if he does not attend an appropriate clinic to be treated. Untreated, the patient's disease will progress and this potentially fatal condition may prevent him from being fully productive at work, lead to his untimely death, and place his family at risk in a strange country. Ambulatory health services could provide substantial treatments for this patient and his family.

Ambulatory services make a major contribution in improving the health of mothers and children and preventing negative health outcomes., In Luton, Bedfordshire, England, for example, comparatively (as compared with the rest of the UK) high child and maternal morbidity is linked with the presence of numerous immigrants from Pakistan, Bangladesh, and India as well as from many African countries. These immigrants may not seek preventative maternal child services and thus suffer disproportionately high mortality rates.

Once immigrants have been accepted into a community in the UK, they are entitled to all the same health services as the rest of the population. In other countries, health services may be linked to insurance or public programs. Health Authorities in towns in the UK have set up special teams of nurses and health visitors to make contact with immigrants and to enable immigrants to use ambulatory health services and ensure the health of the population.

The first study about the utilization of ambulatory mental health services by South Asians (Indians, Pakistanis, and Bangladeshis) was carried out at the Institute of Psychiatry, London in 1970. The results suggested that these groups of immigrants appeared to utilize ambulatory services differently from the general population. The immigrants presented when their symptoms were so advanced that their behavior was clearly changed. They were discharged from hospital more quickly, missed outpatient appointments more frequently, and were discharged as outpatients more frequently than the indigenous population.

Recently, a study of the utilization of an ambulatory service for first episode psychosis in the town of Luton showed similar results. The patients were second-generation immigrants (that is, the children of immigrants). They, too, tended to present when their symptoms were so advanced that their behavior was clearly changed, tended to miss outpatient appointments more frequently, and also to be discharged from outpatients more frequently than the indigenous population. The examples highlight the importance of understanding how immigrants utilize ambulatory services to maintain their health.

It has been well reported that the utilization of ambulatory health services, including mental health services, may be different among certain groups of immigrants as compared to the general population. A number of reasons may be suggested.

First, immigrants may not be aware of the services to which they are entitled in their new country of residence or they may expect to pay for certain services, when these services are available to them for free.

Second, the "explanatory model" about the cause of various illnesses may differ from that which exists among the indigenous population of the country of residence. For example, many patients and families from India and Pakistan may believe a psychotic illness occurs because the patient is possessed by a "gene" or spirit, rather than that he is suffering from a disease of the brain. Consequently, these persons may seek a holy man to have the spirit appeased or persuaded to leave rather than attending outpatient appointments. This difference in belief of the cause of disease or illness is referred to as the "explanatory model." Lastly, the aims and motivations of the immigrant, in attending outpatient appointments, may be quite different from those of the host population. Thus, an immigrant's perception of when treatment begins and ends may very well be different from that of the native population. An immigrant is often poor and cannot "afford" to take much time off being ill. Prolonged absence from work may lead to losing his job, and even his livelihood. Hence, he may stop returning to outpatient appointments when he feels better. Such an expectation of a rapid return to work may not be as common in patients from the indigenous population, who may have greater knowledge of their rights to employment or sickness benefit and a greater sense of entitlement.

Differences in the use of ambulatory health services may persist in "second-generation immigrants," that is, the children of immigrants into a host country, who have been born in that host country, but may often continue to experience the original culture of their parents within the family home.

Cultural differences in the perceived utility of the ambulatory services may be an important cause of the reduced use of ambulatory services by some immigrant groups.

Health authorities and public health practitioners must engage immigrant groups and educate them regarding the importance of health services and what services they are entitled to access. Encouraging appropriate outpatient services early will avoid costly emergency treatment later. This will contribute to general population health of the host community as well as the general health of the immigrant populations.

Related Topics

- ▶ Access to care
- ▶ Ambulatory care
- ▶ Child health care access
- ▶ Community health workers
- ▶ Community-oriented primary care
- ▶ Explanatory model of illness
- ▶ Health barriers
- ▶ Health beliefs
- ▶ Health care
- ▶ Health care utilization
- ▶ Health disparities
- ▶ Health education
- ▶ Health literacy
- ▶ Health services utilization

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Amnesty

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The term amnesty has two defined meanings in the English language: "the official act of forgiving people who have committed offences against the state and allowing them to go free" and "a period of time during which people can admit to doing something wrong without fear or punishment." In the context of immigration, amnesty has been of great relevance in recent years in two ways.

First, immigrants who are undocumented often lack access to adequate health care. This may be the case where the State wishes to withhold certain benefits such as free health care to undocumented immigrants. Legislation and entitlement for undocumented immigrants varies across and often even within countries; undocumented immigrants may fear that efforts to obtain health services will draw attention to their immigration status. Additionally, many immigrants, including those with documentation, face non-statutory barriers to health care, such as culture and language.

It is difficult to quantify the extent to which undocumented immigrants attempt to obtain health services as past research has not often collected data relating to immigration status. However, reviews from North America have consistently shown that immigrants overall have a lower health status. Researchers found that in the USA, immigrants' spending on emergency medicine was three times higher than that of US citizens, while health spending on other aspects of services was lower. This demonstrates that immigrants tend to seek health care services in the case of emergency but do not do so for preventive services. These findings echo the experiences of physicians providing health care to immigrants who have observed that their immigrant patients often seek medical help only after an illness has become worse. In the USA, undocumented immigrants have limited access to health insurance, which poses an additional barrier to diagnosis and treatment. A review of studies conducted in North America found that use of health care services is closely associated with insurance coverage, and that undocumented immigrants consistently seek fewer health care services than those with legal status.

Amnesty for undocumented immigrants has often faced opposition because of concerns related to the costs associated with providing health care to immigrants. Research findings documenting the relationship between undocumented status, lack of access to health insurance, and lack of access to health care present a strong humanitarian rationale for amnesty for undocumented immigrants.

Related Topics

- ► Health barriers
- ► Health disparities
- ► Illegal immigration
- ► Immigration Reform and Control Act of 1986 (U.S.)
- ► Irregular immigration
- ► Undocumented

Suggested Readings

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Amnesty International

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Founded in 1961 by a British lawyer, Peter Benenson, Amnesty International is a well-known international human rights organization with more than 2.2 millions of supporters and subscribers from more than 150 countries. The declared mission of the organization is to work around the globe in order to stop the abuse of human rights; its purpose is to protect people wherever justice, freedom, truth, and dignity are denied.

According to its statute, Amnesty International is autonomous organization that does not support or oppose any government or political system. Moreover, the organization does not necessarily support or oppose the views of the victims/survivors or human rights defenders whose rights it seeks to protect. As it is fully funded through individual contributions and donations, Amnesty International is able to be free from any influence, since it does not depend on any government, political ideology, economic interest, or religion.

The basic premise of Amnesty International's activity is that each and every person has the right to enjoy all of the human rights enshrined in the Universal Declaration of Human Rights. When States or institutions fail to protect these rights, Amnesty International seeks to mobilize large numbers of individuals to react and offer public displays of support for those who need such protection. By undertaking meticulous research focused on preventing and ending grave abuses of the rights to physical and mental integrity, freedom of conscience and expression, and freedom from discrimination, Amnesty International documents abuses and violations; based on these findings it publicly demands governments, international institutions, and corporations to respect the rule of law. A large database of more than 50,000 reports about human rights issues, press releases, and appeals for action written by AI researchers is available online for any interested party at http://www.amnesty.org/en/library.

The philosophy of the organization is to campaign globally and locally in order to make a difference. Supporters and activists of the organizations work to improve human rights by, especially, organizing impressive mass demonstrations, vigils and direct lobbying, and attractive online and offline campaigning in order to mobilize large support for its causes. This is how Amnesty International is a powerful voice that can, to a certain extent, exert pressure on governments, political bodies, companies, and intergovernmental groups to put an end to human rights violations.

Starting with early years of activity, the organization has gathered an impressive record in gathering massive support for different campaigns such as to stop violence against women, stop political killings, abolish the death penalty, oppose torture and combat terror with justice, free prisoners of conscience, protect the rights of refugees and migrants, regulate the global arms trade, end poverty, and so on.

There are many significant milestones in the history of the organization: in January 1969, UNESCO granted Amnesty International consultative status as the organization reached another milestone and 2,000 prisoners of conscience were released as a direct result of the organization's campaigns. In 1971, the first worldwide campaign for the abolition of torture was launched and 2 years later the United Nations unanimously approved the Amnesty International-inspired resolution formally denouncing torture. In 1977, Amnesty International was awarded the Nobel Peace Prize for "having contributed to securing the ground for freedom, for justice, and thereby also for peace in the world." The following year, the organization won the United Nations Human Rights prize for "outstanding contributions in the field of human rights."

In 1985, the International Council Meeting in Helsinki, Finland, made a decision to broaden the statute of the organization to include work for refugees. At that moment, membership in the organization counted more than half a million members, supporters, and subscribers.

In 1996, Amnesty International launched the campaign for a permanent International Criminal Court, and a year later the human rights of the refugees worldwide became one of the crucial themes for campaigning for the organization. In 1998, the Rome Statute of the International Criminal Court was adopted.

In 2007, after a mobilizing campaign organized by Amnesty International and its partners in the World

Coalition Against the Death Penalty, the UN General Assembly (UNGA) Third Committee's 62nd session adopted resolution L29 calling for a global moratorium on executions.

Related Topics

- ► Human rights
- ► Refugee
- ► Torture
- ► Violence

Suggested Resources

http://www.amnesty.org/en
http://www.amnesty.org/en/library
http://www.amnestyusa.org
http://www.encyclopedia.com/topic/Amnesty_International.aspx

Amok

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Amok, often referred to as a Malaysian culture-bound or culture-related syndrome, is characterized by an unrestrained, sudden episode of extreme, often homicidal, violence. Although prodromal symptoms of *amok*, such as intense brooding, increased anxiety and agitation, or upset over a perceived criticism or insult have been reported, the majority of *amok* acts are largely indiscriminate, neither premeditated nor provoked. The extreme violence perpetrated during an episode of *amok* is further thought to be unconscious to the individual "going *amok*," as the perpetrator, or *pengamok*, is said to be in a dissociative state or amnesia. Due to the excessive frenzied nature of the *pengamok*, outside force is generally required to end an *amok* episode. Such confrontation and force may result in the death or suicide of the *pengamok*. If the *pengamok* survives, the destructive and murderous outburst is characteristically followed by total amnesia and intense fatigue.

Amok is classified as a culture-bound syndrome in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders (DSM IV-TR)* and the World Health Organization's *ICD-10 Classification of Mental and Behavioral Disorders*. The *DSM-IV-TR* reports *amok* as occurring solely in males. Further, the *DSM* posits a possible coterminous relationship between certain episodes of amok and acute or chronic psychotic processes. Both DSM and ICD classifications recognize the occurrence of *amok*-like behavioral patterns in other areas of the world. Examples of similar culture-related syndromes of unrestrained violence include, but are not limited to, *beserkergang* in Scandinavia and *ahade idzi be* in Papua New Guinea.

The term *amok* is also used in a modified form in common language. Co-opted as an adverb, amok is often used as a descriptor suggesting undisciplined, unruly, or uncontrolled behavior.

Related Topics

- ► Cultural background
- ► Culture-specific diagnoses

Suggested Readings

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Anger

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Anger is an intense emotion typically experienced in relation to feelings of displeasure or antagonism. It can be induced by a real or supposed injury or insult to one's self or others, or by the intent to do such injury. It is a common human emotion. It has been experienced by almost every person throughout human history. It is recognizable in infants and emerges at a predictable stage of their early development irrespective of culture or ethnicity. It is described in our oldest oral and written histories and has continued to be referenced in modern media and research.

The ubiquitous and enduring nature of anger as part of the human emotional experience makes it probable that it has served an adaptive function during the course of human evolution. However, anger has more often been viewed as a problematic and negative emotion due to its complex association with extremes of aggressive and violent behavior.

While there has been some disagreement over the intrinsic value of anger by scholars over the centuries, the view that anger is a natural and mature emotion is a reasonably modern one. It is also an important consideration when discussing anger in relation to immigration and health. Migrant populations are particularly vulnerable to a range of health problems that can potentially be affected by the regulation and expression of anger.

However migrant groups are also ethnically diverse and vary in their individual and collective capacities to sublimate anger and use it in adaptive ways. Understanding the origins and functions of human anger can thus help clarify how it differentially affects health outcomes of immigrant groups in a process of acculturation to the destination culture.

The Origin and Function of Aggression

Anger has primarily been considered to be a human emotion although our early understanding of its function was led by the study of comparative animal biology and behavior. Species-specific neurological pathways have now been identified that are presumed to have evolved to process emotionally significant information. These pathways run from the sensory organs to the amygdala, through the limbic system and to the forebrain. Complex neurochemical and hormonal cascades further activate the hypothalamic-pituitary-adrenocortical and pituitary-gonadal systems to release epinephrine, norepinephrine, and testosterone which help activate the body to respond.

For many decades anger was researched only in relation to aggressive and violent behavior and became subsumed within the behavioral and biological research traditions of the early and mid-twentieth century. Definitions were at times blurred and the terms anger, rage, and aggression were often used interchangeably. Anger came to be seen as a part of the general autonomic arousal system of the fight flight behavioral response. It was not until late in the twentieth century that any meaningful analyses of the cognitive processes underpinning anger were conducted.

Using cognitive-behavioral and social learning paradigms, researchers have since discovered that anger can be feigned or exaggerated as a strategy to achieve one's goals by manipulating or influencing others. People who look angry are perceived as more powerful than those who seem sad. Showing anger during a negotiation can be perceived as being dominant and powerful and people may be inclined to easily give up negotiations with an angry compared to a happy opponent.

It has been suggested that people analyze their opponent's emotions in order to decide about their own emotional expression and behavioral responses. Anger may therefore be considered as an evolved bargaining tactic that involves choosing to use certain behaviors to resolve conflicts in favor of one's own interests. It is a reaction that motivates a response connected to the impulse for self-preservation.

Anger is thus an emotional response to the provocation of an overt threat or perceived or anticipated transgression. It occurs through an interplay between cognitive (appraisals), somatic-affective (tension and agitations), and behavioral (withdrawal and antagonism) components. Anger reactivity and regulation are related to behavioral self controls that emerge out of our interpretation of learned social norms derived from our early environmental experience. These social norms in turn uphold accepted standards of conduct within any given social group.

Pathological Expressions of Anger

Different people at different times may express their anger adaptively or pathologically depending on social circumstances (states) and personality predispositions (traits). Extreme expressions of anger can impair one's ability to process information to exert cognitive control over their behavior. An angry person may therefore lose objectivity, empathy, or rationality and cause harm to others. If self-directed, anger can result in acts of impulsive deliberate self-harm or suicide.

The proposition of inherited predispositions, or traits, affecting the phenotypic expression of anger has led to promising advances in molecular genetics. The monoamine oxidase A gene, for example, appears to play an important role in differentially mediating neurotransmitters and hormones in the pathological anger responses between individuals. However, there remains a complex interplay between individual genetic and environmental factors that is yet to be fully elaborated.

The social and personal cost associated with the aggressive and violent extremes of anger has meant these areas have received a lot of research attention to prevent such behavior. However, modern psychologists have become increasingly interested in the possible harmful effects of suppression of anger. The passive anger response can relate to repression and denial of anger when it would be an appropriate response to the situation. This can also lead to persistent violent thoughts or uncontrolled violent displacement behavior.

Anger can also lead to mental health problems or aggravate pre-existing conditions. Research shows that people who suffer from excessive anger often harbor and act on dysfunctional attributions, assumptions and evaluations of people and situations. Distorted cognitive schemas are common across a range of mental health problems including depression, anxiety, adjustment disorders, posttraumatic stress disorder, and substance abuse problems. Anger can also fuel paranoia or prejudice in everyday situations and often presents as a symptom of underlying mental health problems.

Anger, Immigration, and Health

Understanding individual differences in regulating pathological and non-pathological expressions of anger is an important field of research. However, when considering anger in relation to immigration and health one needs to consider its expression in heterogeneous groups of individuals. The literature is full of comparative studies of poor mental health outcomes in migrant populations. Typically it compares the mental health of migrants to that of natives in the destination country as a result of acculturation, and overlooks preexisting differences between these groups.

To truly understand the effect of migration on mental health one must also consider what the mental health of migrants was like before they left their place of origin. The migration experience can be extremely traumatic and arduous for some and their different experiences en route can differentially affect mental health status prior to arrival at the destination. People generally migrate to improve their economic or social well-being, although for some the decision may be related to situations of extreme poverty, war, violence, or persecution.

The numerous losses experienced during the migration process coupled with the potential high level of distress prior to migration are undeniable sources of stress which can negatively impact on mental health prior to arrival in the new host culture. Individual variables primarily influence mental health status before arrival in the host country and include education level, socioeconomic status, sex, ethnicity, and identification to the group of origin.

In the post-migration context, there can be a crucial interrelationship between individual mental health with factors such as detention, bureaucratic processes, homelessness, poverty, unemployment, loss of language and culture, loss of family and friends, and social isolation. Acculturation refers to the cultural and psychological changes that occur as a result of intercultural interactions after arrival at the destination country. Factors contributing to the acculturation stress include those at both an individual and group level.

Group Identity, Self-Esteem, and Mental Health

Retaining a sense of one's ethnic identity greatly enhances psychological adaptation. Social groups are an important source of self-definition and have implications for the psychological well-being of individuals in the groups. Affective and evaluative components of cultural identity are integral to self-esteem and positive adaption to the host country and can enable a clear sense of personal and cultural identity, good mental health, and good self-esteem.

Integration within one's original and host culture provides more favorable psychological outcomes. Marginalization from host and original culture is the least favorable acculturation strategy. Negative outcomes can be associated with feelings of anger, anomie, depression, anxiety, psychosomatic symptoms, and identity confusion.

The variable rate of the expression of anger in migrant groups is far from clear. However, migrants are overly represented in mental health statistics although findings vary across ethnic groups. Given that anger can be a common symptom of a range of mental health problems, it is reasonable to suggest that migrant mental health problems may be a proxy measure for migrant anger problems. The ultimate expression of anger will however depend on social norms in their prevailing cultures.

Recent reports on the mental health care of migrants in Europe have drawn attention to several key issues in relation to the quality and quantity of available services. There are problems in the accessibility of mental health care and an absence of participation of migrants in the development and delivery of services. There is also poor quality and quantity of data on migrant's mental health problems and their use of services to guide good practice.

Anger, Discrimination, and Prejudice

When asked directly, migrants will most often identify discrimination as the thing that makes them most angry. Because social groups are characterized as cognitive representations of those belonging to the group, similar motivational and cognitive mechanisms apply to the social processes of both intergroup and interpersonal hostility. When individuals identify with one group over another they tend to over rate their intrinsic worth and evaluate themselves more favorably in reference to the out group on dimensions relevant to in-group definitions.

Structural social realities are subjectively perceived by the individual and come to affect a person's thoughts, feelings, and behaviors about themselves and their group. An individual's personal experience of negative stereotypes, prejudice and discrimination, low group status and social deprivation was once thought sufficient to explain both group hostility and individual anger.

However, the capacity of the individual to understand when collective deprivation is experienced by the group in relation to other groups also contributes to the expression of individual and group anger. Individuals can thus find solidarity with the group and defer to the decision of the group as to how to confront the discrimination. The anger of the group can in turn be expressed adaptively such as negotiating within the wider political systems of the host group or maladapatively through retaliatory violence.

Conclusions

Anger is a psychobiological state that varies in the intensity of expression between individuals and groups of individuals. It is functional in many ways and can motivate people to affect great change for personal or social benefit. However, anger also has the capacity to result in extreme aggressive and violent behavior and cause great harm to oneself and others. Anger can thus be considered as either adaptive or pathological.

Pathological expressions of anger are often associated with mental health problems. Migrant populations tend to be overly represented in poor health outcomes when compared to members of the dominant culture. However, these problems can emerge before, during, or after they migrate from their country of origin. To the extent that anger is related to mental health problems in different mental health statistics can serve as proxy measures of anger problems. Migrants should therefore be entitled to a full range of mental health services in response to their needs.

However, if services are to be effective they must seek to identify the interplay of factors and function to ameliorate the problems at different levels. Policies and procedures should be developed to ensure that the appropriate ranges of services are available for migrants to reflect their needs in relation to their individual migration journey.

Mental health services should be seen as vital part of immigration services and work in partnership with migrants to breakdown prejudice and stereotypes that can result in anger. Encouraging the active participation of migrants in defining needs is important to develop a knowledge base of good clinical practice for the future.

Related Topics

- ▶ Acculturative stress
- ▶ Battered spouse
- ▶ Depression
- ▶ Discrimination
- ▶ Domestic violence
- ▶ Emotions
- ▶ Family violence
- ▶ Gender-based violence
- ▶ Mental health
- ▶ Violence

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Anti-Asian Violence

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The history of Asians in the USA is replete with incidents of anti-Asian violence. This violence ran the gamut of physical assaults from individual perpetrators to mob violence. The violence also was perpetrated by the government on a local, state, or federal basis through officially sanctioned actions, or through inaction by the state, thereby denying Asians of any protection from the law. From the first wave of Chinese arriving in San Francisco in the 1850s to the most recent Indian immigrant coming off any plane in the twenty-first century, Asians, irrespective of their nationality, class status, age, and gender, could be potential victims of anti-Asian violence or bias.

When the Chinese arrived in California following the Gold Rush of 1848, many local city, state, and federal laws were enacted and implemented against them since they were seen as economic competitors. However, these laws were preceded by anti-Chinese hysteria and direct physical violence. The infamous 1854 case of *People v. Hall* demonstrated that even when there were witnesses to convict a White defendant who murdered a Chinese victim, the California Supreme Court still nullified the conviction because it was based upon the testimony of Chinese witnesses. Thereafter in California, the Chinese were disqualified from testifying for or against any Whites in any court proceeding. This was the beginning of the creation of a system of institutional racism and oppression against Asians in the USA.

Anti-Chinese political platforms (“The Chinese Must Go”) were established throughout the Western states from the 1850s to the 1870s. Political parties and unions held meetings and rallies to organize against the “yellow peril.” At one point in time, the USA was open to having many smaller remote Chinatowns and Chinese settlements scattered throughout the Western states, but anti-Chinese mob violence forced the Chinese to abandon these locations for the protection that bigger Chinatowns offered. There were countless episodes of destruction and violence by White lynch mobs throughout the Western USA. For example, in 1871, around 21 Chinese were murdered in Los Angeles and the Chinatown looted and burnt down; in 1885, over 40 Chinese were killed in the “Rock Springs Massacre” in Wyoming; in 1887, around 31 Chinese were murdered and mutilated in the “Snake River Massacre” in Oregon. Over the course of this anti-Chinese period in the nineteenth century, many Chinese were rounded up in smaller towns, some murdered, while the lucky survivors were forcibly put on ships or other transport and herded back to San Francisco Chinatown.

When various exclusion acts prevented the Chinese from immigrating in larger numbers, the cycle for the need of cheap labor continued for other Asians in the late nineteenth century and early twentieth century. Following the Chinese were the Japanese, then the Filipinos, Koreans, and Asian Indians. Each succeeding group experienced their own history of intimidation, violence, and eventual exclusion similar to the earlier experiences of the Chinese.

In the twentieth century, around 120,000 Japanese and Japanese Americans were forcibly removed from their homes during World War II and incarcerated in American concentration camps. The US government operated out of the assumption that there were some inherently disloyal Japanese residing in the USA. Since it was difficult to discern who in the general population were loyal or disloyal to the USA, it was easier to incarcerate everyone, from the babies up to the elderly. Similar camps existed for Japanese Canadians as well. Ethnic Japanese residing in South American countries were rounded up as prisoners of war and sent to US camps. This whole-scale incarceration did not occur for ethnic Germans or Italians in the USA.

By 1965, racially restrictive immigration quotas were removed and the Asian population began to increase in the USA. The end of the Vietnam War also meant refugee resettlement programs for Vietnamese, Cambodians, and other Southeast Asian groups throughout the 1970s. With the increase of Asians in the general population came a correlating increase of acts of violence against Asian Americans. The 1982 murder of Chinese American Vincent Chin by two unemployed White autoworkers illustrates some of the motivation in the hatred against Asian Americans. Mr. Chin was seen by his murderers as Japanese and thus responsible for the recession and decline of the auto industry in Detroit, Michigan. Similar to the result in the 1854 *Hall* case, the two killers of Mr. Chin never received 1 day of jail sentence as they were paroled and fined $3,000 for the killing. The Chin case led Asian Americans to begin organizing around the issue of anti-Asian violence. Organizations began collecting hate crime data and demonstrated a steady statistical increase against Asian victims. Civil rights advocates have indicated that for each hate crime reported, 5–15 other incidents are not documented due to cultural and language barriers on the part of the victim, or police or prosecutorial neglect. The range of impact to the victim is often physical; yet, the underlying emotional and mental trauma are often overlooked nor dealt with.

In anti-Asian violence cases, Asian victims are often blamed for economic woes in their newly adopted land since they are seen as foreign economic competitors. The stereotyping of Asians as the "model minority" leads to resentment by non-Asian groups when Asians are perceived to be able to achieve enormous success despite major obstacles. Victims are often erroneously labeled by their perpetrators to be of a different ethnicity or nationality, and repeatedly considered to be foreign (the "perpetual foreigner syndrome") even when the victims are natural born citizens. The numerous wars and conflicts that the USA has engaged in during the twentieth century against Japan, and in Korea and Vietnam, along with the Cold War with China, contribute to the hatred. Whether they are victims to overt physical violence or constant racial taunts, Asians in the USA and other adopted countries continue to experience a disparate number of such biased experiences or hate crimes.

Related Topics

► Chinese
► Discrimination
► Internment
► Race
► Racism
► Trauma

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Suggested Resources

http://www.fbi.gov/hq/cid/civilrights/hate.htm
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Antiterrorism and Effective Death Penalty Act of 1996 (U.S.)

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The Antiterrorism and Effective Death Penalty Act of 1996 (AEDPA) is an Act of the United States Congress signed into law on April 24, 1996. The bill was introduced as part of Speaker of the House Newt Gingrich's Contract with America, passed with broad bipartisan support by Congress following the Oklahoma City bombing, and signed into law by the United States President Bill Clinton.

AEDPA created a new procedure for the removal of alien terrorists. (The law uses the term "alien" to refer to any individual, including those who are permanent residents, who is not a citizen of the United States.) Special removal proceedings apply to any noncitizen who has engaged, is engaged, or at any time after admission into the United States engages in any terrorist activity as defined in the Immigration and Naturalization Act (INA). For noncitizens who meet the terrorist definition, a removal court was appointed, consisting of five federal district court judges. Proceedings before the special removal court will only occur if the noncitizen's removal through the normal removal procedures would pose a risk to the national security of the United States.

The regular rules of evidence applicable to trials are not applied in these special terrorist removal proceedings. A judge reviewing the application for removal may consider information that is not contained in the application for removal. This includes classified material. The noncitizen is provided some "standard" protections, which include the rights to: (1) be given a reasonable notice of the nature of the charges against him or her and reasonable notice of the time and place of the hearing, (2) counsel, (3) introduce evidence on his or her behalf, and (4) examine the evidence and cross-examine witnesses.

The government must show that the individual is an "alien terrorist" as defined in the INA. If the government is able to prove the individual is an "alien terrorist," then the court will order that the individual be removed from the United States. Either party may appeal the final decision of the special removal court. If, after appeals are final, the individual is still found to be removable, he or she will be removed to another country. If no other country will accept the individual who was found by the court to be an alien terrorist, the United States may detain the individual in custody while making periodic attempts to find a country that will accept him or her.

AEDPA states that membership in, or representation of, a terrorist organization is a ground to deny a noncitizen admission to the United States. It also adds provisions to the INA that limit the Attorney General's discretion to suspend deportation, adjust status, or allow voluntary departure, among other things, for those deemed to be alien terrorists. Additionally, the AEDPA states that asylum cannot be granted to any alien terrorist unless the Attorney General determines there is no basis to consider that individual a threat to the United States' national security.

AEDPA provisions affect the treatment of criminal noncitizens. The AEDPA added several immigration offenses to be considered offenses for Racketeer Influenced and Corrupt Organization (RICO) convictions. Other provisions include long-distance relocation plans for any individual found to be a criminal alien who has already attempted illegal entry into the United States at least three times. AEDPA also provides for deportation of noncitizen criminals before their entire prison sentence is served. If such an individual were to later illegally enter the United States, that noncitizen individual would have to serve the remainder of the prison sentence at that time.

AEDPA also added crimes to the list of aggravated felonies for which a criminal noncitizen would be subject to expedited removal. These offenses include forgery of a passport or other documentation for entry into the United States and running a gambling business. It also modified the expedited procedures, including limits on any challenge to the removal order and limitations on discretionary review of a removal order.

AEDPA provisions affect the access to health care for immigrants who have been deemed alien terrorists.

If an immigrant is suspected of being an alien terrorist, he or she will be held in custody according to the rules of the AEDPA. While in custody, the individual does not have access to private or public health care. These individuals are subject to the health care provided by the penal system. While in custody, the immigrant is allowed to communicate with and receive visits from members of their family, and to contact, retain, and communicate with an attorney. The immigrant is also allowed to contact an appropriate diplomatic or consular official of the alien's country of citizenship or nationality or of any country providing representation services.

Under the AEDPA, there are special rules for individuals who hold permanent residence in the United States. An alien lawfully admitted for permanent residence is entitled to a release hearing before the judge assigned to hear the removal hearing. The individual will be detained pending the removal hearing, unless the individual demonstrates to the court that he or she is a person lawfully admitted for permanent residence in the United States; if released upon such terms and conditions as the court may prescribe (including the posting of any monetary amount), he or she is not likely to flee; and he or she will not endanger national security, or the safety of any person or the community, if released.

Critics of the 1996 Antiterrorism and Effective Death Penalty Act point out that definitions of what constitutes crimes of “moral turpitude” or “aggravated felony” are intentionally vague and frequently changed to increase the number of deportable individuals. As a result, noncitizens are subject to laws that apply no matter how long ago their crime was committed, regardless of the amount of time they may have already served, without recourse to judicial review or appeal and without the chance to challenge their deportation based on ties to family or length of time in the United States, even if they arrived as infants.

Related Topics

- ► Immigration status
- ► Terrorism

Suggested Resources

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Anxiety

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Anxiety is both a psychological and a physiological state and includes cognitive, somatic, emotional, and behavioral components. These components, put together, produce an unpleasant feeling, which is usually associated with unease, apprehension, fear, or worry. Whereas fear leads to behaviors such as escape and avoidance, anxiety occurs as a consequence of threats that are perceived to be uncontrollable or unavoidable.

Anxiety is a normal reaction to stress. It acts to help a person deal with a difficult situation by prompting and enabling the person to cope with it. While anxiety can be adaptive, when it becomes excessive, it may manifest as an anxiety disorder, and such disorders may become important medical problems.

Anxiety acts to alert the person to the possible risks within the environment so that the person can manage them appropriately. Anxiety can cause a number of physical effects, which include heart palpitations, muscle weakness and tension, fatigue, nausea, chest pain, shortness of breath, stomach aches, or headaches. Physiologically, the body prepares to deal with a threat: blood pressure and heart rate are increased, sweating is increased, bloodflow to the major muscle groups is increased, and immune and digestive system functions are inhibited. This has been described as the *fight or flight* response. External signs of anxiety include pale skin, sweating, trembling, and pupillary dilation. A person with anxiety might also experience a sense of dread or panic. A person who experiences a panic attack, a particularly pernicious manifestation of anxiety may feel as if he or she is about to die or pass out.

Common sources of anxiety include seeking a better way of life and achieving a better financial status. For immigrants, living and working in an environment where they face competition from both the indigenous population as well as other immigrants can be a particularly potent source of anxiety. Some immigrants may find it unexpectedly difficult to find a job and may face resentment from the indigenous population, which can lead to discrimination.

Immigration is often associated with anxiety since it often exposes immigrants to entirely new environments, individuals with different cultural norms and customs, and different expectations about achieving success. The process of immigration can be anxiety provoking for many individuals. Immigrants, especially those entering the host country illegally, may have to travel long distances in inappropriate and risky forms of transport, with guides who in some cases put their lives at risk. Even when immigrants have legal status in a host country, uncertainty about the future and potential language barriers may induce anxiety. Research suggests that for some immigrants, obligations to support family at home or to repay debts that were made to underwrite their journey may be associated with anxiety. In some cases, immigrants may not have realized the demands that their host country places on themselves and their children to adapt to local norms, which in turn may pose a challenge to their own identity. Also, learning new methods of carrying out business in the host country may be challenging and may result in anxiety.

Issues about immigration status are another source of anxiety to immigrants. Those who have entered the host country may be particularly prone to anxiety; however, in many host countries, immigration is itself a source of political concern to the indigenous population, so that it is frequently discussed in the media by politicians in a way which can induce worry. Legal immigrants may face increased anxiety when visas need to be renewed; they may be required to leave the host country in order for visas to be processed.

Immigrants with anxiety may also experience feelings of apprehension or dread, difficulty in concentrating, feeling tense or jumpy, constantly anticipating the worst, feeling irritable, being restless, and being excessively vigilant for signs of danger. Cognitive effects of anxiety also include thoughts about suspected dangers, including fear of dying. Hence, chest pains (a physical symptom of anxiety) may come to be interpreted as being a "heart attack."

Because of the multiple stressors associated with immigration, anxiety is commonly experienced by immigrants. Clinicians who work with immigrants should consider routinely assessing and addressing anxiety.

Related Topics

- ▶ Access to care
- ▶ Acculturation
- ▶ Acculturative stress
- ▶ Illegal immigration
- ▶ Irregular immigration
- ▶ Job stress
- ▶ Mental health
- ▶ Mental illness
- ▶ Posttraumatic stress disorder

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Suggested Resources

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Appetite Suppressants

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Obesity has been a growing global health epidemic in recent years. The prevalence of obesity is 16% among immigrants in the United States (US) and 22% among US-born individuals. A 2004 study on obesity in US immigrants showed that living in the US for 15 years or more resulted in a body mass index (BMI) increase of 1.39 kg/m^2. Furthermore, immigrants were found to be less likely than US-born individuals to discuss diet and exercise with clinicians. Immigrants may be vulnerable to increased obesity – particularly when entering the US at an early age. Sons of immigrants have higher levels of childhood obesity than American boys. Some experts contend that a key factor in the development of this pattern of obesity is more readily available drinks and snacks in the US as compared to the immigrant's home country.

Medications and supplements used for weight loss have become more widely available in the past 2 decades. There has been a growing appeal among various ethnic groups to use these therapies. The use of medication for weight loss has been questioned due to concerns about safety and efficacy, with the subsequent withdrawal of several medications (Ephedrine and Fenfluramine) from the market by the US Food and Drug Administration (FDA). Immigrants may have different notions regarding these therapies. Studies have shown that negative perceptions of being overweight varied across ethnicities and races, such as among African-Americans, Whites, and Latinos. Therefore, the social stigma of obesity may vary with immigrants, resulting in a greater or lesser desire for weight loss medications and supplements.

Antiobesity medications can be used as an adjunct to diet and exercise for those with a body mass index (BMI) greater than 30 kg/m^2. After weight loss has not been achieved with at least six months of nonpharmacological treatment, antiobesity medications may be indicated, when used in conjunction with diet and exercise. It is suggested that drug therapy should be attempted by those considering gastrointestinal bypass surgery and by obese patients with sleep apnea. The goal of therapy with these medications is not to return to normal body weight; rather, therapy is considered successful when a more than 2 kg weight loss is achieved in the first month, and a weight loss of 5% below baseline by 3–6 months is achieved and maintained at that level.

Several medications have been approved by the US FDA for weight loss, including sibutramine, phentermine, diethylpropion, and orlistat. The first three are appetite-suppressing sympathomimetic drugs that influence the level of norepinephrine, serotonin, and/or dopamine by altering their reuptake into nerve terminals. These changes in neurochemicals result in early satiety or a feeling of fullness. Due to the potential for increased blood pressure, in those with high blood pressure, these drugs must be avoided altogether or used with extreme caution. Use of these medications results in more success when combined with appropriate lifestyle modifications, such as a calorie-restricted diet and exercise program.

These appetite suppressants are indicated for short-term use. Phentermine may be used for up to 12 weeks, while sibutramine has been used in trials for up to 2 years. Persons taking these medications should be aware that when therapeutic effect is achieved, weight loss stops, and when people discontinue therapy, weight is regained. Therefore, this is not a cure for obesity, as the medications do not have a significant long-term benefit on weight reduction. Common adverse effects with sibutramine and phentermine are dry mouth, headache, constipation, and insomnia; also patients may experience palpitations and tachycardia.

The atypical antidepressant bupropion has been shown to potentiate early satiety by modulating the action of norepinephrine and serotonin. Weight loss has been noted in depressed patients treated with bupropion for 6–12 months. Due to the small number of subjects studied, this drug is not currently FDA approved for the treatment of obesity.

There are multiple dietary supplements that are available over-the-counter that are marketed for weight loss. These include supplements purported to (1) increase energy expenditure, (2) modulate carbohydrate metabolism, (3) increase satiety, and (4) reduce production of fat. Due to uncertain product safety and/or uncertain efficacy, none of these supplements can be recommended at this time and should be discouraged or used with extreme caution. Glucomannan, psyllium, and guar gum have been marketed as appetite suppressants. It is theorized that, as soluble fibers, they may absorb water within the gut, thereby causing an increased sensation of fullness. While they are felt to be safe to use, in large randomized controlled trials, guar gum and psyllium have not been shown to have a weight loss benefit. Glucomannan has not been studied in large trials.

Pharmacological therapy for obesity has been found to be unsafe when multiple agents were compounded into one pill. Therefore, in 2006, the FDA banned the sale of compounded diet pills in the US. However, compounded diet pills appear to appeal to certain immigrant groups. For instance, in a Massachusetts clinic, of the women born in Brazil and now living in the US who were surveyed, 15% reported using compounded diet pills imported from Brazil. Of those who reported using the FDA-banned pills, 66% reported adverse effects, including palpitations, anxiety, and vomiting. In that particular study, factors identified increasing the odds of appetite suppressant use included being unmarried, college educated, and dissatisfied with one's weight. The pills frequently included three to six prescription medications, including amphetamines, benzodiazepines, antidepressants, diuretics, and laxatives.

Immigrants' perceptions may vary widely regarding obesity and their need to achieve weight loss with medications or supplements. Prescription appetite suppressants should be used with caution and only after counseling with a physician, especially for patients with hypertension. They are indicated for short-term use only, and after lifestyle modifications with exercise and diet adjustments have failed to achieve weight loss. Over-the-counter appetite suppressants have not been shown to have a weight loss benefit in trials.

Related Topics

- ▶ Health perception
- ▶ Lifestyle
- ▶ Nutrition knowledge
- ▶ Nutrition programs
- ▶ Obesity
- ▶ Weight control

Suggested Readings

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Arab

- ▶ Islam
- ▶ Muslim

Arab-Americans

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Arab-Americans are immigrants to the USA from Arabic-speaking countries. Arabic-speaking countries are primarily located in North Africa and West Asia. The following countries comprise the Arab world: Africa – Algeria, Djibouti, Egypt, Eritrea, Libya, Mauritania, Morocco, Somalia, Sudan, and Tunisia; Asia – Bahrain, Iraq, Jordan, Kuwait, Lebanon, Oman, Qatar, Saudi Arabia, Syria, United Arab Emirates, Yemen, and the Palestinian territories.

The majority of Arab-Americans nationwide live on the West Coast, in the Midwest, and on the East Coast, respectively. The 2000 US Census reveals that 48% of Arabs live in the following states: California, Michigan, New York, Florida, and New Jersey. California has the largest number of Arabs with an estimated 750,000 inhabitants. Southeastern Michigan has the highest ethnic density of Arabs in the country, numbering greater than 490,000. There are significant demographic differences between Arab-Americans living in different parts of the country. For example, Arab-Americans living in California tend to have higher educational levels than Arab-Americans in other parts of the country. Arab-Americans in the Midwest generally have lower socioeconomic status than those in other regions of the US. Arab-Americans in the Midwest and on the East Coast have poorer access to health care than Arab-Americans nationwide.

Arab-Americans predominantly practice Christianity or Islam. Thirty-nine percent of Arab-Americans are Roman Catholic, 34% are Muslim, and 18% are Eastern Orthodox Christian. Religion is highly relevant for Arab-Americans and is a potential risk factor for traumatic exposure. For example, Christians in the Middle East have faced increasing religious discrimination. Churches have been targets of religiously based violence such as bombings and shootings. In addition, Muslims have faced increased discrimination following the September 11, 2001, terrorist attacks, and some have felt marginalized in subsequent years.

A Brief History of Arab Immigration to the USA

Arab immigration to the USA can roughly be divided into three waves: 1870s to World War I, 1948 through the mid-1960s, and 1967 through the present. The first wave was from the 1870s until World War I (1914–1918). This first group of immigrants primarily came from Syria, Lebanon, Jordan, and part of Palestine. They were predominantly Christian (70–90%) and came to the USA for better economic opportunities. They were highly assimilated into American culture and settled primarily in the Northeast. Following World War I, the Immigration Act of 1924 significantly curtailed the flow of immigrants, including Arabs, into the USA. Immigration was capped at an annual quota of 2% of the population. Further, 1920s immigration laws and regulations favored immigrants from Britain, Ireland, and Northern Europe over those from Eastern Europe, Southern Europe, and other parts of the world.

The second wave of Arab immigrants to the USA was from 1948 until the mid-1960s. These immigrants mostly came from Israel and the Palestinian territories. This group was comprised of relatively more Muslims who came seeking refuge from conflicts in the Middle East. The Immigration Act of 1965 substantially changed US immigration law by abolishing quotas based upon national origin, establishing rules that favored family reunification, and reducing barriers faced by non-European immigrants.

Against the backdrop of a more open US immigration policy and increasing upheaval in the Middle East, the third wave of Arab immigrants began in 1967, following the 1967 Arab–Israeli War, and has continued to the present. This group comes from various countries, is predominantly Muslim, and has primarily come to escape economic, social, and political turmoil in their countries of origin. The second and third waves of immigrants have been assimilated less completely than the first wave.

Arab-American Acculturation

Acculturation is defined by Merriam-Webster in relevant part as “cultural modification of an individual, group, or people by adapting to or borrowing traits from another culture" or "a merging of cultures as a result of prolonged contact." The process of acculturation can be categorized into three types: assimilation, integration, and marginalization. Assimilation occurs when the immigrant becomes subsumed by the new culture to the exclusion of the native culture. Integration occurs when the immigrant accepts the new culture while retaining her native culture. Marginalization occurs when the immigrant feels as though he does not belong to either culture. Acculturation problems are potentially linked to poorer mental health and are sometimes the focus of treatment. In fact, the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision* (*DSM IV-TR*) recognizes "Acculturation Problem" as a potential focus of treatment.

Acculturation heavily depends on how integrated an individual is into his or her host country. Factors associated with successful acculturation in Arab immigrants include earlier age at immigration, a lack of recent travel to homeland, Christian religion, being US-born, fluency in English, and overall length of time spent in the USA (greater than 10 years).

Jack Shaheen's book, *Reel Bad Arabs: How Hollywood Vilifies a People*, focused on the portrayal of Arabs in films. Shaheen suggests that the nation has been inundated with images of Arabs as being perpetrators of terror and other negative connotations, while positive imagery of Arabs is lacking. In addition, the September 11, 2001, terrorist attacks and subsequent terrorism has led to increased negative stigma of Arab-Americans, many of whom came to the USA to escape terrorism or other forms of violence in their countries of origin. Experiencing discrimination has been linked to poor health outcomes and poor birth outcomes. Further studies are needed to examine more thoroughly the relationship between acculturation and health outcomes for both physical and mental illnesses in Arab-Americans.

Arab-American Health Status

In 2000 and 2001, the National Health Interview Surveys (NHIS), conducted by the US Census Bureau, was administered to Americans of European origin and Arab-Americans. Most of the previous studies suggested that immigrants of Arab descent were of poorer health than European Americans. However, these studies were limited by the fact that they were primarily conducted in southeast Michigan, where there is a preponderance of recent immigrants of lower socioeconomic status. The NHIS survey included 85,707 native-born non-Hispanic Whites, and 481 foreign-born Arab-Americans. Prior to the accumulation of the NHIS data, Arab immigrants were believed to have a higher incidence of hypertension, diabetes mellitus, and obesity than US-born non-Hispanic Whites. The study concluded that nationwide, Arab-Americans did not have poorer health outcomes than US-born non-Hispanic Whites. The following factors were associated with similar or improved health status in Arab-Americans compared with native-born non-Hispanic White Americans: noncitizenry, higher education, employment, annual income greater than $20,000, and the presence of health insurance. Conversely, US citizenship, lack of higher education (educational level less than high school), lack of employment, annual income less than $20,000, and lack of access to health care were associated with worse outcomes than the native-born non-Hispanic White cohort. The use of self-report without any objective corroborating evidence is a significant limitation of the NHIS survey. In a review article of 34 peer-reviewed studies of Arab-Americans' physical and mental health, El-Sayed and Galea highlight the presence of conflicting data, especially regarding the prevalence of diabetes and hypertension.

Mental Health

The mental health status of Arab-Americans is difficult to study because there are many barriers that prevent Arab-Americans from seeking mental health treatment. First, Arab-Americans, as a group, tend to hold negative views of mental illness. It is sometimes viewed as a moral flaw or divine punishment. For example, one of the authors (SS) treated an Arab-American patient who only came to treatment for severe depression after several months of prayer with his local religious leader. In fact, when he did not improve, the patient actually considered religious conversion before he considered mental health treatment. There are also culturally based beliefs about mental illness in the Arab-American community that transcend religious differences. One such belief is that mental illness is the result of the "evil eye." One variant of this belief is that the victim of mental illness was in effect cursed by a jealous person. Individuals who flaunt their success or wealth are often warned by family and friends about incurring the “evil eye,” which is believed to always lead to misfortune, such as a loss of health or property. Second, psychiatrists and other mental health providers often encourage patients to discuss their family background and ask about traumatic childhood experiences, usually during the initial diagnostic interview. Arab-American patients are often reluctant to discuss family information with outsiders, seeing the family, rather than the individual, as the most critical unit. Third, Arab-Americans may have a general unfamiliarity with Western approaches to psychiatry, which place an emphasis on the individual, rather than the family unit, as is the norm in Arab culture. Fourth, Arab-Americans often express emotional symptoms in physical terms. This may be due in part to the deeply ingrained negative attitudes about mental illness.

As with other patients, Arab-Americans who have been exposed to traumatic experiences in their countries of origin are at greater risk for posttraumatic stress disorder (PTSD). Intuitively, the prevalence is expected to vary significantly among Arab-Americans depending on the time and circumstances of immigration. There is a wide range of traumatic experiences that Arab-Americans may have been exposed to in their countries of origin, including war, atrocities committed by local governments, religious and sectarian violence, and terrorism. Some traumatic experiences may carry a greater risk of PTSD than others. For example, a study of 91 Palestinian children who had been exposed to home bombardment and demolition compared with a group who had been exposed to other traumas found higher levels of posttraumatic stress disorder among the children who had been exposed to home bombardment.

In a sample of 187 Arab-American mental health patients, Jamil and colleagues reported that the most common primary psychiatric diagnosis was depressive disorders, occurring in about half of the patients (49.9%). Anxiety disorders (other than PTSD) occurred in 12.5% of the patients, and schizophrenia was the primary diagnosis in 12.3%. PTSD was the primary diagnosis in 8.8% of the patients, but the rate among Iraqi refugees was nearly double that (16.7%). Of note, this study was conducted in 2002 and therefore measured rates of PTSD among Iraqi refuges following the 1991 rather than the 2003 Iraq war.

The data suggest that Arab-Americans, especially recent immigrants, may be at greater risk for PTSD due to the current social and political turmoil in the Middle East. Further, the prevalence of other mental illnesses may be underreported because of the many cultural barriers to seeking mental health treatment among Arab-Americans. More studies are needed to further define the prevalence of mental illness among Arab-Americans and the unique ways in which mental illness manifests itself.

Addiction

Substance abuse and dependence studies in Arab-Americans are currently in their infancy. A study examining a group of Muslim immigrant males in the Midwest who had been referred through the court for mandated substance abuse treatment is the first to describe an association between an increased level of acculturation and polysubstance abuse. Factors associated with polysubstance abuse compared with abuse of a single substance included fluency in English and greater time in the USA. Alcohol was the primary substance of abuse in 91% of the 156 men studied. Those who used more than one substance were likely to use alcohol as the main substance of abuse at 76.3%, then marijuana at 20.5%, followed by cocaine at 15.4%. Arab-Americans have a significantly higher prevalence of nicotine use, with one survey reporting 39% of Arab immigrants using tobacco while non-Hispanic Whites had a prevalence of 29%.

A Culturally Competent Approach to Arab-Americans

Translating descriptive data about Arab-Americans into practical suggestions for working with them is challenging due to the lack of controlled trials of different assessment and treatment strategies. However, clinical experience and the limited available evidence offer some guidance.

The assessment of Arab-American patients should take into account age, education level, time of immigration (if not born in the USA), country of origin, and reason for immigration. In addition, exposure to traumatic events in the country of origin or in the USA should be taken into account. Feelings of rejection by the host culture and by the culture of origin should be explored in detail as they have been correlated with increased risk for mental illness. Family and community support should also be assessed.

The treatment of Arab-American patients should also take into account cultural and religious factors. The importance of the family unit over the individual is a feature of Arab-American culture that transcends religious differences. Thus, it is not uncommon for Arab-Americans to wish to involve family members and even extended family members in the treatment. Individuation from the family should not, in general, be used to gauge psychological maturity as it sometimes is in western cultures. Arab families tend to remain close well into adulthood. It is not unusual for extended family members to live in the same home or nearby such as in the same apartment building and to be closely involved in daily life activities. The frequency and duration of treatment should be explicitly stated. Al-Krenawi and Graham have postulated that more directive treatment approaches are more effective in Arab-Americans. While all of the above factors are important to consider, the assessment and treatment must be tailored to the individual needs of the patient.

Conclusion

Arab-Americans are a diverse group of immigrants. They face a significant risk of having been exposed to traumatic experiences in their countries of origin and of discrimination in their host country. They face unique physical and mental health challenges and require culturally competent approaches to assessment and treatment.

Related Topics

- ► Asian Americans
- ► Assimilation
- ► Barriers to care
- ► Chaldean Americans
- ► Christianity
- ► Discrimination
- ► Islam
- ► Latinos
- ► Muslim
- ► Posttraumatic stress disorder
- ► Trauma exposure

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Argentina

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Introduction

In the sixteenth century, Spanish explorers visited the region that is now Argentina; in 1580, they established a permanent colony in what is now Buenos Aires. In 1776, Spain created the Vice-Royalty of Río de la Plata, and Argentina became a flourishing port and an integral part of the Empire. In 1816, the United Provinces of the Rio Plata declared their independence from Spain. Bolivia, Paraguay, and Uruguay vacated the region, and the area that remained became Argentina. Argentina's population and culture were influenced greatly by European immigrants, particularly those from Italy and Spain. Combined, from 1860 to 1930, they provided the largest percentage of immigrants to the young country.

Geography

Argentina is the second largest country in Latin America, its 2,780,400 sq. km occupies most of the southern part of the South American continent. It is bounded by the Atlantic Ocean in the east and south; its neighbors are Brazil and Uruguay to the northeast and east, Bolivia and Paraguay to the north, and Chile to the west. The terrain is made up mostly of flatlands, although it features some mountain ranges and tablelands situated at a high altitude, the most famous being the Andes with its highest peak Aconcagua. By total area, Argentina is the eighth largest country in the world; it is slightly less than three-tenths the size of the United States.

Climate

Although Argentina's climate is temperate generally, there are great variations, including extreme heat in the northern Chaco region, a mild climate in the central pampas, to the subantarctic cold of the glacial regions of southern Patagonia. The wide variations of climate are owing to the country's range in altitude and to its large expanse of land. Recorded in the extreme north, the highest temperature on record in Argentina is 49°C (120°F). Conversely, recorded in the southern tip of Argentina, the lowest temperature on record is −16°C (3°F). Rainfall diminishes from east to west; at Buenos Aires it averages 94 cm (37 in.) annually, and the average annual temperature is 16°C (61°F). January is the warmest month and June and July are the coldest. North of the Río Negro, the winter months (May–August) are the driest period of the year.

Politics

On July 9, 1816, under the leadership of José de San Martin, Argentina formally declared its independence from Spain. A protracted period followed of conflict between federalist and centralist forces, and the Constitution of the Argentine Republic was not written until 1853. Conservative forces dominated until 1916, when – in Argentina's first free popular election – Hipolito Yrigoyen, the candidate of the Radical Civic Union, was elected president. In 1930, Yrigoyen was overthrown by a military coup, a catalyst for the subsequent pattern in Argentine political history of alternating civilian and military governments. After a failed bid to seize the Falkland (Malvinas) Islands by force, democracy returned in 1983 and has persisted despite numerous challenges.

Education

All children in Argentina who are between the ages of 6 and 14 are required by law to attend school. High school education is affordable and available generally, although attendance falls by roughly 50% among those older than 14. There are state and private schools, and primary and secondary schools; those in the city areas are better equipped usually than those in the country. School curriculum is similar to that in Australia and includes science, mathematics, languages, art, history, sports, and geography. Among Latin American countries Argentina has the highest levels of education and literacy. The country's public university system is free of charge also. The university system is comprised of nearly 70 institutions, divided equally between national institutions, public institutions, and private institutions.

Health

National health policy in Argentina is determined by the Department of Public Health, an agency of the Ministry of Social Welfare. In 1998, Argentina had an estimated 108,800 physicians, 28,900 dentists, 15,300 pharmacists, 29,000 nurses, and 11,100 medical technicians. There were an estimated 2.7 doctors per 1,000 people as of 1999. In 2000, 79% of the population had access to safe drinking water and 85% had adequate sanitation. Health and medical services for workers are provided by clinics of unions, and employers are usually required to provide free medical and pharmaceutical care for injured workers. The private sector plays a role in providing health services, ensuring social security through organizations called Obras Sociales. Funding for health services comes from employee payroll taxes and contributions.

According to the World Health Organization, there are currently 39, 134,000 people in Argentina. The life expectancy at birth today is 72 for males and 78 for females. Per 1,000 live births, the probability of dying under age 5 is 17, while the probability of dying between 15 and 60 years is 162 for males and 86 for females. The total expenditure on health as a percentage of GDP is 10.1.

Of the major infectious diseases, smallpox, malaria, and diphtheria have been nearly eliminated, and poliomyelitis has been reduced significantly. The incidence of tuberculosis in 1999 was 55 per 100,000 people, down 47% from 20 years earlier. The HIV rate was 0.69 per 100 adults in 1999, when a total of 130,000 people were infected. Argentina reported the second-highest incidence of AIDS cases (41 per million) in South America during the mid-1990s.

Immigration

For much of its history, Argentina was a country of immigration, welcoming millions of immigrants, many from Spain and Italy. Recent economic, political, and social instability, however, have seen Argentina in a state of immigration, emigration, and transit. Since the 1990s, dismal employment prospects combined with intense foreign-labor demand has given rise to increased emigration to countries such as the United States, Spain, Italy, and Israel. In a 5-year period during the early 2000s, an estimated 300,000 persons emigrated from Argentina. Despite those recent trends, however, Argentina's strong demand for predominantly unskilled, low-wage labor ensures its role as a regional immigration hub.

Related Topics

- ► Hispanics
- ► Labor migration
- ► Latinos

Suggested Readings

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World Health Organization. For information on Argentina from the World Health Organization. http://www.who.int/countries/arg/en/

Arthritis

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According to the Centers for Disease Control & Prevention, an estimated 50 million people (1 in 5) in the USA have been diagnosed with arthritis by a physician. By 2020 the prevalence will increase to 60 million. In the USA, arthritis is the most common cause of disability and limits the activity of approximately 21 million people. Increased public awareness about arthritis may help improve early diagnosis and management.

Arthritis is joint inflammation associated with pain and stiffness in one or more joints. Mild forms of arthritis may be self-limited and require only reassurance and symptomatic treatment. Progressive forms of arthritis need further evaluation to obtain appropriate diagnosis, long-term management, and symptomatic treatment to reduce disability and morbidity. Aggressive forms such as infectious arthritis (septic arthritis) require urgent attention to avoid permanent joint destruction and disability. Arthritis is classified based on the number of joints, such as monoarticular, if one joint is involved and polyarticular if more than two joints are involved. Further classification is based on the pathologic process, such as inflammatory, non-inflammatory, crystal-induced, and infectious. A few examples of these classification types will be discussed: osteoarthritis, rheumatoid arthritis, gout, and septic arthritis.

Osteoarthritis is non-inflammatory and the most common arthritis. Key features of osteoarthritis include joint stiffness lasting less than 15 min that improves with rest and worsens with activity or weight bearing, minimal joint effusion, and lack of systemic manifestations. Risk factors for osteoarthritis include age greater than 40, repetitive joint use, joint trauma, and obesity. There are two forms of osteoarthritis: primary and secondary. The primary form is idiopathic and more common than the secondary form, which is due to an underlying cause. In primary osteoarthritis weight bearing joints are affected, such as knees, hips, and spine and other joints include hands and shoulders. Some causes of secondary osteoarthritis are joint overuse, neurologic disorders, metabolic disease, and trauma.

Excessive joint loading or abnormal cartilage/bones results in the cartilage loss and bone remodeling seen in osteoarthritis. In addition, osteophytes (bone spurs) and bone overgrowth around the joint can restrict joint movement. Management of osteoarthritis can include medication, physical activity, joint protection, physical or occupational therapy, rest, and weight loss. Medications can include acetaminophen, nonsteroidal anti-inflammatory drugs (NSAIDs), glucosamine and chondroitin sulfate. Surgical joint replacement is reserved for severe cases.

Rheumatoid arthritis (RA) is a chronic inflammatory arthritis which results in proliferation of the synovium, thickening of the joint capsule, and subsequent bone and cartilage destruction. Small joints frequently affected are the hands, elbows, knees, and ankles. In some cases involvement of the atlantoaxial joint (spinal bone at the base of the skull) leads to subluxation (dislocation) with spinal cord compression. Typical symptoms include joint swelling, tenderness, and limited range of motion. Generalized weakness, fatigue, and anorexia are common systemic symptoms in early rheumatoid arthritis. Other organ involvement can occur due to the systemic nature of rheumatoid arthritis.

The American College of Rheumatology established guidelines, which require at least four out of seven criteria for the diagnosis of rheumatoid arthritis. The seven criteria include: (1) morning joint stiffness which lasts at least for 1 h, (2) at least three or more joint areas affected by arthritis, (3) arthritis in the hand joints, (4) involvement of joints in a symmetric distribution, (5) firm nontender subcutaneous nodules (rheumatoid nodules), (6) positive serum rheumatoid factor, and (7) bony erosions in hands and wrists on x-rays.

First line medications aim to control pain and minimize inflammation with NSAIDs. Glucocorticoids are second line medications which aim to suppress inflammation and disease progression. Third line medications are disease modifying anti-rheumatic drugs (DMARDs), fourth line medications are cytokine-neutralizing agents, fifth line medications are immunosuppressive/cytotoxic agents, which are used to mitigate disease progression.

Gout is a crystal-induced arthritis (metabolic disease) which results in abnormal amounts of urate in the serum and affects mostly middle-aged men (over age 30), elderly men, and postmenopausal women. Acute gouty arthritis is typically monoarticular; however, in long-standing disease it presents as asymmetric polyarticular arthritis. Classically, acute gout presents with sudden pain at night localized in the great toe (podagra). Other involved joints and tophi (urate crystal soft tissue deposits) locations include the hands, elbow, knees, and ankles. The two forms of gout are primary and secondary. Primary gout is rare, caused by a genetic defect and secondary gout is the result of an underlying cause such as high ethanol intake. Rapid changes in urate serum levels, ethanol, high purine diet, or serious medical illness are common triggers for acute gout attacks.

Identification of urate crystals in synovial joint fluid or tophi is diagnostic for gout. Infection and gout can co-exist, thus, the synovial fluid should be analyzed accordingly. Medical treatment for acute attacks includes anti-inflammatory agents such as colchicine or NSAIDs; traditionally indomethacin is effective in 90% of patients. Oral glucocorticoids can be used if NSAIDs are contraindicated and as an alternative if NSAIDs are ineffective. Prophylactic management includes a low-purine diet, limited ethanol, and weight loss. If these measures fail to lower urate levels, then hypouricemic medications are used. Urate overproducers are treated with allopurinol and underexcreters are treated with probenecid.

Infectious arthritis (septic arthritis) is an aggressive acute arthritis which warrants urgent evaluation to prevent joint destruction, instability, deformity, and degenerative arthritis. The port of entry for infection is generally hematogenous (via the blood stream), direct extension from an adjacent infection, or inoculation from a penetrating procedure or injury. Within 48 h cartilaginous destruction can develop. Etiologies of infectious arthritis include mycobacteria, fungi, viruses, and bacteria such as *Staphylococcus aureus* and *Neisseria gonorrhoeae*. Generally, 90% of acute cases are monoarticular. Mycobacteria or fungi are associated with subacute or chronic monoarticular infections. Syphilis, reactive arthritis, and Lyme disease are associated with periodic inflammation, while *Pasteurella multocida* is associated with an animal bite or scratch. Key features of acute bacterial arthritis are sudden onset of monoarticular joint pain in a large weight bearing joint, elbow or wrist, accompanied with a joint effusion, severe pain, redness, limited range of motion, and fever. Definitive diagnosis is based on identification of a pathogen on the smear and/or culture. In order to prevent joint destruction, immediate synovial fluid studies, joint drainage, and systemic antibiotics are critical.

In summary, osteoarthritis, rheumatoid arthritis, gout, and septic arthritis are only a few of the many types of arthritis. There are limited data on arthritis particular to immigrant groups. However, the challenges that immigrant groups face with respect to health care access and the greater likelihood of undiagnosed infections in these populations both suggest that arthritis may well be a concern in these groups. Public awareness regarding arthritis may help reduce disability, and in the context of immigrants, physician sensitivity to the potential for arthritis is warranted. Several public health initiatives on education, prevention, and management are outlined in the 1999 *National Arthritis Action Plan: A Public Health Strategy*. Many federal and state agencies, organizations, and communities have partnered to continue to implement these national arthritis-related objectives.

Related Topics

► Access to care
► Back pain

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Asia

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History

Usage of the term “Asia” became common in ancient Greece. In antiquity the continent was presumed not to extend past India. Asia’s coastal margin was home to some of the world’s earliest known civilizations, including those that developed in Mesopotamia, the Indus Valley, and the Huanghe. These civilizations may have exchanged discoveries such as mathematics and the wheel, while other creations appear to have been developed individually in each area. Cities, states, and empires developed in these lowlands.

Geography

Because the borders of the landmass are ambiguous, typically Asia is defined from the standpoint of both a cultural concept and a physical entity. Asia is a subregion of the super-continent Eurasia, which contains portions of Europe and Asia. The continent is comprised of eight regions: Central Asia, the Iranian Plateau, East Asia, the Far East, North Asia, South Asia, Southeast Asia, and West Asia.

It is characterized as the largest continent, containing approximately 30% of the world's landmass. It includes nearly 50 countries, assorted islands, and/or dependencies – although there is some disagreement over its boundaries. Mountains and plateaus comprise much of the continent, with the highest mountains located in Central Asia and north of the Indian subcontinent. Asia's significant features include the world's tallest mountain, Mt Everest, rising to 8,850 m, and the world's lowest point, found in the Dead Sea, at 392 m below sea level. The continent is bounded by three oceans: the Arctic, Pacific, and Indian. The western boundary is formed by a combination of Europe; the eastern Ural Mountains; the Caspian, Black, Aegean, Mediterranean, and Red Seas; and the Suez Canal. Asia is formed also by the islands of Sri Lanka, Taiwan, Indonesia's archipelagoes (excluding New Guinea), the Philippines, and Japan. The continent covers 44,614,000 sq. km and has a population estimated at 3,879,659,000.

Asia includes the most populated countries in the world, China and India. As of mid-2008, China had a population of over 1.3 billion people. As the country represents a full 20% of the world's population, approximately one out of every five persons on the planet is a resident of China. India, the world's second most populated country, has approximately 1.18 billion residents. Asia has approximately four billion people, hosting roughly 60% of the world's current population, and during the twentieth century the population nearly quadrupled.

Culture and Economy

While Asia is culturally diverse, there are five main cultural influences: Chinese, Indian, Islamic, European, and Central Asian. China has had the greatest influence in East Asia, from which originated Confucianism, artistic styles, and the Chinese writing system. Indian influence has manifested in Hinduism and Buddhism, impacting the Tibet Autonomous Region of China, Indonesia, Cambodia, and Central Asia.

Asia has five principle language groups including Sino-Tibetan, Indo-Aryan, Austronesian, Austro-Asiatic, and Semitic, while key singular languages include Japanese and Korean. East Asia contains three main ethnic groups: Chinese, Japanese, and Korean. The Indian subcontinent is extremely diverse; the majority of the people speak languages from the Indo-Aryan subgroup of the Indo-European family. Owing to the influence of China and the former Soviet Union, the Mandarin Chinese dialect and the Russian language are used widely.

The world's major religions have origins found in Asia. Hinduism originated in southern Asia; Buddhism and Jainism emerged in the fifth and sixth centuries BC. Judaism, Christianity, and Islam are traced to Southwest Asia. Daoism and Confucianism, originating also in the fifth or sixth century BC, have profoundly influenced Chinese culture and the cultures of surrounding peoples.

Asia is home to four major financial centers including Tokyo, Hong Kong, Singapore, and Shanghai. Due to the availability of a large pool of skilled English-speaking workers, call centers and business process outsourcings (BPOs) are becoming major employers in India and the Philippines. Due to extremely competitive information technology industry, India has become a major hub for outsourcing.

As in most regions of the world, there are great disparities in wealth. This is true especially of Asia due to its tremendous size and range of cultures, environments, historical ties, and political systems. The largest economies in Asia, in terms of gross domestic product, are China, Japan, India, South Korea, Indonesia, and Iran. If examining wealth as measured by gross domestic product per capita, it is mostly concentrated in East Asian territories such as Hong Kong, Japan, South Korea, Singapore, and Taiwan, and in the oil-rich Middle Eastern countries of Iran, Saudi Arabia, Qatar, and United Arab Emirates. China and India are the two most rapidly growing economies in the world, and much of Asia is currently experiencing rapid growth and industrialization. For economic growth, East Asian and Southeast Asian countries rely generally on manufacturing and trade, while countries in the Middle East depend more on the production of commodities, chiefly oil. With rapid economic growth and a large trade surplus with the rest of the world, Asia has accumulated more than half the world's total of foreign exchange reserves.

Politics

Asia's political landscape is continually evolving and diverse, including multi-party democracies and some of the world's most repressive regimes. Asia has three important recognized political divisions: The Middle East, Southeast Asia, and North Asia. While historical mistrust has the potential to explode rivalries into conflict, the creation of cooperative endeavors offers new opportunities for peace.

Health

Health measures for Asia vary dramatically. The World Health Organization uses the Human Development Index (HDI) as a composite statistic to rank countries by level of human development. The statistic is composed from data on life expectancy, access to knowledge (mean years of school and expected years of schooling), and standard of living (per-capita Gross National Income). East Asia has the strongest overall HDI performance of any region in the world; it has nearly doubled in average HDI attainment over the past 40 years. China is the second highest achiever in the world in terms of HDI improvement since 1970; its per capita income increased a stunning 21-fold over the last 4 decades. However, China was not among the top performance in improving school enrollment and life expectancy.

Mainly due to health and education achievements, Nepal, a South Asian country, is one of the world's fastest movers since 1970. The present life expectancy is 25 years longer than the 1970s, and more than four of every five school-age children now attend primary school – compared to just one in five 40 years ago. Out of the 169 countries assessed, Japan and South Korea currently rank highest, number 11 and 12 in the world, followed by Hong Kong, China, and Singapore. Afghanistan ranked lowest among Asian countries

Related Topics

► Cambodia
► Chinese
► East Asians
► Gujaratis
► India
► Japan
► Korea
► Labor migration
► Pakistan
► Philippines
► South Asians
► Southeast Asia
► Tajikistan
► Tamils
► Thailand
► Vietnam

Suggested Readings

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Suggested Resources

For information on emigration policy. http://www.migrationpolicy.org/
For information on environmental health in Southeast and East Asian countries. http://www.environment-health.asia/
World Health Organization. For information on South-East Asia from the World Health Organization. http://www.searo.who.int/

Asian Americans

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The conceptualization of the term "Asian American" is a fairly recent development due in part to the 1965 Immigration Reform Act. As a social construct, this term attempts to categorize people from East and Southeast Asia. Accordingly, six groups (Indian, Chinese, Filipino, Japanese, Korean, and Vietnamese) in the USA make up about 90% of all Asian Americans. The attempt to create a collectivity based on assumed commonalities often masks the actual differences in languages, cultures, histories, etc., and thus the immigrants' modes of incorporation and associated outcomes. For example, although about one out of three Asian Americans was native-born, Japanese Americans have the highest proportions of native-born persons

(58%) while Koreans have the lowest (24%) among the Asian subgroups. A general trend among the Asian American literature is the paucity of data that look at individual Asian American groups and what each group looks like over time.

The top three leading causes of death for Asian Americans in 2006 were cancer (malignant neoplasms), heart diseases, and brain complications (cerebrovascular diseases). Asian Americans tend to be disproportionately affected by cancers of the liver, breast, cervix, and stomach with respect to other racial groups (Whites, Blacks, and Latinos). Liver and stomach cancer rates among Asian Americans were the highest among all races for both men and women and cancer was the leading cause of death among Asian American women in the USA. In general, there was a positive association for Asian males and females regarding age and deaths per 100,000. Further, the frequency of deaths per 100,000 due to HIV were rather small for males (1–2) and females (the rates were so small that some accounts were deemed "unreliable"). In contrast, for Black Americans, the rates fluctuated from 12.2 to 61.4 depending upon the age group and sex. Though it may appear useful to speak of Asian American health outcomes, it is important to couch this discussion within their modes of incorporation in America.

Assimilation and Health

The traditional model of assimilation has been used with respect to European (White) immigrants. Due to the National Origins Quota Act (1921 and revised in 1924), non-White immigration was essentially stalled until 1965. Thus, White modes of incorporation are depicted by terms such as "assimilation," "straight-line assimilation," "pressure-cooking assimilation," "melting pot," and "triple-melting pot." For the greater part of the twentieth century, it was assumed that as White immigrants broke away from their country of origin and amalgamated into "White Americans" that they would progressively (inter- and intragenerationally) achieve higher levels of socioeconomic status (SES). In fact, classical assimilation models posited that as individual differences replaced group differences, one's life chances (thus health) would improve.

However, non-White modes of incorporation do not fit the traditional European models. Color precludes structural assimilation. Thus, terms such as "selective acculturation," "segmented assimilation," "ethnic enclaves," and "negative acculturation" are used to depict the Asian American modes of incorporation. Acculturation is a conceptualization of how acclimated one becomes in "American" culture. In some contexts, ethnicity and culture serve as a form of capital that is beneficial to health outcomes and post-immigration adjustments. At other times, retaining ethnicity and culture can become a hindrance to positive health outcomes. Further, the "push" and "pull" factors on post-1965 Asian immigrants can be very (self-) selective. Thus, different Asian American waves have unique contexts of departure and entry which in turn impact their health.

One measure of acculturation for Asian Americans is English proficiency. Japanese Americans are the most likely to have the highest median age and to speak only English at home. Indians and Vietnamese have the highest proportions of children under the age of 18 who speak another language than English at home. Over three out of five Asian Americans who are 5 years old or older, use only English at home or speak English very well. Although 77% of Asian Americans use another language than English at home, the range spanned from 47% (Japanese Americans) to 88% (Vietnamese). Around 35% of Asian Americans are deemed to have "limited English proficiency" (LEP). Some studies found that LEP is associated with psychiatric disorders for men but not for women. Language and cultural compatibility between the patient and caregiver have also been attributed to low rates of health utilization among Asian Americans. This may lead to the seeking of health services when the health condition becomes very severe. Asian Americans also tend to receive less medical counseling from their physicians and report lower favorable interactions than their White counterparts.

Health Patterns Among Native- and Foreign-Born Asian Americans

About 70% of Asian Americans are US citizens (via birth or naturalization). Around half of foreign-born Asian Americans arrived since 1990 and one out of three arrived in the 1990s. Foreign-born Asian Americans tend to evince better health patterns than their native-born counterparts. These disparities are especially pronounced prior to emigration but the differences shrink after immigration via acculturation processes. Some studies have found that intergenerational conflicts are associated with greater rates of depression for the second generation. Foreign-born Asian (and Hispanic) Americans appear to have better psychological dispositions and less behavioral disorders than native-born Asian Americans. For example, native-born Asian (and Hispanic) adolescents are more than twice as likely to be obese than their foreign-born counterparts. In general, pre-immigrants tend to have lower levels of obesity than those who have been acculturated in America. Yet, these weight differentials tend to disappear after 15 years as increased time in the USA is associated with poorer health and greater odds of obesity. Some studies claim that about 40% of the Asian women who came to the USA at age 18 or later would eventually gain over 20 pounds. In a study from 1976 to 1980, 15% of Asian American adults were considered obese. This proportion increased to 35% in 2005–2006. Further, under the same time frames, children aged 6–11 and adolescents aged 12–19 also experienced substantial increased obesity rates, from 7% to 15% and 5% to 18%, respectively.

In general, there is a positive association among first- and second-generation Asian Americans regarding duration in the USA and poorer health (mental and physical). Ten years appears to be a benchmark regarding duration in the USA and the positive correlation between linguistic discrimination and mental health and depression; for those who have lived in the USA for 10 years or longer, the greater the propensity of poorer health. It is possible that those who have been in the USA for less than 10 years did not recognize when discriminatory acts were leveled against them. Although Asian American adults and youths tend to use mental health services at a lower rate than other racial groups, the native-born are more likely than the foreign-born to seek psychological help. Further research is required to determine whether this difference is due to cultural differences (a stigma factor) or actual mental health differences. Another level of complexity concerning acculturation and health outcomes is that acculturation does not work in the same direction for the first and second (and third) generations.

Various studies posit that Asian American elders are among the fastest growing elderly population. Three common barriers in accessing adequate health care among the elderly were the absence of health insurance, mobility, and language. This group also tends to have higher rates of depression than their non-Asian elder counterparts. Among the elderly (65 and over), Asian women had the highest rates of suicide in their age category among all racial groups. Whereas some studies showed that Asian American females between the ages of 14 and 24 also had the highest rates of suicide in their age category among all racial groups, other studies placed native Americans as the leading group, followed by Asian Americans. In contrast, Asian males (and Black females) had the lowest rates among all races in 2006 with their respective sex. Since these Asians have a bifurcated distribution regarding SES, further disaggregated data is needed to make more definitive conclusions.

For example, first-generation Korean Americans, when controlling for SES, have a negative correlation with acculturation and depressive symptoms. Thus, higher levels of acculturation are associated with lower levels of depressive symptoms. Smoking is another example that shows the generational complexity of acculturation and health outcomes. Asian American mothers were the least likely among all racial categories to have smoked (2.4% versus 12.2% of all mothers). Studies have found that cigarette smoking is linked with low (less than 2,500 g) and very low (less than 1,500 g) birthweight. Interestingly, when using 12 years of education as a baseline (less than, equal to, and greater than) for all racial groups except Asians, the greater the level of education the lower the rates for low birthweight. However, for Asians, greater levels of education increased the odds for low birthweight.

Lower acculturation among first-generation Asian Americans has also been found to be associated with higher levels of smoking. However, for the second generation (males and females), higher acculturation was associated with higher levels of smoking. Among Asian subgroups, it has been estimated that over 70% of the Laotian and Cambodian men are current smokers. Studies have also found that the greater the duration an Asian female has resided in the USA, the greater the number of cigarettes she would smoke per day. Nonetheless, in a study conducted from 2005 to 2007, Asian men (17.2%) and Asian women (4.8%) were found to have the lowest proportions of those who were current smokers among all racial groups, with their respective sexes. In 2007, Asian Americans were also the least likely to report having used tobacco products, alcohol, and any illegal drug among all racial groups.

Thus, although Asian immigrants tend to have better health prior to their entrance into the USA, their health behaviors and outcomes appear to mirror the general population of Americans over time. Asian immigrants tend to gain weight as their health habits drift toward the consumption of foods with higher fat and sugar while physical activity diminishes. Filipinos have the greatest proportions of overweight and obese persons among all Asians. In 2007, about 40% of Asian Americans self-reported that they were physically inactive and 30% claimed that they were engaged in semiregular or regular physical activities. Interestingly, although studies show poorer health from the first to the second generation, the third generation does not appear to have significant differences in health with respect to their American counterparts. These findings are consistent with regard to educational attainment as well. Whereas second-generation Asians evince bifurcation ("model minority" and "culture of poverty"), there are relatively fewer differences between the third generation and their White counterparts. This is important because education and health have been found to have a positive correlation.

However, it is not just the duration of time (post-immigration) that affects immigrant health. The particular life stage at the time of entry may also affect health outcomes. Some studies have found that Asian Americans who arrived in the USA between the ages of 18 and 40 were less likely than those who arrived before the age of 18 and those who arrived after the age of 40 to experience substance abuse and mental disorders, even when controlling for sex and length of residence. Regarding Asian males and the risk of adolescent substance abuse, the native-born evinced the highest odds, followed by the 1.25 (individuals who arrived between the ages of 13 and 17) and then the 1.5 (individuals who arrived between the ages of 6 and 12) generations.

Socioeconomic Status and Health

Further, using SES (particularly education) to measure health outcomes for Asian Americans can be problematic for two reasons. First, Asian Americans are mistakenly identified as a "model minority" that conflates structural factors with (positive) cultural values. Second, Asian Americans are bifurcated regarding life chances in general and in education in particular. Among those who were 25 or older, about one out of five Asian Americans had a graduate or professional degree, compared to 10% of the general population. It would appear that Asians are highly educated but this is one end of the spectrum. Using a bachelor's degree as an educational measure, Indian Americans represented the high end (68% had at least a bachelor's degree) and Vietnamese Americans represented the other end (26% had at least a bachelor's degree). Similar to evincing a "high" level of educational attainment, Asian Americans had the highest median household (not individual) income among all racial groups ($61,094 in 2005). Again, by disaggregating Asian Americans via subgroups, Indians showed one end ($73,575) while Vietnamese showed the other end ($50,925). Based on 2004 data, Indians (alone) had the highest and Koreans (alone) had the lowest.

In 2004, about 12% of all Asians lived below the poverty level. However, those under the age of 18 had a rate of 13.2% (below the poverty level) and those who were 65 and older had a rate of 12.8%. Further, there is significant variation among the subgroups who fall below the poverty level: all ages (Filipino 5.2% and Korean 14.9%), under 18 (Japanese 5.7% and Vietnamese 17.1%), and 65 and older (Japanese 5.9% and Korean 19.2%). In 2007, 12.5% of the US population fell below the poverty line. Further, regarding all Asians, under 18, 18–64, and 65 and over, the respective poverty rates were 10.2%, 12.5%, 9.2%, and 11.3%. Regarding all races, for the respective age groups, the poverty levels were 12.5%, 18%, 10.9%, and 9.7%. Thus, for all of the groups except for the last category (65 and over), Asians had lower proportions of poverty compared to all races. Again, one may falsely conclude that most Asians are doing better than average. Yet, some studies have shown that the Hmong have a 30% poverty rate. Disaggregated data, or looking at individual Asian groups as opposed to "Asian Americans," is important because it shows that Asians are not in fact a "model minority" but evince bifurcated patterns of income, poverty, and education, and thus health outcomes. Further, disaggregating Asian Americans is important because some researchers claim, when holding race constant, it is actually class that affects life chances and thus health outcomes. The perennial argument between race and class is, of course, not delimited to Asians in particular.

Health Insurance Coverage

Southeast (SE) Asians (represented by the Vietnamese, Laotians, Cambodians, Hmong, and Indochinese) differ in their contexts of departure from other Asian Americans who were directly impacted by the 1965 Immigration Reform Act in two ways. SE Asians arrived more recently and are more likely to be comprised of refugees and family-reunification persons. Non-SE Asians have a longer immigration history and their first waves were generally comprised of labor-recruits who became naturalized and then enacted family-reunification provisions. Thus, it is problematic to incorporate indiscriminately SE Asians within the "Asian American" rubric. Although the first waves of both groups tend to have higher SES than the latter waves, which parallel non-Asian immigration inflows, SE and non-SE Asians have different contexts of departure and arrival. Further, SE Asians tend to have lower SES which is then associated with poorer health. Some of the poorer health traits associated with SE Asians can be attributed to their contexts of departure (physical and mental traumas) as well as their low SES in the USA. Later waves of SE refugees tend to have significantly lower SES and English-language proficiency when compared to other Asian Americans. Some studies have found that SE Asian refugees experience a delayed effect with respect to mental health, usually 6–24 months after their arrival into the USA. Among the SE Asian refugees, Cambodians and Hmong evince the highest proportions of mental health problems.

In 2006, the rates of uninsured for Asians, non-Hispanic Whites, Blacks, and Hispanics were, respectively, 15.5%, 10.8%, 20.5%, and 34%. Uninsured rates varied among Asian subgroups as the Japanese had the lowest (9%) and Koreans had the highest (35.5%). Among children (under the age of 18 and ages 6–17), Asian Americans accounted for the greatest proportions of uninsured among all racial categories. That is, these children were the most likely to be uninsured based on race. Asian adults had the highest rates of lack of health coverage (24.8%) in 1993–1994, yet in 2006–2007 the uninsured rates dropped whereby they had the lowest percentage (17.3%) of uninsured adults among all racial groups.

Regarding visits to a health care provider in the past year, Asians had the highest or tied for the highest of no visits in the past year for children under 18 (14.5%), under 6 (6.9%), and ages 6–17 (18.8%) among all racial groups. However, when asked about avoiding medical care, Asians reported the lowest proportions regarding costs. That is, it does not appear that cost precluded medical attention for these youths. Concerning health care coverage via employment in 2007, Asians under the age of 65 had a rate of 64.4% which was above all races combined (61.6%) and for all other racial groups except non-Hispanic Whites (70.2%). Conversely, 15.4% of all Asian Americans reported that they had no health insurance, which although lower than all races combined (16.6%) was greater than non-Hispanic Whites (12.6%).

In conclusion, there are pros and cons in using the term "Asian American" in general, and with respect to health in particular. The term is one of nominal convenience (particularly for non-Asians) based on appearance. It is also a term used by data collectors, researchers, academics, and policy makers. Unfortunately, Asian Americans are often mistaken to be a "model minority." Not only does this belie historical and structural factors, it also reifies a culture of poverty thesis for other minorities to fall short. A further unintended consequence of this ideology is that it hides Asian subgroups who have poor health status. The reality is that because the first waves tended to be overrepresented via high SES and better health, Asian American health patterns evince bifurcation. Health trends are evinced via different Asian subgroups and also among differing waves of departure and entrance to the USA. As many researchers have noted, future disaggregated (by subgroup, longitudinal, and generational) data are needed with respect to modes of incorporation to the USA and health outcomes. Of particular interest would be the use of religion in acculturation contexts, pushing the discussion of Asian American modes of incorporation beyond the intersection of race, class, and gender, and how this impacts health outcomes.

Related Topics

- ► Access to care
- ► Acculturation
- ► Depression
- ► Discrimination
- ► Language barriers

Suggested Readings

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Trinh-Shevrin, C., Islam, N. S., & Rey, M. J. (2009). *Asian American communities and health: Context, research, policy, and action*. San Francisco: Jossey-Bass.

Yoo, H. C., Gee, G. C., & Takeuchi, D. (2009). Discrimination and health among Asian American immigrants: Disentangling racial from language discrimination. *Social Science & Medicine, 68*, 726–732.

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U.S. Department of Commerce Economics and Statistics Administration. (2007). *The American community – Asians: 2004*. Retrieved from http://www.census.gov/prod/2007pubs/acs-05.pdf

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Asian Indians

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Demographics

Asian Indians or Indian Americans are individuals of Indian ancestry. India is the seventh-largest country by geographical area, the second-most populous country with 1.18 billion people, and the most populous democracy in the world. The US Census Bureau popularized the term "Asian Indian" to avoid confusion with "American Indian." They are represented under the broader classification of Asian Americans (AA) or Asian American and Pacific Islanders (AAPI). Sometimes they are also referred to as South Asians that denotes people belonging to various countries from the Indian subcontinent (India, Pakistan, Sri Lanka, Bangladesh, and Nepal). Asian Indians are a subgroup of the Asian American population. Asian Americans are a heterogeneous group and comprise 5% (13.9 million) of the US population. According to the Census Bureau population estimate, Asian Americans are the fastest growing racial/ethnic group and expected to reach 22 million by 2050 (212% increase). However, Asian Americans are frequently aggregated as a homogenized group. This is problematic as it masks the vast diversity among the over 50 Asian American subgroups (example, Chinese, Filipinos, Asian Indians, Pakistanis, Vietnamese, Koreans, Laotians, Japanese, Cambodians, Hmong, Thais, etc.). Asian Americans, whether they are immigrants or US born, represent a diversified and rich mixture of cultures, languages, beliefs, and practices.

Asian Indians are the third largest Asian American subgroup in the United States, after Chinese Americans and Filipino Americans. They are also one of the fastest growing Asian subgroups. For example, between 1980 and 1990, the Asian Indian population in the United States grew by 126% as compared to the 108% growth of all Asian Americans combined. The growth rate of Asian Indians between 1990 and 2000 was 106% and, according to the American Community Survey of the

US Census Bureau, the Asian Indian population increased from 1,679,000 in 2000 to 2,570,000 in 2007 with a growth rate of 53%, the highest for any Asian American community and among the fastest growing Asian subgroup in the United States. According to the US Census Bureau, currently Asian Indians are 16.4% of Asian Americans living in the USA.

Most Asian Indian immigrants entered the United States in the last 30 years, following the passage of the Immigration Act of 1965 which allowed increasing numbers of Asian Indians to enter the United States. The majority (71%) are 18–64 years old, and 77% are immigrants. Despite their increasing numbers, current research on Asian American health does not adequately address the health needs of Asian Indians. The literature on health behaviors and chronic disease indicates an increase in behavioral risk factors (e.g., consumption of high fat diet and more animal products, sedentary lifestyle) as well as biological risk factors (e.g., obesity, hypertension) for chronic diseases when individuals migrate to more prosperous countries. This is true among Japanese and Hispanic immigrants to the USA. A review of current health literature shows that while there has been a fair amount of research focused on some groups of immigrants such as the Japanese, Chinese, and Filipinos, others, particularly Asian Indians, have been less studied. Current national surveys are incapable of assessing preventive health behaviors and disease prevalence in specific Asian subpopulations because multiple ethnic groups are aggregated into the general category of "Asian and Pacific Islander," and because sample sizes of individual Asian subgroups are small.

Diversity

Unlike other Asian immigrants in the USA, Asian Indians are a more diverse and distinct subgroup than other Asian immigrants originating from a single nation due to their primary languages, provincialism, religious affiliations, and caste system. There are 14 official languages and Indians come from 28 different provinces or states. Additionally, there are at least four distinct racial types and five major religions representing this group. This diversity prevents Asian Indians to form clusters like the Chinese, Japanese, and Filipinos and contributes toward their lack of visibility socially, politically, and geographically in this country. Furthermore, Asian Indians, unlike many other Asian and South American immigrant groups, do not depend upon localized ethnic networks for financial and/or occupational support due to their high educational status and professional jobs. Although localized networks for different Asian Indian communities do exist, many immigrant Asian Indians do not use them very often. Consequently they are dispersed geographically. This geographic dispersion combined with the extreme internal diversities does not encourage them to form ethnic clusters in defined geographic areas as seen among Chinese immigrants.

First generation Asian Indians tend to retain the distinct languages, culture, and religious practices of their subgroups, which inhibits the development of ethnic solidarity as seen among Chinese, Japanese, or Filipino immigrants.

Religions

While the majority of Asian Indians emigrating to the USA are Hindus, there are significant numbers of Indian Sikhs, Muslims, Christians, and Jains that enter the country. As of 2000, the American Hindu population was around a million. The religious diversity is evident from numerous (diverse) Asian Indian cultural and religious associations and various communities of Hindus, Sikhs, Jains, Buddhists, Muslims, Christians, Parsis, and Jews from India that have established their religious organizations in the United States.

The first religious center of an Indian religion to be established in the USA was a Sikh Gurudwara in Stockton, California, in 1912. However, Asian Indians who follow the Hindu religion believe themselves to be quite different from Sikhs from the state of Punjab. Today there are many Sikh Gurudwaras and Hindu, Buddhist, and Jain Temples in all the 50 states. In addition, many sects such as ISKCON, Swaminarayan Sampraday, BAPS Swaminarayan Sanstha, Chinmaya Mission, and Swadhyay Pariwar are also well established in the USA. Yoga is also promoted and practiced by the religious leaders. More than 18 million Americans are now practicing some form of Yoga.

Indian Muslim Americans generally congregate with other South Asian and American Muslims, including those from Pakistan and Bangladesh. Immigrant Asian Indian Muslim organizations (such as the

Indian Muslim Council) exist in the USA. Christians, who comprise approximately 6% of the Indian population in India, are concentrated in states such as Kerala and Maharashtra (Goa). Immigrant Asian Indian Christians have several Indian Christian churches across the USA such as the Syro-Malabar Catholic Church, Syro-Malankara Catholic Church, Indian Orthodox Church, and Church of South India to name a few. There are also a number of Asian Indian Christians who use the mainstream American churches. The Indian Christian Americans have formed the *Federation of Indian American Christian Organizations of North America (FIACONA)* to represent a network of Indian Christian Organizations in the United States and Canada. The Parsi community and Indian Jews are perhaps the smallest Asian Indian minority communities in the USA.

Language

There are 14 official languages and Asian Indians from different states speak different languages. Hindi is the official national language in India. However, English is one of the official languages of India, and according to the census of India there are approximately 19 million Indian English speakers (as second or third language) due to the colonial rule of Britain in India. With the exception of some families who communicate primarily in English, as well as members of the relatively small Anglo-Indian community numbering less than half a million, speakers of Indian English use it as a second or third language, after their indigenous Indian language(s), such as Assamese, Oriya, Urdu, Gujarati, Punjabi, Hindi, Sindhi, Bengali, Kannada, Telugu, Marathi, Tamil, and Malayalam.

Socioeconomic Status

Education

Asian Indians also differ in their average educational level from other immigrant Asian groups. Asian Indians have the highest percentage of higher education when compared to other racial groups. According to the American Association of Physicians of Indian Origin, there are close to 35,000 Indian American doctors. AAPI is the largest ethnic minority physician in the United States. According to the 2000 census, about 64% of Indian Americans have attained a Bachelor's degree or more (compared to 28% nationally, and 44% average for all Asian American groups). As indicated by the Indian American Centre for Political Awareness, almost 40% of all Indians have a master's, doctorate, or other professional degree, which is five times the national average. Among Indian Americans, 72.3% participate in the US work force, of which 57.7% are employed in managerial and professional specialties.

Income

Asian Indians tend to be highly educated professionals, prosperous, and English speaking in the United States. Their mean income level is 25% above the national average, and the median income is $60,093, compared to $41,110 for non-Hispanic Whites. Hence, the economic power of Asian Indians in the USA is indisputable. Furthermore, 67% of foreign-born Asian Indians have a college education as compared to 21% of non-Hispanic Whites. Hence, Asian Indians are perceived as having good access to health care. However, there are marked variations in educational attainment, income, and wealth among Asian Indians. Recent immigrant cohorts comprise both highly educated professionals as well as individuals who lack education and job skills. The latter are mostly family members of earlier immigrants.

According to the 2000 US Census, Asian Indian men had "the highest year-round, full-time median earnings ($51,094)," while Asian Indian women had a medium income of $35,173. This phenomenon has been linked to the "brain drain" of the Indian intelligence from India. Recently, however, there has been a drop in immigration of Indians from India to the United States. This is generally attributed to the improving economy of India. With the immigrants from India since 1965, the percent of Asian Indians who are second or third generation is growing.

Although the majority of Asian Indians are professionals (doctors, computer scientists, academics, etc.), a significant number are business owners or involved with the hotel/motel industry. Indian Americans own 50% of all economy lodges and 35% of all hotels in the United States. In 2002, there were over 223,000 Asian Indian-owned firms in the USA, employing more than 610,000 workers, and generating more than $88 billion in revenue.

Culture

Food

Asian Indians have popularized the Indian cuisine in the United States, and there are hundreds of Indian restaurants and eateries nationwide. There are many Indian markets and ethnic grocery stores in the United States, especially in the cities with a large Asian Indian population. Some of the biggest Indian markets are in Silicon Valley, Chicago, New York City, the Philadelphia metropolitan area, and Edison, New Jersey. Areas with a significant Indian market presence also include Devon Avenue neighborhood/market in Chicago, Pioneer Blvd. in the Los Angeles region, and University Ave in Berkeley, California. Other predominantly Indian neighborhoods are Journal Square in Jersey City, New Jersey; Jackson Heights in Queens, New York; Hillcroft Avenue in Houston, Texas; and Richardson near Dallas, Texas.

Entertainment

Hindi (the national language of India) radio and television stations are available in areas with high Indian populations. Several cable and satellite providers offer Asian Indian channels such as the Sony TV, Zee TV, and Star Plus. Furthermore, many metropolitan areas with high Asian Indian populations now have movie theaters specialized for showing Indian movies produced at Bollywood (named after Hollywood). Bollywood is the informal term popularly used for the Hindi-language film industry based in Mumbai, Maharashtra, India. Bollywood cinemas and musicals are believed to influence musical films in the Western world and the USA since 2000. Bollywood film industry individuals such as A. R. Rahman, an Indian film composer, is popular since the music he wrote for Danny Boyle's *Slumdog Millionaire* (2008) has won four Golden Globes and eight Academy Awards. The influence of Bollywood music can also be seen in popular music elsewhere in the world.

Geographical Concentration

The US states with the largest Asian Indian populations, in order, are California, New York, New Jersey, Texas, and Illinois. There are also large Asian Indian populations in Pennsylvania, Florida, Michigan, Maryland, Virginia, Georgia, and Ohio. The New York metropolitan area, consisting of New York City and adjacent areas within the state of New York as well as nearby areas within the states of New Jersey, Connecticut, and Pennsylvania, is home to approximately 600,000 Asian Indians as of 2009, comprising by far the largest Asian Indian population of any metropolitan area in the United States. At least 17 Asian Indian enclaves characterized as a Little India have emerged in the New York metropolitan area.

Other metropolitan areas with large Asian Indian populations include San Francisco/San Jose/Oakland, Chicago, Los Angeles, Washington/Baltimore, Philadelphia, Boston, Detroit, Houston, Dallas/Ft. Worth, Charlotte, North Carolina, and Atlanta. The town of Edison, New Jersey (total population 100,499), is 17.5% Asian Indian – the highest percentage of any municipality in the United States. But the mostly agrarian Imperial Valley, California, near the Mexican border has a long history of Asian Indians (an estimated 21,000 live in Imperial County, California alone) since the first arrivals to the California desert in the early 1900s. The first American Sikh temples were in the Sacramento (Marysville and Yuba City) and San Joaquin Valleys (Lodi and Stockton) to serve the early wave of Sikh Indian workers arrived there. In contrast with East Asian Americans, who tend to be concentrated in California and other areas near the Pacific coast, Asian Indians are more evenly distributed throughout the United States.

High Risk for Chronic Diseases

The burden of diabetes and cardiovascular disease among Asian Indians living in the USA is well documented. For example, Foucan et al. found that Asian Indians with type-2 diabetes mellitus had a fivefold higher risk of cardiovascular disease than the general US population. Cardiovascular disease and diabetes among Asian Indians is among the highest in the world for both men and women. The relative risk of coronary artery disease (CAD) mortality is about 1.4 for American Asian Indians compared with the general US population. Enas and his colleagues reported Asian Indians have the highest rate of heart attacks of any ethnic group in the world. Similarly, the prevalence of diabetes is strikingly high in Asian Indian immigrants to the USA and is estimated to be two- to threefold higher than in the general US population. Diabetes may be a contributing factor in up to 20% of cardiovascular deaths in Asian Indians.

It is unclear why the CAD rate is so much higher in this population given that risk factors such as hypertension, smoking, and obesity are actually less prevalent than in the non-Hispanic White population. However, many Asian Indians have abdominal/visceral adiposity without BMI obesity. The prevalence of a high triglyceride (TG)/low High Density Lipoprotein (HDL) pattern in this population is high in India and in Britain, and this pattern is associated with excess cardiovascular risk. Lipoprotein (a) has been shown to be an independent risk factor for CAD, and this has also been reported to be especially prevalent in Asian Indians. Inactivity, commonly found in Asian Indians in the USA, and dietary patterns that are high in carbohydrates and low in fat exacerbate the high TG/low HDL pattern even further. Paradoxically, vegetarians appear to be an especially high-risk group because of the high carbohydrate dietary pattern, and some preliminary reports suggest an even higher CAD risk in vegetarians. Healthy diet and regular physical activity could help control these abnormalities. These factors warrant further research into disease prevalence and health behavior patterns of this high-risk ethnic Asian subgroup.

Conclusion

Asian Indians have distinctly different classes, social habits, cultural practices, diets, and lifestyles that characterize the Asian Indian diversity. They are generally well educated with the highest annual income among all Asian American immigrants. Hence, Asian Indians are perceived as having good access to health care. However, there are marked variations in educational attainment, income, and wealth among Asian Indians. Further, they have a genetic predisposition to chronic diseases such as diabetes and cardiovascular disease. Hence, primary and secondary prevention programs can help improve their health outcomes and quality of life. Although Asian Indians retain a high ethnic identity, they are known to assimilate into American culture while at the same time keeping the culture of their ancestors. They more easily assimilate than many other Asian immigrant groups due to the lack of language barrier (English is widely spoken in India), high educational level, and professional jobs. As a result of their assimilation, mixed European/White and Indian backgrounds are becoming more prevalent in the United States.

Related Topics

► Asian Americans
► Brain drain
► Chronic disease
► Cross-cultural health
► Ethnic enclaves
► Herbal medicines
► Language acculturation
► South Asians

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Asians

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In 2002, the U.S. Census Bureau documented that 25% of foreign-born people were from Asia. Of these foreign-born, 1.5 million were born in China, which is the leading country of birth for this nation's immigrants. Of note, also in the top ten countries of origin were India, the Philippines, Vietnam, and Korea. In fact, it is projected that by the year 2050, the population of people who identify as Asian will increase by 213%, making up 8% of the total population in America. Given the impact that this burgeoning immigrant group will have on this nation, including education and health services, it is imperative to understand how immigration and adjustment to living in a new society will affect their health and well-being.

In order to further our understanding of this immigrant group, it must be first considered that the labeling of all immigrants from the Asian continent as "Asians" is a socially constructed category that can have a unique bearing on how these unique immigrant groups see themselves. Many individuals that Americans might describe as "Asian" may in fact not identify themselves as such. There is great importance, therefore, in considering individuals' countries and subcultures of origin, regions within these countries, languages and dialects, and intraindividual identity differences when working with individuals from Asian countries. For example, within the USA, some "Asians" may actually consider themselves Black due to darker skin color and whether others treat them as Black rather than Asian. With this racial stereotyping, certain groups of Asian immigrants may experience discrimination and prejudice similar to other minority groups, such as Latinos and Blacks, while other groups of Asians may have the reverse experience being treated as "superior" to other minority racial groups but still inferior to Whites. For these Asians, they are subject to being treated as the "model minority," such that they experience expectations from the majority to outperform their other ethnic minority peers academically and occupationally (being smarter, more hard working, and more trustworthy) while still being treated like foreigners and a "threat" to native-born counterparts from whom they might take college scholarships and jobs. Further, due to political and economic turmoil in certain areas of Asia, immigrants from a country may not have necessarily originated from there, but rather emigrated from their place of birth to another country en route to America. While the rest of this chapter attempts to inform the reader about development of these diverse Asian individuals within this nation, as well as provide an understanding of their risk and protective factors and issues surrounding physical and mental health, it is imperative to take into account the diverse and unique pathways of individuals from various areas of the Asian continent.

Historical Context

The first documented immigrants from the "Far East" to the USA arrived in the mid-1700s and were Filipino sailors who escaped from Spanish galleons traveling to colonies in Mexico. However, major migration from East Asia to the USA did not occur until 1848, precipitated by the discovery of gold in California. The Gold Rush is considered one of the dominant factors in many Chinese leaving their home country to seek fortune in America and return home to their families wealthy. Simultaneous with this economic pull, there were other political factors that drove Chinese away from their country, namely, British dominance over China following their defeat in the Opium War (1839–1842). In addition, some Chinese were contracted as laborers in the sugar plantations of Hawaii and to work on the railroads in California. As a consequence, there was a tremendous influx of immigrants from China which the American people and policy makers did not know how to handle.

Initially, Chinese miners were welcomed in California as cheaper laborers, but soon White miners began to resent these migrant workers who were discovering gold that White miners thought they deserved. In 1852, California legislature passed the Foreign Miners Tax which levied egregious taxes aimed at the Chinese, forcing many to give up their land or to find other jobs. This was but one of the many growing political pushes to segregate and force Chinese immigrants into lower social class. In addition, they were forbidden from owning their own land, attending school, having certain occupations, living in certain parts of cities, and even marrying a White person. Because of these laws, Chinese and other Asian immigrants became more isolated, forming small communities and working in jobs that would support each others' lives (i.e., grocers, gardeners, etc.). This heated issue of immigration from the East culminated in the Chinese Exclusion Act of 1923, which sought to forever bar Chinese immigrants from coming to the USA, and those who were already in the USA were made permanent alien residents. Leaving the country provided little chance that one could return, preventing many Asian men from reuniting with their families back home. However, these policies that were meant to drive these immigrant groups home did not take into account the perseverance, determination, and astuteness of these individuals as they strove to make new communities in the USA and to bring their families over.

Finally, the Chinese Exclusion Act was repealed in 1943, though immigration was still severely restricted compared to before. However, Asians in the USA could not find "peace" from discrimination for long as World War II had devastating effects on the treatment of Asians, particularly Japanese. Prison internment camps forever changed the structure of the traditional Japanese family as they were forced to live communally, without privacy, and without the formal patriarchal structure. Moreover, though in some cases reparations have been made, the trauma and shame endured by these immigrants during this recent time period has invariably influenced their acculturation. For example, the experience of Japanese Americans in internment camps has irreparably impacted the cultural values and beliefs of successive generations of Japanese immigrant families.

Finally, in more recent history, global political turmoil has influenced the departure of many other Asian groups from their home lands to seek refuge in the USA (i.e., Vietnamese in the 1970s and Cambodians following Khmer Rouge). Given changes in US policy regarding immigration, the focus of these newcomers is on family reunification; however, the effects of these emigrations should not be forgotten and as the context of the experience of each of these immigrant groups is unique, much consideration should be given to understanding their unique acculturative experiences and how these experiences may impact both their mental and physical health and development.

Acculturation: What Does It Mean to Be Asian American?

For most immigrants coming to the USA, this nation shines as a beacon of hope and fortune. Many come to better the lives of their families and to raise their children in a land of opportunity and resources, which is in contrast to the sometimes dismal and stressful situations of their home country. In the past, the process of acculturation has been viewed as "stripping" one's self from the culture and identity of origins and embracing a new identity in the host country. However, this perspective was considered antiquated and did not embrace the dynamic and unique experiences of immigrants in adjusting to a new cultural context. Therefore, in the past few decades, there has been a shift from the "unidimensional model of acculturation," which posits this one-way shift to a new identity, to a dynamic "bidimensional model" that presents acculturation as a function of the degree to which immigrants strive to maintain their cultural heritage and identity and the degree to which they become immersed and involved in their new cultural environment. During this process, there is great variation in how individuals engage in acculturation strategies, generally related to their behaviors and their attitudes. Changes in these two areas are seen as a function of how the individual and society interact and how the individual tries to cope with the stress of acculturation. In examining psychological adaptation, immigrants tend to engage in one of four different strategies in acculturation: (1) integration, where individuals seek to maintain their cultural values while still engaging with society; (2) assimilation, where individuals choose not to retain their ethnic identity and fully embrace the culture of their host country; (3) separation, where individuals value holding onto their culture and do not engage with society; (4) marginalization, when there is no interest in maintaining one's culture (because of segregation or cultural loss) or engaging in the new culture (related to feelings discrimination or exclusion). Immigrants who utilize the strategy of integration or assimilation often have the best psychological outcomes, demonstrating higher self-esteem related to identity and less conflict and stress. However, for some immigrant groups, there is no choice for strategy, as in the case of marginalization, where society has enforced segregation or discrimination that does not encourage these immigrants to engage with the host culture nor is there means of remaining connected to their home country.

Regardless of nationality, emigration and immigration is a time of great stress (i.e., identity crises, economic/career changes, and family systems disruption) but also a time for growth and opportunity as individuals seek a new identity and opportunities within the host country. The process of assimilation varies from individual to individual and across the unique experiences and interactions with the mainstream culture. Furthermore, the process of acculturation for Asians has been further described as “segmented,” such that immigrants received into society may be propelled in different trajectories given differences in social mobility. Specifically, immigrant groups may either be confined to certain social status, such as lower class, without much mobility (i.e., impoverished refugees from South East Asia), or they could experience rapid economic and social upward or downward mobility (i.e., those who come with education or job experience either do or do not carry over to the American system), in which change, especially for those in the lower class, becomes much more difficult.

It is important to keep in mind the demographics of incoming immigrants and how these affect their outcomes within the USA. For example, Asian immigrants from less developed areas who immigrate to urban, industrialized areas may experience more difficulty in adjusting due to differences in cultural values, economic status, and support structures, while Asians from cities similar to the metropolitan areas in the USA (often the most common port of entries and areas of immigrant settlement) may experience less stress and conflict because there is less dissonance between their city of origin and destination city in terms of job status and environment. In addition, having an established community of their ethnic peers could provide irreplaceable social and structural support for newcomers, such that they feel a sense of belongings and are able to remain connected to their culture. Therefore, the characteristics of their areas of origin may affect the type and degree of acculturative stress they experience in the USA, while having similarities between destination and origin may actually buffer some negative effects for some outcomes.

Acculturation does not stop at any period after an immigrant moves to the USA. Rather it is an extensive and dynamic process for each individual. For those who move to the USA before adulthood, the experience of acculturation is vastly different. According to the 2000 US census, one out of every five children is the child of immigrants; either the child is an immigrant or has at least one parent who is an immigrant. These children and adolescents are experiencing a shift in their cultural values, beliefs, and identity during a period of development that is crucial to later physical, mental, and emotional health. As they are engaging in self-conceptualization, forming their identities through family and peer relationships, and participating in society, the experience of immigration can have a colossal impact on these processes, which result in varying pathways of development. For some children who arrive in early childhood, the process of acculturation may have less immediate consequences, though growing up in an immigrant family invariably affects their development; however, research with this population during this developmental period is limited leaving much supposition about current knowledge of early childhood among the Asian immigrant population. Undoubtedly, children who immigrate in middle childhood and adolescence experience greater amounts of stress and upheaval as they engage in normative processes of development within a novel cultural context. What this means for these children is that they will negotiate their identities as multicultural individuals, having to assimilate American and Asian cultural beliefs, ideals, and behaviors, often times without the assistance of their parents or family members who may not understand the experiences they are going through.

In addition, for some of these youth, there is an established ideal of the “model minority,” such that they must perform well scholastically, without outdoing their White peers, while also not engaging in negative behaviors, such as smoking, drinking, and participating in other delinquent behaviors that might be more typical of other minority groups. While delinquent behavior has been noted among recent, or first-generation, immigrants from Asian countries, it also appears that as these groups become more acculturated to the dominant culture, there is a significant increase in the prevalence of these negative behaviors. Specifically, in the second, third, and fourth generation of immigrant families, these youth are demonstrating an increase in risky behaviors, such as underage smoking and drinking and unsafe sexual activity. In addition, they experience an increase in depression, anxiety, and other negative mental health conditions related to intergenerational conflict with their families, struggles with identity, and discrimination from society. In order to combat marginalization, some groups of Asians have even formed gangs, modeled similarly to gangs of other ethnic minority groups, for protection and support. Though they appear to engage in these negative behaviors similar to other minority groups, for these youth, the factors related to initiation in gang membership, having unprotected sex, and performing delinquent behaviors may be much different, and stem from difficulties in identity development, cultural and societal pressure, and issues of generational conflict within the family. Finally, as there is greater acceptance of biracial relationships, this country will witness an increase of biracial Asian children for whom the process of development, including self-identity, peer relationships, and even racial status, is less understood. It is imperative that professionals who engage with these diverse individuals are aware of their very unique and challenging experiences and seek to gain more understanding rather than make assumptions based on statements of their general ethnic backgrounds as "Asian."

Despite evidence of acculturation and changes in cultural values and behaviors through generations, there is continued stigma in immigrant communities regarding health support and resources. Many still rely on traditional, Eastern methods of healing, often resorting to hospitals only when they are in dire condition and need immediate medical treatment. Further, the concept of mental health may be foreign and inconsistent with the cultural values of some Asians. The destigmatization of mental health is currently at the forefront as these groups are often the least likely to receive services or to seek mental health services support. In addition, health professionals must be educated in these barriers to service utilization as they will impact whether individuals seek treatment and whether they adhere with the treatment provided. Cultural adaptations of therapy and ways of speaking about health services are just some of the methods that current practitioners must educate themselves on in order to effectively engage with and treat this hard-to-reach group of immigrants. More information on the health of Asian immigrants will be covered later in this chapter.

Finally, immigrants may not have a full understanding of the laws and policies as they differ from their country of origin. While embassies and other resources exist, there may be fear and hesitation in the community regarding contacting these organizations for information about immigration services or naturalization processes. Because of their position in society, they may not have the means to hire an attorney nor locate a representative who speaks their language. Furthermore, interpreters are in short supply with a large demand, often lacking adequate training or support to effectively work with their clients. For policy makers and education professionals, it is imperative to support efforts to increase the skills of bilingual individuals, such that they may work as assets in bridging services with a hard-to-reach community. Providing training and education for bilinguals as interpreters will not only provide them with invaluable marketable skills for the work force, but also increase access of resources for the underserved. However, it is extremely important to recognize that immediate or extended family members should not be utilized in this role as they have been historically. For these individuals, the role conflict of interpreting between service professionals and their family members can be deleterious, such that they experience stress from having to convey often negative information to family members, as well as perform a role that may be in direct conflict with their position in the family. This tension may exacerbate family relationships and create tension with the service professionals.

Asian Immigrant Physical Health

A recent Surgeon General's Report found that Asian immigrants have less incidence of coronary disease and stroke than non-Hispanic Whites and are generally more healthy with few exceptions (high rate of cervical cancer among Vietnamese women which may be related to less prevalence of screenings and decreased utilization of Western medicine). However, evidence exists for underreporting and underdiagnosis of mental health issues which may lead to increase in physical health problems through somatization, effects of depression and anxiety, etc. For all immigrant groups, there are noticeable differences between the health of recent immigrants and the native citizens of the USA. The National Health Survey from 1992–1995 indicated that the general health of Asian and Pacific Islander immigrants was better than their native counterparts. Moreover, there was a consistent pattern of deterioration in health as length of residence in the USA increased. It was also noted that use by Asian and Pacific Islander immigrants of formal medical care increased with duration of immigration, perhaps due to decreased cultural barriers to using these services. The variation in the health of Asian groups, especially those for whom there is a large, established community in the USA, can be fully understood only by taking into account additional factors, such as immigration history and diversity among cultural norms and values.

Among Asians, there was noticeably better physical health compared to their native-born peers, which differed among immigrants' areas of origin. For example, the mental and physical health of refugees from countries experiencing internal conflict and war may be markedly less compared to Asian immigrants from less unstable nations but with better preexisting health services. However, this does not blind us to the findings that regardless of moving from Third World countries or areas with less health care, these immigrants still show better health than native-born Americans. Regardless, this seeming advantage over earlier immigrant or American-born individuals appears to dissipate the longer they live in the USA, and this is assumed to be a by-product of acculturation. There are hypotheses as to the cause of this deterioration in health condition, such as limited access to health care in the USA, exposure to health risks (i.e., environmental toxins, cigarettes, high-fat foods, etc.) which may invariably result in increases in health issues. While there do not appear to be any biological bases for health differences, there do appear to be cultural differences in health practices, such as eating and exercise habits, as well as health service utilization, which could influence these observed group differences. This perspective appears most cogent when examining evidence of generational deterioration of health benefits and increased health risks. For these immigrant groups, it is imperative to promote interventions aimed at targeting stigma surrounding health professionals and Western models of medicine, and the adaptation of these interventions and services to incorporate cultural values and perspectives. For most professionals, one of the most important variables in treatment is gaining an alliance with the client, such that there is trust and credibility in the relationship. Thus, given the variety of viewpoints among professionals, there should be flexibility in service delivery in order to be able to reach these individuals. Specifically, if we are to ask them to engage in a behavior that is novel and foreign, there should be some flexibility on the part of the professionals to establish credibility by utilizing knowledge of the individual's culture and make the service valuable to them within that context.

Asian Immigrant Mental Health

In contrast to their natural "protective" barriers for physical health, Asian immigrants tend to experience disparities in mental health, such that they report greater prevalence of certain mental health issues. For example, the National Health Interview Survey (1992–1995) found that Vietnamese immigrants demonstrate a significant increase in depression as their length of residence in the U.S. increases. Among other Asian immigrant groups, there are also noticeable increases in depression, anxiety, and substance abuse, such that there is a significant increase in these issues with length of residence and generational status where second- and third-generation immigrants are significantly more at risk than their first-generation peers.

Findings from ADD Health, a national survey of adolescents' health, indicated that Filipino adolescents experienced more depressive symptoms and engaged in more delinquent behaviors than other Asian groups and compared with European American adolescents. For Chinese American adolescents, they reported increased somatic symptoms associated with third-generation status, compared to both first and second generations for Chinese Americans. Generational influences on delinquency and substance use were noted with both Chinese and Filipino American youth. Being second generation was associated with more delinquency compared to first-generation status among Filipino youth only. Generation effects for delinquency were not significant for Chinese youth. However, generational influences were present among both Chinese and Filipino adolescents with respect to substance use. For the Chinese Americans, being third generation, compared to second, was associated with increased substance use. For Filipino youth, being second and third generations, compared to first, was associated with increased substance use. These findings highlight the differences among Asian groups, such that differences in skin color, cultural values and behaviors, and environment may influence engagement in negative health behaviors. For example, Chinese Americans have historically been considered one of the "model minorities" and there is an expectation of higher academic achievement and less involvement in delinquency, while for other Asian immigrants, specifically from South East Asia, they may experience more stereotyping as being less educated and more likely to engage in delinquent behaviors. Finally, these findings demonstrate differences influenced by generation or length of residence in the USA. Most of our knowledge about mental health issues comes from research with Asian youth in middle childhood, adolescence, and young adults, given the convenience of collecting information with these groups. There is still a paucity of information in early childhood when many children are immigrating to the USA. Therefore, research with this area has increased recently and continues to be an area for interest in understanding mental health issues in development among young Asian immigrants.

Descriptive studies among various Asian immigrant groups have noticed a significantly higher level of internalizing symptomatology compared to native-born peers, which may be related to the cultural value of maintaining group harmony while suppressing one's own feelings. Additionally, these groups also exhibit high anxiety, specific to social situations in which their language proficiency or other factors may make them feel uncomfortable. However, compared to native-born peers or Americans, recent immigrants exhibit much less externalizing symptoms, such as aggression. As stated previously, the prevalence of these issues appears to change dynamically in line with acculturation. In addition, perceived discrimination among Asian immigrants severely impacts mental health. A great deal of evidence has demonstrated the impact of racial discrimination on the health of Asians, such that the stress of experiencing overt or micro-aggressions from others can impact self-esteem and well-being. For these groups, feeling marginalized and experiencing discrimination is related to increases in depression. However, perceiving social support from friends and family can decrease the impact of discrimination, acting as a buffer against these negative experiences. Furthermore, Asians who are members of other marginalized groups, such as the lesbian-gay-bisexual-transgender-questioning community, may experience more negative mental health effects due to increased experiences of marginalization related to their culturally disparate behaviors, family conflict, and legal barriers to marriage and child-rearing, including adoption and acceptance in schools. These groups are subject to greater family conflict given their sexual orientation which is not acceptable within their traditional cultures. For these individuals, there is a struggle between family honor and piety and living a more individualized, "free" life in the USA. America may serve as "safe" place to explore their sexuality while pressure from their families may make it difficult to do so and cause interpersonal conflict and distress. Though these groups are not noticeable in mainstream culture, they exist and more knowledge is needed to be able to provide appropriate support and counseling surrounding safe sex, parenting, couples therapy, etc.

There are cultural barriers and misconceptions about the health care system that decrease the likelihood of Asians seeking help for any mental health problems, especially child behavior problems. In general, Asian immigrants tend to be extremely wary of mental health services as they are even more incongruent with some of their cultural beliefs than physical health services. However, in terms of seeking services, it appears that, especially in the case of child behavior issues, the perceived severity of the problems influences parents' intentions for seeking help. Value orientation indirectly influences help-seeking intentions of individuals through its effects on their feelings about the issue. These findings coincide with evidence that the severity of the mental health issue is often the catalytic factor in seeking services. For some Asians, like the Chinese, depression can be seen as a sign of character and part of life, and therefore, it is not necessary to seek intervention. Furthermore, among these groups, because of collectivistic ideals that value the privacy of family issues, mental health services carry a heavy stigma, because seeking therapy can be viewed as betraying the trust and secrets of the family. Therapy can be seen as "complaining" about your family situation and lead to experiences of "losing face" or diminishing the respect and honor of one's family in front of a stranger. For example, more traditional Chinese American parents tend to respond to hypothetical child behavior problems with higher levels of shame and stigma-related negative affect related to communicating about one's family issues. Historically, Asians tend to seek support from their friends and family before seeking services outside, and like physical health issues, they often enter therapy when they have exhausted all other resources and are in crisis.

Moreover, recent immigrant adolescents who are experiencing high parent–child conflict (possibly related to differential rates of acculturation between parent and child) are significantly more likely to engage in suicidal behaviors than their more acculturated counterparts. While there are many factors that influence psychopathology and self-injurious behavior, among them perceived discrimination/marginalization, peer and family support, and ethnic identity, it is important to note the paucity of knowledge in measurement and training on identification of these factors to recognize immigrants at risk. While frequent experiences of perceived discrimination, a lack of social support, and a history of comorbid psychopathology are excellent indicators of Asian immigrants at risk for suicidality, more information is still needed to understand the role of culture and mental health in identifying those who are more or less likely to complete suicidal behaviors. For example, for some Asians groups (i.e., Japanese), committing suicide following experiencing extreme shame (i.e., losing a job) may be culturally normative and expected within the context. Therefore, working with such an individual would entail understanding those cultural beliefs but also abiding by American ethics, such that therapy would work toward decreasing suicidality and preventing suicidal actions but also acknowledge the cultural bases of the client's values and behaviors.

Further, discussing the limits of confidentiality and the role of their service provider can be particularly difficult when working with individuals who carry stigma about mental health and who may not see the services as necessary or beneficial. For these clients, feeling like they have "lost face" or that their personal information has been shared with someone with whom they have not established trust or credibility could result in an abruptly terminated relationship, and that client may never seek services again. Therefore, knowledge in the areas of cultural competence pertinent to the populations you will be working with is essential for forming positive working relationships. Even with this knowledge, individual differences among Asian immigrants also need to be taken into account so that the nuances of each person's experience are not ignored. By taking an integrative approach, one can utilize a culturally sensitive perspective supported by empirical research in understanding and working with Asian immigrants.

Related Topics

- ▶ Acculturation
- ▶ Acculturative stress
- ▶ Anti-Asian violence
- ▶ Asian Americans
- ▶ Assimilation
- ▶ Cultural adaptation resources
- ▶ Cultural competence
- ▶ Cultural humility
- ▶ Discrimination
- ▶ East Asians
- ▶ Ethnic enclaves
- ▶ First generation immigrants
- ▶ Herbal medicines
- ▶ Labor migration
- ▶ Marginalization
- ▶ Psychological acculturation
- ▶ Segregation
- ▶ South Asians
- ▶ Stigma
- ▶ Traditional Chinese medicine

Suggested Readings

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Suggested Resources

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National Network for Immigrant and Refugee Rights. www.nnirr.org

Southeast Asian Resource Action Center. www.searac.org

www.southasianhealth.org

www.asian-nation.org

Assimilation

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It is almost inevitable that when an immigrant moves from his or her home culture to a different culture, there will be some tension between the cultures of the home and host countries, which will influence the immigrant's behavior.

Culture may be viewed as a set of shared attitudes, values, goals, and practices that characterizes an organization, institution, or group. Cultures have evolved over centuries and continue to do so. Furthermore, culture may provide a strong sense of identity to members and may inform how members view themselves and others. Some immigrants find it challenging to navigate potentially discrepant home and host cultural beliefs and practices.

Acculturation is a dynamic process. It reflects the degree to which the original culture is retained while adapting to the new culture. There are four different patterns of acculturation: integration, assimilation, separation, and marginalization. Assimilation may be described as "unicultural acculturation." Assimilation may involve changes in choice of language spoken and the adoption of the host culture's attitudes and values. In extreme cases, the immigrant who assimilates adopts all the values of the host culture and eschews those of the home culture. In practice, this is a process that may take many generations. For example, the Rhodans who moved to Malta with the Knights of Saint John in the sixteenth century kept their own churches and parishes for many years. Over the course of centuries, they intermarried with the Maltese; all their churches were closed except one, which has maintained its Greek Rite till today.

Acculturation is usually viewed, particularly by the host nation, in terms of the extent to which immigrants adopt the habits or language patterns of the host culture. However, acculturation may be reciprocal, with the members of the host culture adopting patterns typical of the immigrant group. For example, in Britain, Chicken Tikka Masala, a South Asian dish, may be viewed as a national dish alongside British "fish and chips." In countries with a diversity of immigrant groups, such as the United Kingdom, it is now frequently argued that a multicultural society in which all cultures are valued has now evolved.

Related Topics

- ► Acculturation
- ► Cross-cultural health
- ► Cross-cultural medicine
- ► Cultural adaptation resources
- ► Cultural appropriateness

- ▶ Ethnic enclave
- ▶ Ethnic identity
- ▶ Ethnic minority group
- ▶ Ethnicity
- ▶ Ethnocentrism
- ▶ Exclusion
- ▶ First generation immigrants
- ▶ Health beliefs
- ▶ Health perception
- ▶ Intergenerational differences
- ▶ Isolation
- ▶ Language acculturation
- ▶ Linguistic minority community
- ▶ Marginalization
- ▶ Multiculturalism
- ▶ Psychological acculturation
- ▶ Religion, religiosity, and spirituality
- ▶ Situational ethnic identity
- ▶ Social integration
- ▶ Transcultural psychiatry

Suggested Readings

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Suggested Resources

Different cultures working together. http://www.vitae.ac.uk/researchers/1294/Different–cultures-working-together.html

What different cultures can teach us – Mental health: ethnic minority carers experiences. http://www.healthtalkonline.org/mental_health/mentalhealthcarers/Topic/3487/

Asthma

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Once thought to be an acute, sporadic illness, asthma is now understood to be a chronic, inflammatory lung process which is becoming increasingly common across the globe. Generally the diagnosis is made when the patient, usually a child, presents to the health care provider with wheeze, cough, and/or breathlessness which is not accompanied by an acute illness. The diagnosis is not made, however, on the first presentation, but at the second or third, with the patient having normal respiration at other points in time, and the chronic nature of the ailment can be established.

The chronic inflammation causes the interior wall of the airways to become swollen, reddened, with increased mucus production. This causes the lumen of the airway to narrow, and the wall itself becomes more irritable and responds easily to irritants. This response takes the form of bronchoconstriction (tightening of the muscles which circle the smallest airway bronchioles). While the bronchoconstriction is reversible when the appropriate medication is administered, different medications are needed to decrease the airway inflammation. It is because of these two different components that the presentation of asthma varies greatly between those persons in which the bronchospasm takes precedence, causing wheezing and chest tightness; as opposed to those individuals who develop chronic cough due to inflammation, who may never wheeze. In older children and adults, objective measurement of airflow obstruction and airway inflammation is easily made, but objective data is difficult to obtain in children under the age of 5. Yet, asthma is increasingly one of the most chronic illnesses with the greatest morbidity in childhood.

The goal of asthma treatment is to diminish the chronic inflammation; thus decreasing the bronchospastic component as well. This is done through the use of "maintenance" or "controller" medical therapy, medication taken daily rather than episodically. Those medications required at the time of an exacerbation are termed "rescue" medications. Most medications are inhaled, thus placing the treatment directly on the area of concern. The medication is provided in metered dose inhalers in which the medication is suspended in dispersal medium; fine powder inhalers and nebulized therapy in which the medication, in salt water, is suspended into small droplets through a nebulizer device connected to an air compressor. Control is achieved when patients are able to go for prolonged periods of time asymptomatic, thus requiring little or no rescue medication.

A number of natural history studies of asthma have identified biologic, genetic, and environmental risk factors for persistent asthma. Among the biologic risks are atopic dermatitis, allergic rhinitis, elevated total serum IgE in the first year of life, peripheral blood eosinophilia >4% (2–3 years of age), and food or inhalant allergen sensitization. Parental asthma or other atopic conditions may indicate genetic risk. Early lower respiratory tract infections and environmental tobacco smoke exposure are among the exogenous causes. The Tucson Children's Respiratory Study in Tucson, Arizona, established a predictive index with two major and three minor criteria: the former are parental asthma and eczema; the latter, allergic rhinitis, wheezing apart from viral respiratory infections and an eosinophil count greater than 4%. These criteria were amended by Guilbert and colleagues during their PEAK (Prevention of Early Asthma in Kids) to add "Allergic sensitization to one or more aeroallergen" to the major criteria group, and "allergic sensitization to milk, egg, or peanuts" to the minor criteria group.

The eight-center Childhood Asthma Management Program (CAMP) study of over 1000 asthmatic children ages 5–12 years found that allergy-associated asthma appears to be the most common form of asthma in elementary school-aged children in the USA, and that 88% of the study group were sensitized to at least one inhalant allergen at study enrollment.

In the ISAAC studies (The International Study of Asthma and Allergies in Childhood, established in 1991 to investigate asthma, rhinitis and eczema in children worldwide) and the European Community Respiratory Health Survey, asthma has been found to be more common in those English-speaking countries that are predominantly countries with high dust mite exposure. However, The ISAAC findings to date have shown that while these diseases are increasing in developing countries, they have little to do with allergy, especially in the developing world. Further population studies are urgently needed to discover more about the underlying mechanisms of non-allergic causes of asthma, rhinoconjunctivitis, and eczema and the burden of these conditions. ISAAC is the largest worldwide collaborative research project ever undertaken, (involving more than 100 countries and two million children); its aim is to develop environmental measures and disease monitoring in order to form the basis for future interventions to reduce the burden of allergic and non-allergic diseases, especially for children in developing countries.

There are many current theories as to the mechanism non-allergic asthma, rhinoconjunctivitis, and eczema. For one author, in rural Greece, the explanation is simple, arguing that villages have not changed for hundreds of years and that what is new are motorized vehicles and equipment. This author notes that in many low-income countries, people rely on solid fuel and that secondhand smoke has become more common as well.

However, with immigration, other factors emerge. There are a number of conflicting studies, wherein immigrants to new environments have statistically more or less susceptibility to asthma than natives. Most immigrants move from developing countries to more developed ones seeking better opportunity; in doing so they may either improve or worsen their exposure to pollens, pollution, and sanitation. In the circumstance where immigrants are less likely than the local natives to develop asthma and "allergic" type diseases, the "hygiene" hypothesis holds great appeal. It postulates that children born in less developed countries with poor sanitation are more likely to acquire protective infections (most likely parasitic, helminthes, etc.), early in life.

Alternative theories involve sunlight exposure and Vitamin D effects. Dietary changes may also affect the immune response; clearly diets rich in fish oil and the protective effects of omega-3 fatty acid are immunogenic. Diets rich in fruits and vegetables (filled with antioxidants) are preferable to those diets rich in meat and carbohydrates which are consumed post-migration to the United States. The prevalence of obesity (itself an inflammatory illness) has significant comorbidity with asthma and again is tied to poor dietary habits of those in lower socioeconomic strata of the industrial world.

Depending upon the countries of origin and destination, immigration may confer some immunity or offer some added risk to the acquisition of asthma. However, asthma, although chronic, is very treatable, making access to healthcare the critical element in asthma severity for the individual immigrant.

Related Topics

- ▶ Air pollution
- ▶ Allergies
- ▶ Environmental health
- ▶ Housing
- ▶ Sanitation
- ▶ Tobacco

Suggested Readings

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Mantzouranis, E. (2008). Taking your child's breath away – the extension of asthma's global reach. *NEJM 2008, 358*, 1211–1213.

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Suggested Resources

GINA: The Global Initiative for Asthma. Global strategy for asthma prevention and management in children 5 years and younger. www.ginasthma.org

ISAAC Steering Committee. http://isaac.auckland.ac.nz/index.html

Asylum

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Globalization is one of the most significant factors that favors the phenomena of migration, along with the deepening disparities between countries. Migration is most commonly caused by poor economic and social conditions that pressure people to look for employment or a better education outside their native country. Following family or reuniting with family members also serve as the impetus for people to leave their home country. However, the most decisive factors that force people to migrate are the need to escape from a conflict zone, to avoid war, and to flee from persecution. A civil war, rebellion, or any kind of violence that continues over a long period of time or is directed towards specific targets, such as minorities or political opponents, presents such a high degree of risk that people from that country or habitual residents decide to go outside that territory. These persons may be persecuted because of their religion, political opinion or affiliation, sex, race, ethnicity, or national origin, becoming refugees within the definition of the relevant international conventions.

International Regulation

Internationally, one of the most comprehensive legal guides to refugees' status and rights was promulgated in 1951 by the United Nations and entered into force in 1954. A unified international codification of the rights of refugees, the United Nations Convention on the Status of Refugees ("Refugee Convention") reinforces previous international instruments concerning refugees and provides additional clarity with respect to international practices. At the same time, the

Convention broadens the concept of refugees and defines the circumstances in which a person becomes a refugee: a person who, due to a certain degree of fear of being persecuted, finds himself or herself outside of his or her national territory and is unable or unwilling to return under the protection of that state. A stateless person may be a refugee if he or she cannot return or due to fear is unwilling to return to his or her country of last residence. Individuals having more than one nationality become refugees only when they cannot benefit from the protection of either of the countries of which they are nationals.

The Convention specifies the basis of persecution that would entitle a person to seek refuge in another country as being political, racial, nationality, membership in a particular social group or political opinion. The Refugee Convention and the subsequent 1967 Protocol Relating to the Status of Refugees, which removed the geographic and date limitations imposed by the Convention, guide the national legislation of the signatory States in terms of defining refugees and their rights. These documents also enable the United Nations to monitor the application of the Convention's and Protocol's provisions. The signatory States provide the U.N. with the information and statistics required to complete reports for the relevant bodies of the U.N. This information must be submitted in a specific form and contain data relating to the refugee's condition, the stage of the application of the Protocol, and any legislative act that has or may have an impact on the status of refugees.

The United Nations High Commissioner for Refugees (UNHCR) recognizes the importance of border control in fighting international crimes, but at the same time it reinforces the U.N.'s mission to ensure protection for those who left their countries in search of freedom. As an example, the UNHCR evaluates the measures used to combat crimes to determine whether they are applied so excessively that refugees are denied access to a safe place.

The Convention states the conditions to be met in order for a person to be recognized as a refugee; however, this status should not be confused with the political asylum seekers. While refugees represent a compact group of persons in search of a safe territory, the right of asylum refers to individuals and so each case is analyzed differently. The Institute of International Law defines *asylum* as a State's commitment to offer protection within its territory to a person who is in search of such a protection. A State can offer asylum to an individual also in another territory that is subjected to one of that State's organs.

Non-Refoulement Rule

A State can grant asylum either implicitly or explicitly or simply refuse to grant asylum. If asylum is denied, the person who requested it is subject to expulsion from that country. The Convention of Geneva established the non-refoulement rule to prevent repercussions to asylum applicants who are denied that status and would otherwise be returned to their countries. Article 33 of the Convention prohibits the expulsion or return of any refugee or asylum seeker to the territories where they are most likely to lose their freedom or to face life threatening situations. This danger could be related to race, religion, nationality, or association with a social group or political organization. At the same time, the Convention recognizes the fact that asylum may not be granted to a person who represents a serious danger to the community of the country where he seeks asylum.

The non-refoulement principle is a critical component of international refugee law and has been developed within the human rights international law. Being a customary international law, the principle applies not only to refugees that have been recognized as facing persecution in their country, but also to persons seeking asylum status, as their request may lie on solid grounds.

When asylum is granted to a person, he or she becomes an *asylee* and is protected by international as well as national law. The international law does not solely include the Convention and Protocol Relating to the Status of Refugees. Asylee rights are stated and protected under the Universal Declaration of Human Rights (1948), the International Covenant on Civil and Political Rights of 1966 and additional human rights treaties.

The International Covenant on Civil and Political Rights (ICCPR) reinforces the basic civil rights: freedom from torture, equality before the law and the chance for an unbiased trial, equality, and freedom of opinion. It also recognizes the right of individuals to enjoy civil and political freedom, which must be protected by each State.

Political freedom is closely linked to concepts like civil liberties and individual rights, which are protected by international laws and, in democratic states, are also protected by national laws. The ICCPR states that every person is entitled to hold opinions and to express them freely, as long as they do not break any necessary law. Exercising this right means liberty to seek, share, and obtain information on any matter, even across borders. Peaceful assemblies can be organized by any person and should be allowed. Article 22 provides for the right to form an association freely or to join trade unions or other kind of organizations. Citizens of any country have the right to be part of the public affairs, to be elected as public representatives, to vote, and to have access to the country's public services. Any restrictions relating to these rights are allowed only when necessary to protect others. Limiting these rights beyond the mentioned restrictions is a step towards constraint. The context and the specific measures applied in order to limit or prohibit the exercise of these rights are relevant to a determination of persecution. If persecution is found to exist, those individuals whose rights have been overridden may have a valid claim for asylum. If the rights that are ignored refer to one's opinions, liberty of expression, peaceful assemblies of a political organization, forming such an organization, the persecution is political. As a result, the person who suffers from that type of persecution is entitled to seek political asylum.

During recent years, threats of terrorism have led to various conventions that have a direct impact on the asylum-granting process. As the right to grant asylum is an exercise of a State's national sovereignty, the State has the freedom to offer and grant asylum between its frontiers to any individual as it pleases. At an international level, in doing so, a State could face a negative reaction from other States, not only the one from where the asylee comes.

Related Topics

- ► Bureau of Immigration and Customs Enforcement
- ► Immigration Reform and Control Act of 1986 (U.S.)
- ► Immigration status
- ► Refugee
- ► Refugee health and screening
- ► Refugee status
- ► Torture
- ► United Nations High Commissioner for Refugees

Suggested Readings

DeLaet, D. L. (2000). *U.S. immigration policy in an age of rights.* Westport: Praeger.

Dummett, M. (2001). *On immigration and refugees: Thinking in action.* London: Routledge.

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Suggested Resources

Convention and Protocol Relating to the Status of Refugees, Text of the 1951 Convention Relating to the Status of Refugees, Text of the 1967 Protocol Relating to the Status of Refugees, Resolution 2198 (XXI) Adopted by the United Nations General Assembly, United Nations Refugee Agency, retrieved from http://www.unhcr.org/protect/PROTECTION/3b66c2aa10.pdf

International Covenant on Civil and Political Rights, Adopted and opened for signature, ratification and accession by General Assembly resolution 2200A (XXI) of 16 December 1966, Office of the United Nations High Commissioner for Human Rights. Retrieved from http://www2.ohchr.org/english/law/ccpr.htm

Persaud, S. (2006). Protecting refugees and asylum seekers under the International Covenant on Civil and Political Right. Research Paper No. 132, PDES Working Papers, The U.N. Refugee Agency, Policy Development and Evaluation Service, 1 November.

Protocol Relating to the Status of Refugees, Office of the United Nations High Commissioner for Human Rights. Retrieved from http://www2.ohchr.org/english/law/protocolrefugees.htm

US Government Accountability Office. (2008). *U.S. asylum system, agencies have taken actions to help ensure quality in the asylum adjudication process, but challenges remain.* Report to Congressional Requesters, United States Government Accountability Office, GAO-08-935, September. http://www.gao.gov/new.items/d08935.pdf

Ataque de Nervios

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The Spanish term *ataques de nervios*, translated as "attacks of nerves" and as described in the *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition (DSM) of 1994 glossary of culture-bound syndromes, refers to an "idiom of distress" found among many Latin American and Latin Mediterranean groups. The term "idiom of distress" describes the expression of a range of symptoms, which despite their variable presentation (see below), communicate a message whose meaning is shared within a given culture. Thus, an "ataque de nervios," which can appear as a quiet panic attack, a crying spell or as a violent pseudoseizure, above all, is labeled as such by the affected individual and clearly recognized by other members of that individual's culture as expressing acute discomfort, anguish, and/or actual or perceived impairment in individual or interpersonal functioning necessitating assistance to that individual.

Ataque de nervios first appeared in the North American psychiatric literature as the "Puerto Rican Syndrome" by Fernández-Marina in 1961. Ataques de nervios encompass a range of paroxysmal experiences and behaviors that are often reactive to emotionally laden events (i.e., the announcement of an accident or natural catastrophe, the experiencing of violence, bereavement) or to reminders of those events. Hyperarousal becomes linked to affects of anger, worry, intense fear, despair, or shame.

Affected individuals may seek mental health and/or medical evaluation with self-labeled "ataques de nervios" as a complaint in a number of different settings including the emergency room. Ataques de nervios, importantly again, may not be labeled as such without the subject's naming his or her experience clearly as "ataques de nervios." The scientific literature supports ataques de nervios as having a range of possible clinical presentations ranging from a discretely experienced panic attack to a fit of violent agitation requiring physical restraint, and at times involving self-mutilative, suicidal, and/or other-directed violent behavior.

Typically, the subject experiences an acute sense of distress and hyperarousal preceding and during the episode which is most often, as described above, triggered by a real interaction or event. Shortness of breath, hyperventilation, palpitations, perspiration, trembling, feeling faint even to the point of fainting (syncope), chills, piloerection (i.e., goose pimples), or alternatively a sensation of a "hot flash" are only a few of the commonly described somatic phenomena that accompany ataques de nervios. Frequently, these somatic sensations are associated with subjective fears of "losing control" of one's body and/or behavior. Patients may fear becoming insane, or dying of cardiac or respiratory arrest.

Dissociative phenomena are also quite commonly associated with the episode including depersonalization, derealization, and partial or total amnesia for the occurrence of the ataque, as well as occasionally the feeling that the subject is "possessed" or behaving like a different person. Some ataques resemble pseudoseizures (i.e., a conversion or other somatoform disorder according to the *DSM-IV*) and involve falling to the ground dramatically, writhing, and self-directed aggression, which is followed by a confusional state or by amnesia. These manifestations of ataque may be mistaken for epileptic activity or as evidence of intoxication or withdrawal from alcohol or drugs.

Ataques are relatively common phenomena with an estimated prevalence of 13.8% in Puerto Rico, which is more predominant among females (60%) than males (40%). More than 75% of subjects who reported having experienced one or more ataques sought health care and/or reported significant functional impairment.

Interestingly, at least one study has empirically shown a positive association between "reporting of ataques de nervios as a problem" and years of acculturation to US society. Whereas the ataque may have functioned as a culturally sanctioned rally for support by a social network in the culture of origin, it can be viewed as a "problem" or "form of pathology" only once the immigrant arrives in a new cultural setting. Similarly, the ataque's individual meaning for an individual (i.e., its link to a traumatization) can be misunderstood by, for example, North American medical culture in a hospital emergency room, leading to further traumatization, isolation, and pharmacological intervention that can place the individual at risk.

This suggests that "ataques" might best be considered as a "problem" or form of "pathology" when subjects leave their home countries and there the phenomena are viewed within a new cultural context in which the original function and meaning of the ataques are no longer shared from the same point of view. That being said, individuals reporting chronic ataques de nervios are found to be as much as five to six times as likely to have a depressive and/or anxiety disorder and nearly three times more likely to have a substance abuse disorder. It may therefore be more useful to consider the chronic occurrence of ataques de nervios as a marker of vulnerability for a psychiatric disorder such as, most commonly, posttraumatic stress disorder (PTSD), and comorbid dissociative and depressive symptoms following from traumatic experience(s).

While Fernández-Marina in 1961 made mention of the resemblance of ataques to symptom expression among returning veterans suffering from "war neurosis," an empirical link to childhood trauma, posttraumatic stress disorder (PTSD) as it is presently conceptualized, and dissociative disturbances was not published until more than 40 years later (see Suggested Readings below). As such, one can understand how the ataque might represent a trauma-related disturbance in emotion regulation that has implications for an adult subject who becomes the parent of an infant or cares for a young child during the development of emotion regulation.

In any given clinical situation in which ataques de nervios are encountered, the clinician should try with the patient to understand the patient's individual experience, the precipitants, effects, and meaning that the patient and her/his family attributes to the ataque, along with carrying out a full psychiatric evaluation to look for comorbid conditions – both according to industrialized Western "medical" classification, as well as other cultural-bound syndromes (see, e.g., the entry on Nervios in this encyclopedia).

Phenomena such as "fits" in African-American or African-Caribbean culture are similar in phenomenology to "ataques" as are "hysterical attacks" described in the European psychiatric literature of the late nineteenth century by Charcot in France and others. Despite the similarity of ataques de nervios to these other phenomena, given the absence of empirical comparison to these other phenomena, ataques de nervios should be considered both in terms of its meaning within its respective cultural context and in terms of its meaning to the individual patient. Some inner-city patients, whether Hispanic or of mixed ethnicity, may use "ataques de nervios," "fits," or "falling out" interchangeably.

So, for such a patient, the labeling of their experience of paroxysmal distress has both an individual meaning and may also likely reflect the different cultural influences with which they identify. Similarly, popular culture impacts the individual's use and avoidance of self-labeling distress as an "ataque de nervios." Due to the popularity of the 1988 film by Spanish director Pedro Almadóvar entitled "Mujeres al borde de un ataque de nervios" and its English translation as "Women on the Verge of a Nervous Breakdown," a popular translation of the term has been "nervous breakdown" with all of the latter's attached implications and stigma.

Related Topics

- ► Anxiety
- ► Culture-specific diagnoses
- ► Hispanics
- ► Latinos
- ► Nervios
- ► Posttraumatic stress disorder
- ► Trauma exposure

Suggested Readings

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Australia

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Immigration to Australia

Experts estimate that approximately 50,000 years ago, ancestors of the Australian Aborigines arrived on the continent by means of Malay Archipelago and New Guinea. Europeans followed, arriving in the seventeenth and eighteenth centuries. Britain, needing a new penal colony to alleviate the burden on its overcrowded prisons, set sail for Australia in 1787, 11 ships with approximately 1,350 convicts. On January 26, 1788, the ships landed at Sydney Cove. This date is now celebrated by some as Australia Day, while some Aboriginal people and supporters regard it as "Invasion Day." The new colony was proclaimed as the Colony of New South Wales on February 7, 1788.

The Colony of New South Wales began to grow rapidly in 1815; as settlers arrived from Britain and Ireland, lands were opened for farming. The voyage by sea was long and perilous, but settlers were drawn by the prospect of a new life on virtually free land. Many settlers, known as squatters, occupied land without authority and became the basis of a powerful landowning class. As a result of agitation by the free settlers, transportation of convicts to Sydney ended in 1840, although it continued to smaller colonies for some years longer. The small settlement of Perth, founded in 1829 in Western Australia, failed to prosper. Instead, the settlement asked for convicts. In contrast, South Australia, founded in 1836, has no convict settlement history.

The discovery of gold in 1851 in New South Wales and then in Victoria transformed Australia economically, politically, and demographically. The gold rushes quickly followed a worldwide economic depression. As a result, about 2% of the population of the British Isles emigrated to New South Wales and Victoria during the 1850s. There were also a significant number of continental Europeans, North Americans, and Chinese who immigrated during the gold rush era. From 1851 to 1861, the population of Victoria increased sevenfold – largely due to the gold rush.

During the latter half of the nineteenth century, several colonies funded the immigration of skilled immigrants from Europe. The government found that if it wanted immigrants, it had to subsidize migration. The distance from Europe to Australia made it a more expensive and less attractive destination than Canada and the United States. The number of immigrants needed during different stages of the economic cycle could be controlled by varying the subsidy. Before Federation in 1901, migrants received passage assistance from colonial government funds; the British government paid for the passage of convicts, paupers, the military, and civil servants. Few immigrants received colonial government assistance before 1831.

The need for a common immigration policy was a key impetus for creating a federated Australia. There was significant resistance to Chinese immigration and to importing indentured workers from New Caledonia. The White Australia Policy, the policy of excluding all non-European people from immigrating into Australia, was the official policy of all governments and all mainstream political parties in Australia from the 1890s to the 1950s. Aspects of the policy survived until the 1970s. Notably, although the expression "White Australia Policy" was never in official use, it was common in political and public debate throughout the period.

Over the last 15 years, immigration numbers have grown significantly. For example, net overseas migration increased from 30,042 in 1992–1993 to 177,600 in 2006–2007, the highest number on record. Immigration to Australia is comprised in large part from the skills migration and family reunion programs. Incidentally, the recent decision to mandate the detention of unauthorized arrivals by boat has generated much controversy both for and against.

Immigration Programs

The Australian government seeks in its immigration policy to balance social, economic, humanitarian, and environmental concerns. Australia's permanent immigration program has two components: (a) *migration* – for skilled, family, and special eligibility stream migrants, and (b) *humanitarian* – for refugees and others needing humanitarian aid. The planning level for the 2010–2011 Migration Program is set at 168,700 places, while the Humanitarian Program is set at 13,750 places.

Migration Program

The 2010–2011 Migration Program has allocated 168,700 places. This figure is divided into 54,550 places for family migrants who are sponsored by family members already in Australia; 113,850 places for skilled migrants who gain entry due to their needed skill set; and 300 places for special eligibility migrants and people who apply under the Resolution of Status category and have lived in Australia for 10 or more years. The planned ratio of skilled migrants to family migrants is 6.7:3.2.

Resolution of Status

The Australian Government's Department of Immigration and Citizenship works to engage clients who have overstayed their visas and clients on bridging visas to resolve their immigration status in a fair and timely manner. Resolution of a client's immigration status is reached through either the granting of an appropriate visa or through the client's departure from Australia. The department's status resolution initiatives work with clients to encourage voluntary compliance and to ensure that all decisions to detain individuals are justified.

Unlawful noncitizens may be granted bridging visas which allow one to depart voluntarily or to remain in the community while one or more of the following are being considered: a visa application, the merits of a case, or judicial review proceedings. If it is determined that a client has no lawful entitlement to remain in the country, the client is informed that if a voluntary departure does not follow, the client may be detained and removed.

Humanitarian Program

The Humanitarian Program for 2010–2011 is set at 13,750 places. This total is comprised of 6,000 places allocated for *refugees* and those arriving from overseas and 7,750 places allocated for *other humanitarian*, including the offshore Special Humanitarian Program and onshore needs. The onshore component of the Humanitarian Program provides options for persons who are in Australia and who wish to apply for asylum; each year, several thousand apply. Applicants are granted permanent Protection visas if they are owed protection under Australian migration law – meaning they have been found to be refugees and have satisfied health, character, and security requirements. The United Nations' Refugees Convention qualifies a refugee as one who is outside his or her country and is unable or unwilling to go back due to a well-founded fear of being persecuted because of one's race, religion, nationality, political opinion, or membership in a particular social group.

Offshore Resettlement

The offshore resettlement component of the humanitarian program is comprised of two categories of permanent visas: (a) *Refugee* and (b) *Special Humanitarian Program*. Permanent visas for refugees are for those who are subject to persecution in their home country, usually who are outside of their home country, and who are in need of resettlement. The majority of those considered under this category are identified and referred to Australia for resettlement by the United Nations High Commissioner for Refugees (UNHCR). The Refugee category includes the following visa subclasses: Refugee, In-country Special Humanitarian, Emergency Rescue, and Woman-at-Risk. The Special Humanitarian Program is for persons outside their home country who are subject to substantial discrimination amounting to gross violation of human rights in their home country. A proposer, who is an Australian citizen, permanent resident, or eligible New Zealand citizen, or an organization that is based in Australia must support applications for entry under the SHP.

Offshore Resettlement: Size and Composition

The size and composition of the offshore resettlement program are shaped by a variety of factors, for example, the UNHCR assessment of the resettlement needs of refugees overseas. During regular community consultations, the Minister for Immigration and Citizenship seeks input from individuals and organizations in Australia on the size and composition of offshore resettlement. Australia's capacity to assist perhaps is the most significant factor shaping offshore resettlement.

Australian Politics

The Commonwealth of Australia was created in 1901 when the former British colonies agreed to federate, forming what is now Australia's six states. While Australia is an independent parliamentary democracy, Queen Elizabeth II of the United Kingdom (UK) is formally the Queen of Australia. All citizens over the age of 18 must vote in federal and state government elections, and failure to do so may result in a fine or prosecution. Australia's government is founded in the liberal democratic tradition that is based on the values of: religious tolerance, freedom of speech and association, and the rule of law. Australia's institutions and government reflect British and North American models; yet, they remain uniquely Australian.

Responsible Government

Australia's government is one of the oldest continuous democracies in the world. Such democratic principles that shaped the pre-federation colonial parliaments, such as "one man, one vote" and women's suffrage, were adopted by Australia's first federal government. The Australian colonies had inherited an electoral tradition from Britain; however, abuses such as bribery and intimidation of voters prompted electoral change. Australia pioneered reforms that underpin the electoral practices of modern democracies.

The secret ballot was introduced in Victoria in 1855, quickly becoming known worldwide as "the Australian ballot." In 1856, South Australia eliminated professional and property qualifications in order for men to vote, and in 1892 gave adult women the vote – nearly 30 years before passage in the United States. In the 1890s, the colonies adopted the principle of one vote per person, stopping the practice of plural voting.

Australia's government is based on a popularly elected parliament with two chambers: the House of Representatives and the Senate. Ministers appointed from these chambers conduct executive government, and policy decisions are made in Cabinet meetings – which are not disclosed – apart from the announcement of decisions. Ministers are bound by the principle of Cabinet solidarity, which closely mirrors the British model of Cabinet government responsible to parliament. While Australia is an independent nation, Queen Elizabeth II of Great Britain is formally Queen of Australia also. On the advice of the elected Australian Government, The Queen appoints a Governor-General to represent her. Although the Governor-General has wide powers, on virtually all matters, he or she acts only on the advice of ministers.

Parliament and the Constitution

The Australian Constitution defines the responsibilities of the federal government, including: foreign relations, trade, defense, and immigration. All matters not assigned to the Commonwealth are the responsibility of the states and territories, and they, too, adhere to same principles of government. In the states, the Queen is represented by a Governor for each state. Similar to the Supreme Court in the United States, the High Court of Australia arbitrates on disputes between the Commonwealth and the states. Many of the court's decisions have expanded the constitutional powers and responsibilities of the federal government.

Frequent Elections

A general election must be held within 3 years of the first meeting of a new federal parliament, on average approximately 2.5 years. General elections are held when the Governor-General agrees to a request from the Prime Minister, who then selects the date of the election. On average, the governing party has changed about every 5 years since 1901. The Liberal Party had the longest hold on government – 23 years – from 1949 to 1972, while prior to World War II, several government were in power less than 1 year. However, since 1945, there have been only seven changes of government.

Parties

Although Australia's political parties and their internal operations are somewhat unregulated in comparison to other developed countries, their internal party discipline is extremely tight. Through the Australian Electoral Commission and its state and territory equivalents, there is an official system of party registration and reporting of party activities.

Australia has four main political parties: the Australian Labor Party (ALP), a social democratic party founded by the Australian labor movement; the Liberal Party, a party of the center right; the National Party of Australia, a conservative party representing rural interests; and the Australian Greens, a left-wing and environmentalist party.

Australian Politics: Shaping Immigration

Over the last decade, leaders of the major Federal political parties have demonstrated support for high level immigration. Over the period of the Howard Government, from 1996 to 2007, there was an upward trend in the number of immigrants to Australia; the final immigration intake of the Howard era was the largest in Australia's history. The Rudd Labor Government, that has followed the Howard Government, has increased the quota again. In 2010, both major parties continued to support high immigration.

At times, immigration policy has been controversial, especially during the economic downturn of the early 1990s. It was then that the policy of mandatory detention of unauthorized immigration arrivals was established by the Australian Labor Party. The policy was designed to prevent the circumvention of the immigration process. However, the policy became increasingly controversial, particularly after a system of processing claims for asylum offshore was established. While the policy was popular with the electorate initially, it came under criticism from a range of religious, community, and political groups until, in 2005, the Liberal Government ended the practice of detention of children.

With projections of a population of 35 million by 2050, there is considerable debate as to how to organize infrastructure to accommodate accordingly. The current Federal Finance Minister Lindsay Tanner rejects arguments that Australia should lower immigration on environmental grounds. Still others remain vocal critics of high immigration, touting that population growth is unsustainable on a dry continent. The Australian Greens also favor keeping Australia's population low on environmental grounds.

Emigration

Emigration, persons leaving Australia, has increased steadily in recent years.

A total of 86,277 persons indicated that they left Australia permanently in 2009–2010. Statistics are based on information given by persons as they depart Australia. It is important to note that the figures provide a glimpse of the current emigration trends; however, they do not represent totally the emigration picture. For example, the numbers do not account for those who record they are leaving temporarily but who do not return, nor do they include those who indicate they are leaving permanently but who then return.

Reasons for Emigration

Usually the decision to leave Australia is based on a variety of complex reasons that are influenced frequently by personal, social, or familial concerns. Foreign-born emigrants may return to their country of birth because of feeling homesick or insecure; this is true especially of those who exit within a year or two of arrival. Older emigrants sometimes are spurred to depart after they retire, while widowhood or divorce will motivate others. Also, younger immigrants may return to their country of birth when needed by family in their former country.

For native-born persons, usually the decision to leave permanently is based on economic reasons, particularly employment. Some children born in Australia to former settlers return eventually with their parents to their country of origin. With the exception of New Zealanders, there is no significant relationship between unemployment rates and emigration; high unemployment rates do not necessarily lead to increased emigration.

Emigration by Native-Born

In terms of Australia's foreign-born during the postwar period, emigration levels have been associated with high or low numbers of permanent arrivals 2 years prior, as only a small number migrating to Australia chose to leave within 2 years. In recent years, however, more Australian-born residents have been emigrating, a trend likely to continue as a result of the internationalization of labor markets.

Emigration by Foreign-Born

Of the 86,277 persons who departed permanently in 2009–2010, 50.7% were born overseas, a slight increase on the 2008–2009 figure of 49.1%. The largest group of overseas-born emigrants in 2009–2010 was the New Zealand-born, with 8,744 people, comprising 10.1% of all emigrants. Permanent movements between Australia and New Zealand reflect differences between incomes and employment opportunities in the two countries. The United Kingdom–born were the second largest emigrant group, with 7,127 people (8.3%) leaving permanently. The majority of these groups returned to their country of birth, for example, New Zealand (81.3%), United States (66.9%), Singapore (63.5%), and Vietnam (59%).

Emigration by Australian-Born

In 2009–2010, 42,570 Australia-born persons departed permanently; this includes the Australia-born children of former settlers. The majority of Australia-born who are leaving are emigrating to the United Kingdom, the United States, or to New Zealand. In 2009–2010, 46.3% of Australian-born emigrants went to one of these three countries. The next most popular destinations were Singapore (9.1%), the United Arab Emirates (6.3%), and Hong Kong SAR (5.2%).

Effects of Emigration

The effects of emigration are varied, but in general they include: implications for private and public services planning; represent a potential loss of skills and experience due to *brain drain*; and represent a loss of social investment in education, training, and health services. By facilitating access to overseas markets, emigrants help establish links between Australia and its trading partners. Emigrants may send back substantial remittances and invest foreign currency in Australia, and those who return to Australia may bring back new skills and knowledge.

Health Care

Health care in Australia is provided by private and government institutions. Primary health care is the responsibility of the federal government, elements of which are overseen by individual states. The current system, known as Medicare, was instituted in 1984. Medicare coexists with a private health system and is funded partly by a 1.5% income tax levy, but mostly out of general revenue. An additional levy of 1% is imposed on high-income earners who do not hold private health insurance. As well as Medicare, there is a separate Pharmaceutical Benefits Scheme that subsidizes prescription medications. In 2007–2008, Australia spent 9.1% of its Gross Domestic Product on health care.

Health Statistics

The life expectancy of Australians in 1999–2001 was 79.7 years, 77.0 years for males and 82.4 year for females. In 2000, the infant mortality rate was 5.2 per 1,000, and the death rate was 6.7 deaths per year per 1,000 persons. Also in the year 2000, the neonatal infant mortality rate in Australia was 3.5 per 1,000 births, and the postneonatal infant mortality rate was 1.7 per 1,000.

Indigenous Health

Health and well-being statistics indicate Indigenous Australians are much less healthy than the rest of the Australian community. One leading indicator, infant mortality rates, including stillbirths and deaths in the first month of life, show Indigenous child mortality is two times as high as non-Indigenous child mortality. Another indicator is the 17-year disparity in average life expectancy between indigenous and other Australians.

Preventable Diseases

Tobacco use is the largest preventable cause of death and disease in Australia. Australia has one of the highest proportions of overweight citizens of all developed nations. Australian health statistics reflect that chronic disease such as heart disease, particularly strokes – reflective of a more affluent lifestyle – is a common cause of death. Australians are prone to skin cancer, affecting Queensland the most. Other health issues include compensation for victims of asbestos exposure–related disease, provision of adequate mental health services, and quality care for the elderly.

Related Topics

- ▶ Asylum
- ▶ Brain drain
- ▶ Detention
- ▶ Emigration
- ▶ Health care
- ▶ Health disparities
- ▶ Health policy
- ▶ Human rights
- ▶ Illegal immigration
- ▶ Medical examination (for immigration)
- ▶ Public health insurance
- ▶ United Nations High Commissioner for Refugees

Suggested Readings

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Suggested Resources

For information from the Australian Government: Department of Health and Aging: http://www.health.gov.au/

For information on Emigration from Australia: http://www.immi.gov.au/media/fact-sheets/05emigration.htm

For information on Living in Australia: http://www.immi.gov.au/

For information on the Australian Institute of Health and Welfare: http://www.aihw.gov.au/

For information on the United Nations High Commissioner for Refugees: http://www.unhcr.org

Autonomy

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This entry focuses on autonomy in health care. A patient's right to make decisions about their health and medical care is a fundamental value in the United States. Patient autonomy has a long history in US case law and more recently, in medical ethics. Legal decisions have consistently upheld the doctrine that competent adults have the right to determine if they will receive medical care as well as to choose the type of care they will receive. Similarly, autonomy is a priority in principlism, the prevailing framework for bioethical decisions in the United States. Among the four core ethical principles, respect for autonomy (self-rule or self-governance) is often given priority ahead of beneficence (acting in the patient's best interests), nonmaleficence (doing no harm), and justice (treating people fairly). Veatch emphasizes that autonomy is a foundational principle from which other ethical values stem. Autonomous acts have three components: (1) intentionality, (2) understanding, and (3) freedom from external control.

Background of Autonomy

In making autonomous health care decisions, patient understanding is reflected in the requirement for patients to provide informed consent for medical procedures. To meet this standard, patients should receive the following: complete information about their medical condition, therapeutic options including the choice of no treatment, risks and benefits of treatment options, and the condition's prognosis with and without treatment. Historically, the ethical emphasis on patient autonomy is, in part, a reaction to a recognized power imbalance between health care professionals and patients. This chronological shift away from physician paternalism is illustrated by changes in practice about informing patients of a cancer diagnosis. In 1960, only about 10% of US oncologists reported regularly disclosing a cancer diagnosis to patients. By 1990, the pattern was reversed, with 90% of physicians reporting disclosure. This move away from paternalism was accelerated by legislative reaction to several publicized legal cases involving end-of-life care. In both the Quinlan and Cruzan cases, young women in persistent vegetative states were being maintained on life support or feeding tubes for years, to a large extent, because their wishes regarding treatment options had never been articulated. In the absence of a clearly communicated autonomous choice by the patient, legal authorities were unwilling to withdraw life-sustaining therapy.

Soon after the death of Karen Quinlan, the US Congress passed the Patient Self-Determination Act (PSDA), which included mechanisms to extend individual autonomy to situations in which patients could no longer convey choices. The PSDA required health care institutions receiving federal support to implement policies for educating patients about advance directives (AD). These methods, which would become active when patients could no longer articulate choices, included the living will (documents listing specific desired life-sustaining measures) and the durable power of attorney (a document naming someone, typically a family member, to make decisions on the patient's behalf). Both forms of ADs, in effect, extended patient autonomy to possible future situations where decision-making and/or communication were not possible.

Culture and Autonomy

Challenges to the priority of patient autonomy became apparent early in the PSDA's implementation with minority communities. Particularly among immigrants who were less acculturated to the United States, the requirements for informed consent to medical procedures and patient-centered decision-making were often disturbing. Blackhall and colleagues conducted several studies that provided empirical evidence of cultural differences regarding patient autonomy in making medical decisions. In their now landmark study, 200 adults from each of four ethnic groups were asked whether patients should be directly informed of a diagnosis of metastatic cancer. Among the ethnic groups, there were distinct differences: Korean-Americans were least likely (47%) along with Mexican Americans (65%) to state that patients should be directly informed of their diagnosis compared with European Americans (87%) and African-Americans (63%). When asked who should make decisions regarding life support, 28% of Korean- and 41% of Mexican-Americans indicated that the patients themselves should make these decisions while 60% of European Americans and 65% of African-Americans preferred patient-centered decision-making. Both Korean- and Mexican-Americans reported a preference for family members to make these choices. The results of this study and others suggest that autonomous choice for patients is not a universal value. In particular, cultures which are more collectivist, emphasizing one's relationships and pattern of obligation to others, are less likely to value individualism in making significant health care decisions.

Alternative Conceptions of Autonomy: Rationale

From the perspective of principlism, the de-emphasis on autonomy is associated with greater value for nonmaleficence and beneficence. Nondisclosure, a practice in many countries, is often guided by a desire to avoid emotional harm to the patient as well as to maintain their hope and optimism. In her study of contemporary Japanese health care, Long observed that disclosure of a diagnosis to patients was often at the physician's discretion. In the United States, there are multiple accounts of families of Asian background requesting that the physician not disclose a cancer diagnosis to a parent or grandparent.

Maintaining a positive outlook is also important both for the patient and their family. The patient's knowledge of a serious illness would have a detrimental effect on any hope for recovery and diminish emotional strength for fighting their illness. This theme has emerged in studies involving diverse populations ranging from Caresse and Rhodes' observations of the US Navajo to Searight and Gafford's interviews with Bosnian immigrants.

The norm of non-disclosure may create particular dilemmas when foreign language interpreters are necessary. Case reports indicate that some interpreters either do not interpret physicians' communication of diagnoses of conditions such as cancer. Instead, similar to physicians in many countries, interpreters may use euphemisms such as “tumor” or “mass.” This failure to disclose nearly always stems from concern for the patient’s psychological well-being.

Alternatives to Individual Decision-Making

Cross-culturally, this concern about patients’ emotional welfare is associated with alternative approaches to decision making. With a relative emphasis on beneficence and non-maleficence, family members receive information about the patient’s diagnosis and prognosis from the physician and make treatment choices, often without the patient’s direct input. Several studies have found a preference among Korean-American, Mexican-American, Japanese, and Bosnian patients for physicians to inform the family about a patient’s condition rather than the patient, themselves. With greater acculturation, Mexican-Americans were more likely to agree that patients should be directly informed of their conditions. However, even more acculturated Mexican-Americans continued to view decision-making as a family-centered process.

Among Asian cultures, illness is often considered a family event rather than an individual occurrence. Similarly, treatment decisions are made with a collective orientation which often results in extraordinary measures to maintain a parent’s life in the face of futility. However, interests in Asian families are often bidirectional – there is an equivalent concern about the impact of the elderly person’s death on the family. Among immigrant families attempting to navigate the financial, legal, and social demands of US culture, this mutual responsibility may be diluted with greater emphasis on the individual burden of caring for aging parents.

While multiple forces, such as consumerism and managed care, are contributing to reduced authority among American physicians, many cultures attribute a high degree of authority, respect, and trust to physicians. In these cultures, the physician’s judgment about end-of-life care supersedes that of both the patient and their family. Eastern European medicine has had a long tradition of physician-centered, paternalistic decision-making. In Russian medicine, the physician rather than the patient or patient’s family, often unilaterally determines a patient’s level of life support. Recent Bosnian immigrants to the United States viewed the physician as an expert who would independently make the best decisions on their behalf.

While many investigators and ethicists have concluded that personal autonomy is less significant in collectivist versus individualist cultures, this position is likely to be an oversimplification. Instead, Western concepts of autonomy are challenged by new definitions reflecting broader psychosocial boundaries of the individual. In cultures influenced by collectivism, personhood is defined very differently than in the West. Ethnographic studies of cultures from Italy to many African countries have concluded that individuals are inextricably defined by their participation in social groups. Personhood does not exist outside of these relationships.

While White Europeans’ well-differentiated individual selves are highlighted in cross-cultural studies, a closer examination qualifies this picture. An often cited reason for White Europeans’ desire for complete medical information, treatment options, and prognosis is to address practical issues. Planning is necessary to insure that moral responsibilities to spouses and children are met after one’s death.

Conclusions

Autonomy is an evolving concept in health care. In many countries, it is still a common practice for physicians to withhold diagnostic information from patients. Even in societies such as Japan where patient participants in clinical cancer trials are not informed of their condition or the reasons that they are receiving an experimental treatment, Western views of patient autonomy are beginning to be appreciated. Younger Japanese physicians, particularly those with training in the United States, are informing patients of their diagnosis and their right to decide their own treatment.

The distinction between the individual and the collective in autonomous decision-making may be overstated. From the perspective of principlism, Beauchamp and Childress suggest that patients relying on family-based decision-making are making an independent choice to have others decide for them. Similarly, while informed consent is generally seen as necessary for truly autonomous decisions, patients may intentionally waive their right in the interest of their emotional well-being and to sustain the energy to live as long as possible.

In the United States, health care providers have become increasingly aware of differing definitions of autonomy. Many physicians and nurses have begun asking patients if they would like to be informed of and make decisions about their condition. If patients prefer being uninformed, they should be asked if they have designated someone, such as a family member, to communicate with the health care provider on their behalf.

Related Topics

- ► Collectivism
- ► Cross-cultural medicine
- ► End-of-life care
- ► Ethical issues in research with immigrants and refugees
- ► Ethical issues in the clinical context
- ► Health perception
- ► Individualism

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Autopsy

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Autopsy (also known as necropsy or post mortem examination) is a surgical procedure that consists of the examination of tissues and organs of a corpse to determine the cause and the manner of death. Having in view the medical and judiciary purpose and relevance of this procedure, a distinction between pathology autopsy and forensic autopsy must be made. Pathology autopsy is directly conditioned by the deceased's consent expressed during her/his life or by her/his family's consent. Consent is not required for autopsy in some countries, but families may object to non-forensic autopsies. Survivors may also sue for damages based on their mental anguish for autopsies that were performed without legal approval or that were more extensive than authorized.

Forensic autopsy is carried out when legal authorities explicitly ask for it in the limited situations indicated by the criminal law (violent death, death of unknown causes, suspicious/sudden death). Forensic autopsy is undoubtedly a social necessity in helping to resolve juridical/police investigations. In this case, the wish of the deceased person to not be submitted to an autopsy (a wish that was expressed while the person was still alive) and the family's similar wish cannot prevail in the face of legal provisions that protect the general community's interests (medical or judiciary).

Autopsy has to be clearly differentiated from the anatomic dissection of a human corpse. The invasion of the corpse during autopsy is partial and temporary; at the conclusion of this procedure, the corpse is returned to the family in order to undergo traditional religious and funeral services. The purpose of the autopsy is to determine the cause and manner of death. The anatomic dissection consists of the in-depth exploration of the tissues and organs for teaching or research purposes. The corpse that is submitted to an anatomic dissection does not usually undergo traditional funeral services.

During the autopsy the corpse is obviously subjected to invasive procedures. The necessity to perform the autopsy may conflict with both the right to physical integrity of the deceased person and the respect owed to the human corpse. Nevertheless, performing an autopsy on a human corpse under strictly controlled conditions may be accepted and even obligatory from a moral, ethical, and legal point of view in certain circumstances (such as those indicated by the criminal law).

Traditions, beliefs, and practices surrounding death may conflict with anatomic dissection and postmortem examination. Persons from more Westernized or diverse environments who have less cohesive connections with traditions, religion, and beliefs may show a greater acceptance of autopsy and dissection. However, non-Westernized, less diverse cultural groups may have more unified traditions, beliefs, and practices surrounding death, and they more frequently have religious objections related to autopsy and dissection.

Although cultural or religious beliefs are often cited as reasons for opposition to autopsy, most religions and cultures accept autopsy as a medical procedure either based on the individuals' beliefs or special circumstances. Certain religions prohibit autopsy outright (e.g., Islam and Judaism) in that bodily intrusion violates beliefs about the sanctity of keeping the human body whole; however, religious doctrine does not in itself strictly forbid autopsy. Instead, it is a matter of interpretation of the doctrines which have changed over time.

For example, Jewish law, in general, prohibits cutting or dissecting the body and considers the autopsy an act of desecration, except under exceptional circumstances. It also requires that the body be buried in consecrated ground and that burial take place as soon as possible after death. Islamic tradition requires burial before sunset on the day of death. It is obvious that this requirement cannot be respected when autopsy is performed.

Catholics recognize the value of the autopsy and generally agree with its use for determination of the cause of death and medical education. In the Catholic view the autopsy may even be considered an act of charity.

Worldwide changes in legal systems, particularly in the European countries, often permit the free movement of persons; as a consequence, international migration increased. Apart from legal immigrants, there are also a large number of illegal immigrants who do not hold any identity documents.

Deceased illegal immigrants may become the subject of forensic autopsy, mainly because they cannot be identified (because they do not hold identity documents). Many immigrants do not have access to medical services and that is why it is impossible to have any medical evidence of their health status; therefore when such a person dies, the cause of death is often unknown, and a forensic autopsy is required in order to clarify this aspect.

When an individual dies in a foreign country, the autopsy may be requested or required upon the body's return to her/his home country (even if it has already been autopsied) to clarify insurance claims or to investigate criminal activity.

Related Topics

- ▶ Christianity
- ▶ End-of-life care
- ▶ Injuries
- ▶ Islam
- ▶ Judaism
- ▶ Religion, religiosity, and spirituality
- ▶ Violence

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Suggested Resources

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Back Pain

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Back pain is one of the most frequent medical problems; 80–90% of adults experience back pain at some time in their lives. The low back is most commonly affected. Back pain is also one of the most common reasons why people consult their doctor or are absent from work. Therefore the economic impact of lost productivity due to back pain is substantial, as is the cost of rehabilitation and pensions for back pain.

A number of underlying diseases can give rise to back pain including problems with muscles, bones, intervertebral discs, and nerves, but often no specific cause for the pain can be identified. One differentiates acute back pain (usually lasting for a few days to a few weeks) from chronic back pain (lasting for 3 months or more) by the duration of the problem. Of back pain with an acute onset, about 90% is reversible within a few days to a couple of months. The remainder becomes chronic. The following have been described as risk factors for progression to a chronic condition: problems with integration into society, dissatisfaction with work, unemployment, low educational attainment, depression, and physical strain.

While back pain as a symptom is very common in native and immigrant populations, it may be more common among certain immigrants compared with nonmigrants of the same ethnicity. For example, it has been reported that low back pain is more common among Pakistanis living in England compared with Pakistanis in Pakistan. Furthermore, certain groups of immigrants may differ from native populations of their adopted country with regard to the susceptibility to specific diseases that can cause back pain because of a different ethnic background. For example, elderly women of Asian ethnicity (like non-Hispanic Whites) are at high risk of developing osteoporosis, a disease that can lead to back pain after vertebral fracture; African American and Hispanic women are at lower risk. Psychosocial causes of back pain can also differ according to socioeconomic status or ethnicity and therefore differently affect immigrants and native populations. For example, a recent study found that perceived discrimination was a strong predictor of back pain in African Americans but was minimally related or unrelated to back pain in Whites.

Jobs that involve heavy lifting, bending, or twisting are associated with occupational back injury. Such manual occupations are common among immigrants, especially those who are unskilled or whose qualifications are not recognized in their adopted country.

Approaches to back pain management may also differ between native populations and immigrants, for example, with regard to the use of Western medicine versus alternative and traditional remedies. Access to medical care and social services is vital for those with chronic back pain but can be difficult for illegal immigrants or those with language difficulties.

Related Topics

- ► Chronic pain
- ► Depression
- ► Occupational and environmental health
- ► Pain

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Suggested Resources

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Bangladesh

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Country Characteristics

Bangladesh spans approximately 140,000 km^2 and is home to approximately 150 million people. The country is bordered by India on the west, north, and east; by the Bay of Bengal on the south; and by Myanmar to the southeast. It was part of India until 1947, when it was designated "East Pakistan," finally gaining independence in 1971.

Bangladesh is an Islamic nation and has one of the largest Muslim populations in the world. Approximately 80% of its inhabitants are Muslim, while Hindus account for about 15% of the country's residents. Hindus are concentrated in certain areas, such as Khulna and Barisal. In Bangladesh, the work week is Sunday through Thursday. Friday is considered the holy day in Islam, during which there are large morning prayers at mosques.

Hurricanes, or cyclones, are common in Bangladesh, and they lead frequently to flooding. From May to September, there is heavy rainfall, while during the winter, the country endures a dry season. With its low elevation, Bangladesh is vulnerable to flooding. Due to heavy rainfall and the prevalence of mosquitoes, malaria and dengue are widespread. Three large rivers run through Bangladesh – Ganga, Jamuna, and Meghna. The Sundarbans in the southwest of the country is the world's largest mangrove forest. Cox's Bazaar in southeastern Bangladesh, spanning 75 miles, is the world's longest beach.

The capital, Dhaka, is the country's largest city, followed by Chittagong, located in the southeast. Three-fourths of Bangladeshis live in a rural setting. In urban settings like Dhaka, wealthier people live in tall apartment buildings, while in the villages people live in simple homes mostly made from dried mud with roofs of thatch or metal sheets. Kitchens and toilets in the villages are in separate structures built away from the primary house.

The soil in Bangladesh is quite fertile; however, due to flooding and a high population density, there is comparatively little land for farming and grazing. Rice is the main crop and the main staple of the diet in Bangladesh. Other significant crops are tea, tobacco, and jute. Jute is a fiber that can be used to make ropes or mats; its export is central to the economy. Two-thirds of the country's workforce is involved in agriculture. About one million of the population are fishermen, and many more people fish occasionally to supplement their diet. Chittagong is the main seaport. Also, with a large portion of exports going to the USA, manufacturing garments is a significant part of Bangladesh's industry.

The national currency is the taka, and about 70 taka is equivalent to 1 US dollar. The approximate average yearly income in Bangladesh is about 430 US dollars. Roughly 45% of Bangladeshis are below the poverty line, while 20% of the workforce is comprised of children.

The structure of Bangladesh's government is a parliamentary democracy consisting of 300 members. The National Parliament, called Jatiya Sangsad, is elected by citizens of districts. Forty-five additional seats are reserved for women, and these positions can be obtained by traditional election or by appointment from other Parliament members. The president, elected by Jatiya Sangsad, serves a 5 year term, must be at least 35 years old, and cannot be a Member of Parliament. The president appoints the prime minister from majority party members of Parliament to serve a term up to 5 years. Any other cabinet members are appointed by the prime minister, and the prime minister is responsible primarily for creating and executing public policy.

The country is composed of six administrative areas called divisions, including: Rajshah, Dhaka, Kulna, Sylhet, Barisal, and Chittagong, which are further divided into districts. Bangladeshis can vote at age 18. Awami League, Bangladesh National Party, Jamaat-i-Islam, Jatiya Party, Isla Oikya Jote, and The Bangladesh Communist Party are some of the political parties.

The official language is Bengali, also known as Bangla, derived from the Indo-Aryan linguistic family. Bangla script is composed of 12 vowels and 52 consonants. The food and clothing is similar to neighboring India.

Men in the urban areas wear shirts and pants, while in the rural regions they may wear the traditional lungi, which is a type of sarong. Generally, women wear saris, a long piece of fabric that can be draped in a variety of ways.

The water lily is the national flower. The national flag is a red circle, symbolizing bloodshed during the Liberation War, as well as the "rising sun of a new country" against a green background – referring to Islam and the country's rich plant life. Nobel laureate Rabindranath Tagore, from West Bengal, India, wrote the country's national anthem. The endangered species, the Bengal Tiger, lives in the Sundarbans; however, they are not seen frequently. Popular sports include cricket, hockey, and soccer.

Only about 20% of the population finishes high school. Elementary school is free and compulsory, although not strictly enforced. To encourage women to continue education and not enter into child marriage, secondary school is free for women from rural villages. About 40% of the total population is literate, with about 50% of men and 30% of women able to read and write. The largest university in Bangladesh is the University of Dhaka.

Less than 40% of Bangladeshis have access to a radio, and only 10% have televisions. Music and dance include classical and folk styles; both have roots in Indian culture. The classical dances include bharatnatyam and kathak, while the Bangladeshi folk dances include manipuri and dhali. Terra-cotta pottery is a popular folk-art form. Eid-Ul-Fitr is the largest religious festival in Bangladesh. Secular holidays include Pawhela Boishakh, or Bengali New Year, in mid April and International Mother Language Day on February 21st. Secular holidays often are celebrated with music and dance.

Typically, Bangladeshis eat three meals a day. They may eat flatbread in the morning, but will eat rice for lunch and dinner if financially feasible. Typically they eat with their hands, using the right hand specifically. It is important to understand cultural practices to facilitate patient care, as many immigrants maintain traditions similar to their home countries.

Immigrant Health

A major health problem in Bangladesh is diabetes. For many reasons, including patients not seeking primary care, often diabetes is underdiagnosed. It has been documented that 20% of South Asian immigrants to England suffer from diabetes. Furthermore, South Asian patients have a three- to fourfold higher mortality from cardiovascular disease than other diabetics. It is not known why Bangladeshis suffer more than other populations from high insulin levels and impaired glucose tolerance, but it is postulated that this may have been an evolutionary process to cope with famine and survive in periods of low food consumption.

Bangladeshi immigrants have a high incidence of cardiovascular disease, in addition to insulin resistance; a major risk factor is diabetes. Other risk factors seen in the South Asian population include low high-density lipoprotein cholesterol and high triglycerides. Central obesity has been associated with high levels of insulin and coronary artery disease. A high waist to hip ratio, an indicator of central obesity, has been cited as a strong independent predictor of coronary artery disease. Some nontraditional risk factors in Bangladeshis include arsenic contamination, low physical activity, and ghee (clarified butter) consumption. A high proportion of Bangladeshi immigrants are smokers, and smoking is a known risk factor for coronary artery disease. Smoking cessation is key to cardiovascular health.

Malnutrition is a common finding in Bangladeshi children. The immigrant population in the London borough of Tower Hamlets has been studied, and prevalent maladies include rickets, iron deficiency anemia, difficulty weaning from a milk predominant diet, and gastroenteritis. Immigrants' diets tend to be high in carbohydrates, and generally children consume adequate Vitamin C, calcium, and protein. Many children continue a milk diet even into their second and third years of life. Most of the children with rickets had prolonged breastfeeding without vitamin supplementation. It is essential for children to have adequate vitamins and fortified foods to supplement their diets.

Vaccinations are crucial for improving children's morbidity and mortality. Historically, poliomyelitis has been a problem in Bangladesh – the last reported case was in August 2000. Polio has been controlled successfully with extensive public health programs supported by the World Health Organization. Often other routine vaccinations are missed in Bangladesh and in the immigrant population. Barriers are numerous, but it is essential to emphasize adherence to vaccination schedules. It has been observed that adherence to immunization schedules is higher among children of mothers who have higher incomes and education.

Barriers to healthcare include difficulties with language, transportation, poverty, and stereotypes. Some families may be conservative and not allow women to leave the home alone, and situations have been described in which patients cannot access care because they have no chaperone to accompany them to an appointment. Attending primary care visits can be challenging. Immigrant families may be large, and there can be many different obligations including health care visits for older family members or religious activities that may prevent routine care. Other well-studied barriers common worldwide include poverty and ignorance.

Related Topics

- ► Cardiovascular disease
- ► Diabetes mellitus
- ► Food insecurity
- ► Islam
- ► Nutrition
- ► Refugee health and screening

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Suggested Resources

For immunization information. www.cdc.gov/

For nutrition information. http://www.mypyramid.gov/

For nutrition requirements. http://www.who.int/nutrition/topics/nutrecomm/en/index.html

Barriers to Care

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In seeking health care, immigrants face different kinds of barriers that could affect their willingness to seek care from a doctor or a hospital. Immigrants, often frightened or skeptical of health care and often with no health benefits, may only seek care in emergencies when treatment options may be limited or complications more severe. Understanding barriers to care may reveal strategies to encourage preventive and routine care in this vulnerable group. These barriers are summarized into several categories:

1. Economic and financial barriers
2. Political barriers
3. Legal status barriers
4. Language barriers
5. Cultural and/or religious barriers
6. Social perception barriers
7. Health status

The context of accessing the healthcare system by the immigrants will be illuminated as, each type of these barriers are identified and discussed.

Economic and Financial Barriers

Immigrants, important members of society, contribute to the cultural diversity and the economy of every country. Despite these contributions they receive fewer health services than native-born citizens. The first plausible explanation is the one related to the insurance status. Romania, a country that has a public health insurance system, requires mandatory health insurance contributions paid by legally employed people. In addition, a part of it is paid by the employer, in order that the employee is insured. Therefore, immigrants that work legally and whose employer pays part of the contribution have health-insured status. Direct payments by citizens in Romania will also provide health insurance. Thus, only immigrants that are legally employed or pay themselves are insured in this public healthcare system. If one of the family members is legally employed and health insured, the children are also considered insured. Another member of the family has to pay only a small amount of money (coinsured) to be insured. This public system offers health insurance that benefits the whole family, getting free access to the healthcare system. In other countries, like the USA, the immigrants have to pay for health insurance. Often they cannot afford health insurance or work for an employer who does not offer health insurance. This is why only legally employed immigrants might be considered as health insured.

Lack of health insurance is a major barrier that limits the access to health care of the immigrants. According to the 2006 Report from the New York City, Department of Health and Mental Hygiene, foreign-born adults (under 65 years) are more than twice as likely to be uninsured (22%) than the US-born citizens (9%). The lowest rate of uninsured immigrants in New York City has been attributed to immigrants coming from Israel (2%).

The financial situation of the immigrants, most of them having a very low income, poses a further barrier to health care. The study called "Immigrant in Romania: Perspectives and Risks" (2008) done by the Soros Foundation draws attention to the fact that foreign immigrants in Romania are an easy target for some employers willing to make a good profit with a cheap workforce. Immigrants may have cultural and language differences, lack union representation, and lack information regarding immigrants' rights, making them vulnerable to unscrupulous employers. Usually, immigrants are paid less for the same job than are native-born citizens, though the income is higher than in their native country. Thus, immigrants often have poor work environments and poor wages, and experience financial constraints in accessing services.

Disparities confronting immigrants appear similar to those faced by low-income populations. Yet, still there are differences between immigrants and low-income groups. For example, a study in the USA shows that in 2001 low-income noncitizens were twice as likely to be uninsured than low-income US citizens, more precisely, from 11 million low-income noncitizens, 60% were uninsured, compared to 28% low-income citizens. These facts point out that besides the economic situation and the insurance status, there are other barriers to be considered when analyzing immigrant's access to health care.

Political Barriers

In the USA, the 1996 welfare-reform legislation has restricted immigrants' access to the public-funded health programs, Medicaid, for example. Since 1996, Medicaid has been restricted only to legal immigrants that must wait for 5 years after obtaining a "green card" for permanent residency, in order to apply for this program. Further, it shifted most of the healthcare responsibility to state and local governments that often have fiscal constraints. In addition, another legal provision in 2005 stipulated that every citizen applying for or renewing Medicaid insurance had to provide proof of identity and of US citizenship. These eligibility and documentation requirements pose a barrier for many immigrants in getting needed health care.

In Romania, the policy for access to the healthcare system is directly related to the insured/noninsured status. Only the legal immigrant also employed legally and his/her children may have free to the healthcare system. This policy, the same as the one for Romania's native-born citizens, discourages work on the black market, and attempts to protect immigrants' rights as well as native-born individuals. Most of the countries have policies regarding accessing the healthcare system in emergency cases. In Romania, as well as in the USA, in these situations the access is free, no matter the insured/noninsured status. Although free, immigrants may overutilize emergency care rather than preventive care.

Legal Status Barriers

Laws and regulations affecting immigrants pose substantial barriers to accessing health care. Researchers underscore that immigrants coming from countries where medical practitioners report patients with diseases related to possible illegal activities such as infections resulting from illegal abortions, drug abuse, sexually transmitted diseases acquired through prostitution or extramarital sexual activity to law authorities may be particularly fearful of seeking health care. Illegal immigrants may also be fearful that visiting a hospital could draw the attention of immigration officers and result in deportation. The number of undocumented immigrants is significant and continues to grow emphasizing the importance of the issue. For example, in the USA, in 1970, less than 5% of the immigrants were undocumented, but in 2002, almost 50% among immigrants for less than 5 years, were undocumented. This legal barrier in addition to uninsured status and low-income status may explain why immigrants access the healthcare system mostly in emergency situations.

Language Barriers

Language barriers have two important parts. First, most immigrants face language difficulties. In addition, the level of education of the immigrants is sometimes lower than high-school level. Language barriers impact communication when the patient is not able to understand the medical information and/or the translator may not be available or qualified. Using a translator or interpreter seems logical, and convenient, yet may not be the best solution. For example, some terms or phrases might not be so easily translatable in other languages or are just not translatable (do not have a good equivalent), leading to misinterpretations and confusion. On the other hand, hospitals and clinics are not able to provide translators for every language and the role of a translator might be played by a family member, a friend, a colleague. In this situation, these persons may translate the information with their own opinions and understandings that could contribute to inaccuracies or confusion.

The second aspect of the language barriers is that healthcare providers do not know or comprehend every patient's speaking language, so cannot communicate with the patient or in this manner or check the accuracy of translation.

Language barriers impair the patient–physician relationship that must be based on effective communication and understanding. Good communication influences the patient's autonomy and future willingness to access the healthcare system. For example, a group of Mexican Americans born outside of the USA accessed the mental health services at a rate that was two-fifths of the Mexican Americans born in the USA. Language barriers were suggested as the explanation since none of the mental healthcare providers spoke Spanish.

Cultural and/or Religious Barriers

Cultural and/or religious barriers may conflict with the recommendations of traditional medicine. Beliefs regarding pregnancy such as age at marriage and conception, prescription of herbs or foods encountered in different cultures and religions, illustrate how cultural values may present different perspectives about how to access care and engage in treatment approaches. For example, Southeast Asian immigrants in the USA have been found to have the lowest rate of cervical cancer screening (Papanicolau test) among all racial or ethnic groups. The unacceptability of blood transfusion among Jehovah's Witnesses, not even in emergency cases when it is a matter of life and death, is another example of the influence of cultural and religious values on health care. Circumcision of the newborn after birth, a ritual that may bring the significance of the "social birth," is another example that may conflict with medical practice. In some cultures and traditions, menstruation is seen as a sign of impurity and menstruating women are segregated from their family, partner, or from their religious community.

Also, in some cultures, the autonomy of the patient is not valued in the same way as in Western cultures. For example, in some Indian groups, only the family must be informed about patient's health and they have to decide what is best for their relative; the patient is not informed.

These examples underscore the fact that cultural and/or religious values are strong determinants of "health." In case of the immigrants, these values might come into conflict with medical values, influencing the desire to seek health care and comply with medical guidance.

Social Perception Barriers

Anti-immigrant sentiment is well documented. Immigrants who obtain specific benefits may be perceived as getting these at the expense of natives and thus provoke feelings of unfairness. In addition, the fact that the immigrants work more cheaply than the native-born citizens and cause competition for jobs, may lead to even a stronger anti-immigrant attitude.

Health Status

Studies suggest the US foreign-born population appears to be healthier than the population born outside the USA, when comparing obesity, tobacco use, hypertension, and some forms of cancer. Immigrants are also younger than US-born citizens. Age and health status of immigrants are two reasons that may explain why immigrants defer and avoid going to a doctor and only seek treatment when injured or are acutely ill. They may not feel like they need care if they are perceived as young and healthy.

These barriers play an important role in explaining why immigrants avoid seeking medical care, fear healthcare providers, or are anxious at learning and communicating in an unfamiliar culture. Healthcare seeking, when it occurs, is largely in emergency circumstances. Immigrants generally do not seek preventive primary care services that could maintain their health status. Most of the money spent for immigrants' health care, therefore, is focused on care of acute diseases or emergencies rather than a system of care that addresses the barriers to health care for this population.

Related Topics

- ▶ Access to care
- ▶ Health barriers
- ▶ Health beliefs
- ▶ Health care utilization
- ▶ Health education
- ▶ Health policy
- ▶ Health services utilization
- ▶ Human rights

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Battered Spouse

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The term "battered spouse" has most frequently been used to refer to the beating of a wife by her husband. Later, the use of the term was expanded to include nonmarital heterosexual partners. There has been increasing recognition that battering also occurs between same-sex partners who are cohabiting or dating. More recently, the promulgation of laws in various jurisdictions, including Spain, Canada, Mexico City, various states in the United States, and others, to permit marriage between same-sex partners has called into question current understandings of the dynamic underlying spousal violence.

Understandings of "Battered Spouse" in Heterosexual Marriages

The problem of violence against women by their husbands began to receive increased attention during the mid-twentieth century, as it became increasingly clear that wives were receiving less protection than strangers might for the same injuries, and that husbands were being treated more leniently by legal systems than strangers committing the same degree of violence. There has also been increased recognition of the negative consequences that can result from such violence, at both the individual and family levels.

The historical premises for the patriarchal organization of family and society date back centuries, to times when women were deemed to be the exclusive "property" of men. The passage from polygamy to monogamy has greatly contributed to women's subordination to men, since polygamous relationships often permit privileges to men whereas women are often required to maintain absolute fidelity. The subordination of women within their own marriages was often reinforced through institutional sexism.

It has been estimated that battering occurs in approximately one-quarter of all marriages, although it is much lower or much higher within specific cultures and groups. Why individuals batter their spouses and why the battered spouses remain in the relationship are questions that have been the focus of extensive study. Each case of marital violence occurs under particular conditions and has its specific causes, but there is a series of common factors that define the existence and the tendencies of this phenomenon. In the context of heterosexual marriages, these factors include the social attitudes and stereotypes that support and reinforce the "dominating" role of men and the "subordinate" role of women, gender inequality, the patriarchal organization of family and society, and women's economic dependence on their marital partner. External pressures, such as rapid social changes and an increased societal emphasis on sexuality may also contribute to pressures felt within the family. It is important to note, however, that there is not a linear correlation between the status of women in societies and the rates of wife abuse in those societies.

In many cases, violence against spouses is not just an isolated incident, it is repetitive and it occurs periodically in a specific three-step way: tension, aggression, and detente. During the tension stage the abuser humiliates the victim, using different techniques of intimidation. The victim tries to calm the aggressor because she feels helpless. In the next stage the situation becomes explosive, and therefore violent acts occur. Finally, the aggressor is remorseful and makes overtures to repair the relationship . . . until the cycle begins anew.

In order to continue their existence, abused women may use various strategies, such as trying to conceal or minimize the problem in an attempt to increase safety for themselves and their children. Some of them stand firm, others run away or try to keep peace and quiet in the family, being obedient to their husbands and their requests. Very often, what is seen from the outside as being passive can be just a survival strategy that women have adopted in order to protect their children from the violence.

Many battered spouses prefer not to divulge their history of abuse. In some cases, the attitude of society to violence can produce an acute feeling of embarrassment and even of guilt on the part of the victim for having been aggressed. The general tolerant attitude of society toward violence, manifested in various forms, can lead women to adopt an attitude of resignation and accept pain and humiliation as a "norm of life."

Most cases of immigrant women who are abused are not reported (occult family violence). Many women are abused in the course of a longer period of time and at the same time they are trapped in hopeless situations that they cannot immediately escape. These cases may include either relationships in which the victims are financially dependent, or in which they fear that they could have their children taken away from them or that they could discredit their families or could be ostracized by the other members of their family. Women's desire to become economically independent and to escape the violence that they suffer in their homes may prompt their migration.

In many cases, women do not trust the judicial system because of the prevailing societal attitudes toward women and the trauma associated with police and judicial procedures. This distrust may be heightened among immigrant women, who may fear deportation or whose husbands have threatened them with deportation if they should complain about their abuse.

There are several markers that may indicate to a health care provider that a woman is being abused by her partner, such as: chronic pains that indicate a poor state of health; frequent visits to doctors; sleep disorders (insomnia; violent nightmares); severe agitation, anxiety, permanent state of irritation; mental confusion, incapacity to decide, lack of concentration; use of tranquilizers and/or alcohol consumption; suicidal ideation or suicide attempts; low level of self-respect; emotional dependence on the partner; assuming responsibility for the partner's behavior; and inflexible opinions regarding the role of men and women.

Detection of abuse of immigrant women may be more difficult to identify due to their geographic and/or linguistic isolation. Isolation from family members and their usual social network also inhibits the discovery of and intervention against the violence.

Men may be the victims of partner abuse within heterosexual relationships. They may be even less likely to report the abuse than women, out of a belief that they should "take it like a man" or shame and embarrassment that they are being beaten by a woman. As with battering in same-sex relationships, the battering of men by their female partners challenges the theory that battering is necessarily associated with a patriarchal societal structure and the subordination of women.

Same-Sex Battered Spouse

Significantly less research has been conducted to examine the underlying causes and dynamics of battering within same-sex partner relationships. Current research suggests that the prevalence of battering between male partners may be even greater than that among heterosexual couples. Younger age and HIV seropositivity seem to place men at greater risk of being battered by their male partners.

A major issue for men is their lack of awareness of their situations; men may not see themselves as victims or as suffering from trauma specifically because they are men. They may be less likely than women to report their abuse due to multiple factors, including the perception that they are supposed to be strong, the lack of structural supports such as shelters for battered men, and condemnation of homosexuality by segments of the society in which they live. Some men may have internalized homophobia and feel that they deserve to be battered because they are gay.

Both men and women involved in same-sex partner relationships may also not perceive a distinction between self-defense and battering. They may see themselves as the perpetrator even if the violence that they committed was in response to an attack by their partner. This perception may also reduce the likelihood that they will seek help.

Like immigrant women involved in heterosexual relationships, immigrant men and women involved in same-sex relationships may be reluctant to report their abuse and to seek help. There may be cultural and linguistic barriers that prevent them from doing so. Additionally, in countries that do not permit same-sex marriage, individuals who are undocumented may fear deportation to an even greater degree than their heterosexual counterparts because there is no possibility of regularizing their immigration status through marriage even if they were to become involved in a healthy relationship.

Related Topics

- ► Domestic violence
- ► Family
- ► Marriage
- ► Violence
- ► Women

Suggested Readings

Balsam, K. F., & Szymanski, D. M. (2005). Relationship quality and domestic violence in women's same-sex relationships: The role of minority stress. *Psychology of Women Quarterly, 29*, 258–269.

Letellier, P. (1994). Gay and bisexual male domestic violence victimization: Challenges to feminist theory and responses to violence. *Violence and Victims, 9*(2), 95–106.

Menjívar, C., & Salcido, O. (2002). Immigrant women and domestic violence: Common experiences in different countries. *Gender and Society, 16*(6), 898–920.

Shirwadkar, S. (2004). Canadian domestic violence policy and Indian immigrant women. *Violence Against Women, 10*, 860–879.

Suggested Resources

Hasselbacher, L. (2010). State obligations regarding domestic violence: The European Court of Human Rights, due diligence, and international legal minimums of protection. *Northwestern University Journal of International Human Rights, 8*(2), 190–215. Retrieved January 4, 2011, from http://www.law.northwestern.edu/journals/jihr/v8/n2/3/Hasselbacher.pdf

World Health Organization. (2006). *Summary report: WHO multi-country study on women's health and domestic violence against women: Initial results on prevalence, health outcomes, and women's responses.* Geneva: Author. Retrieved January 4, 2011, from http://www.who.int/gender/violence/who_multicountry_study/en/

Behavioral Health

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Scenario 1

An immigrant family was seen by a family doctor to establish themselves as new patients in his practice. The man was from Hong Kong and had been in the USA for 20 years working as a chef. The woman had emigrated from El Salvador 9 years previously, leaving behind her mother. She was hard-pressed to communicate the details of her prenatal care and experience with an obstetrician with the male doctor. She was uncomfortable having a male doctor perform the pelvic exam; she also seemed apprehensive about having a genital examination in the absence of any symptoms. The doctor explained that there are some diseases that begin without symptoms but they can be detected at an early stage with certain tests. She agreed to see a female doctor, but did not indicate whether she would agree to a PAP smear.

Both the husband and the wife spoke minimal English. Nevertheless, the doctor learned that they had been using the Emergency Department for their healthcare needs. They brought documentation showing that both had been treated for tuberculosis. It seemed that their child prompted them to get a family physician. Although they had been in the USA for an extended period of time, the couple had not seen any reason to go to a family doctor. They had dealt with any illness at home and had sought care at a hospital when they felt other care was necessary. Reliance on a family physician instead of the emergency department permitted them to obtain medical attention while avoiding the extreme costs and burden of the emergency room.

This family was amenable to seeking care through the established medical system. Some immigrants are less willing to do so. A failure to do so may, in some circumstances, compromise their health.

Scenario 2

In 2007, a tragedy struck the campus of Virginia Tech University. Seung-Hui Cho, a 23-year-old Korean immigrant, killed 32 people, wounded many others, and committed suicide. The story is a horrific illustration of the importance of behavioral health in immigrants. Seung-Hui was diagnosed with selective mutism and severe anxiety disorder at age 8 when his family moved to the USA. He underwent therapy and medication during his middle school years. However, his support system was removed when he began college. After the shooting, reports came out that his family had been reaching out to local churches near his college to address concerns with what was referred to as his "demonic power," as one pastor put it. Such reliance on the church and spiritual leaders is common among many immigrant groups. Some immigrants may be reluctant to seek help at all and may attribute mental illness to religious or spiritual roots.

These cases illustrate the importance of behavioral health concepts for health professionals who provide care to immigrants. This entry provides a basic discussion of behavioral health and an introduction to immigrant behavioral health.

Concepts in Immigrant Behavioral Health

Immigrant behavioral health includes many concepts and principles from psychology. They are listed here as a reference for terms used later in the entry.

Acclimatization or *acclimation* is the process of adapting to a new environment. For behavioral psychologists, this term describes a set of behavioral changes that an individual makes to survive in an environment in which living conditions have shifted. This term originated in physiology, but now has application in mental health as well.

Acculturation is a type of acclimation that describes the psychological experience during adaptation to a new culture. Acculturation is paired with another term, enculturation; the idea is multidimensional in that there is the retention of the native culture and also the adoption of the foreign culture or the culture of the new environment. A key point about acculturation/enculturation is that there are degrees of shift away from the culture of origin and degrees of adaptation to the new culture. Thus, an individual may retain features from the culture of origin and combine them with or add to them features of their new culture. Furthermore, this process occurs in multiple domains, such that the culture, practices and norms of business, religion and social relations each may have their own processes of acculturation/enculturation.

Acculturation has been studied extensively and has become a highly relevant topic in the past decade. As an example, the ARSMA – II (Acculturation Rating Scale for Mexican Americans – II) is a psychometric test that was designed to measure the degree of acculturation in an individual. The results of this test have been correlated with measurable behaviors and outcomes such as stress level, pregnancy anxiety, and birth weight.

Many psychologists and psychiatrists in developed nations have examined the barriers that may prevent immigrants from seeking mental health treatment.

Language is a common barrier for any immigrant in any part of the world. Even when the provider and the patient have knowledge of a common language, such as English or Spanish, there are colloquial terms and idioms as well as variant dialects that can make communication challenging.

It is important to recognize the delicate balance a care provider must achieve to adequately diagnose and treat without stigmatizing and alienating an already vulnerable population. Poverty and lack of health insurance are also challenges that are known to impede the receipt of medical services. These factors are often compounded by the inflexibility of a patient's work hours, and the lack of evening office hours in a private practice or clinic, thereby hindering the patient's ability to obtain care.

There may also be vast differences in attitudes toward mental health between an individual's country of origin and his or her country of immigration. Generally, developed countries emphasize mental health more than undeveloped countries; in the USA, for example, this is evident in the media advertisements for antidepressants. This increases the population's awareness of mental illness and, consequently, individuals may be more likely to attribute symptoms to a mental illness. For many immigrants, acknowledgement of a mental illness is not an option due to stigmatization, embarrassment, or shame. Many immigrants are reluctant to share feelings, especially when vocalizing complaints is considered a sign of weakness in their native culture. Some immigrants who are ultimately diagnosed with a psychiatric illness may have initially presented with physical symptoms, such as back pain or digestive abnormalities. These are called somatic symptoms of mental diseases.

Individuals may also be concerned about confidentiality. Immigrants may be apprehensive about sharing personal information with a practitioner because they are not certain how that information will be used. It is important that medical professionals caring for immigrant patients assure the patients that their personal and medical information is kept private.

There is a marked difference between those immigrants who choose to immigrate to new countries and those who are forced out of their countries. Often the circumstances that force people to flee their countries, such as violence and persecution, can lead to severe trauma. Therefore it is important to determine if the immigrant patient has had such experiences. Many individuals who have undergone such experiences will have entered their new country as refugees. Their experiences may have led to the development of severe phobias or posttraumatic stress disorder. These conditions require the attention of mental health professional.

There are additional factors to consider when managing the mental health issues of child and adolescent immigrants. As illustrated by the case of Cho, a support structure is critical for mental stability in early life. Furthermore, a culturally sensitive and responsive education system, focused activities, or targeted guidance can provide a boost to help a child or adolescent better adjust to his or her new environment. Common ailments of immigrant children include anxiety issues and stress management problems. Because the school setting is a key intervention point, efforts are being made in countries such as the USA to include programs in the education system that are directed toward promoting community and acceptance in diversely populated schools.

Culture-Specific Conditions

The American Psychiatric Association publishes the *Diagnostic and Statistical Manual of Mental Disorders IV Text Revision* (*DSM-IV-TR*) to guide mental health providers in making accurate diagnoses of mental illnesses. Appendix I of the *DSM-IV-TR* provides some guidelines to help clinicians to become culturally sensitive, and may be useful for professionals caring for a patient that has recently immigrated. The first section describes the five basic steps for approaching the client: to identify the culture of the individual, to become aware of cultural explanations of the individual's illness, to identify cultural factors that are relevant to the individual's psychosocial environment and levels of functioning, to understand cultural factors relating to the clinician–patient relationship, and to fuse culture with the diagnosis and treatment. The second portion of the appendix is a glossary that provides information about 26 culture-specific syndromes. This is an important resource in trying to understand an immigrant's perspective on a mental illness.

Related Topics

- ► Acculturation
- ► Culture-specific diagnoses
- ► Language
- ► Mental health
- ► Mental illness
- ► Stigma

Suggested Readings

American Psychiatric Association. (2000). *Diagnostic and statistical manual for mental disorders text revision (DSM-IV-TR)* (4th ed.). Washington, DC: Author.

American Psychiatric Association. (2006). *Practice guidelines for the treatment of psychiatric disorders compendium.* Washington, DC: Author.

Suggested Resources

Explaining away mental illness: Many immigrants face cultural barriers, other obstacles to psychiatric treatment. http://www.washingtonpost.com/wp-dyn/content/article/2007/08/31/AR2007083101792.html

Immigrant students and mental health at UCLA's webpage. http://smhp.psych.ucla.edu/qf/immigrantkids.htm

In any language: Mental health care for immigrants. http://www.lcmedia.com/mind380.htm

Bereavement

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Bereavement is generally defined as the feelings of sorrow over the death or loss of a loved one. Bereavement is a normal adaptive process, which is expected and occurs cross-culturally. One works to assimilate and move forward in life, rather than to "get over" the loss. Hand-in-hand with the sorrowful feelings, people may experience symptoms such as decreased appetite, weight loss, and insomnia. Various cultures have their own rituals which are part of the process of healing and moving forward. It behooves a clinician to be aware of these important cultural customs, as many may look to their providers in times of bereavement.

Normal grief and bereavement needs to be considered separately from pathological bereavement. Certainly those who are bereaved feel intensely sad, may experience other strong emotions such as guilt about the person they lost, and may feel like withdrawing from others. Periods of sadness are part of the human condition. However, it is important that normal bereavement and grief be considered separately from depression.

Bereavement and grief may lead to a major depressive episode; however, they more often resolve over time as the person comes to term with the loss and their feelings. Those who are bereaved and who are not clinically depressed are capable of happy feelings, while those with major depression may be depressed for the vast majority of the time. Also those with depression have a marked functional impairment, or are preoccupied with their own suicidal thoughts, or feelings of worthlessness.

A recent study compared depressive episodes related to bereavement with depressive episodes caused by other stressors. The results suggested that the many similarities outweighed the differences and suggested that perhaps the DSM should not exclude those with bereavement and significant associated depressive symptoms from a diagnosis of major depression.

Depending on the loss and the person's history and age, different reactions are expected and considered within the range of normal in bereavement. For example, children may express bereavement differently than their parents. Children may not understand the permanent nature of death, and may experience regressive behaviors. As another example, when one loses a spouse, social isolation may come to the forefront as an issue, differently than if one lost a parent.

While grieving and bereavement are personal experiences, there are commonalities across cultural groups and across time. Ritual is often used as a final expression of caring. Remembrance includes many small rituals over time.

For example, in Caribbean cultures, the traditional religious mourning practices have been fairly constant over time. However, as other cultures assimilate during the immigration process, they may keep some portion of the mourning practices from their homeland and adopt some of their new home culture's practices.

Health care providers and hospices may seek involvement in rituals as appropriate in the ethnic and religious community. Particularly with certain unexpected losses, such as the loss of a child, families may look to the health care community for direction. Some programs specifically have assistance with bereavement, such as helping with the creation of memory/memorial books.

However, there are different rituals cross-culturally, and different accepted behaviors within those rituals. Certain communities have very specific cultural processes of expressing grief and bereavement (e.g., sitting shivah for 7 days in Judaism). Increased grieving and bereavement may occur among immigrants because they may hear distantly of relatives who are decreased and may not have the opportunity to participate with others in their homeland community as they grieve. Beliefs about continuing ties and relationships with the deceased will vary.

Treating health care providers should be aware that persons from different cultures express bereavement differently. Understanding what is normal and what is abnormal bereavement may require liaison with families or other cultural or religious representatives. When the provider and patient are from dissimilar cultures, there is a risk of cultural insensitivity to bereavement, which one must strive to work against. Keep in mind that rituals of funeral and burial provide some support and structure immediately after the loss, there are longer term emotional needs and re-assimilation needs. Attentive active listening can help individuals and families express and work through their feelings of loss. Support groups, as well as phone calls from health care providers at an interval after the loss, may be beneficial to those in mourning. The health care provider should see the eventual goal of bereavement to include the reconstruction of meaning after the loss.

Related Topics

- ► Depression
- ► Grief and grieving

Suggested Readings

Bhugra, D., & Becker, M. A. (2005). Migration, cultural bereavement, and cultural identity. *World Psychiatry, 4*(1), 18–24.

Hardy-Bougere, M. (2008). Cultural manifestations of grief and bereavement: A clinical perspective. *Journal of Cultural Diversity, 15*(2), 66–69.

Maj, M. (2008). Depression, bereavement, and "understandable" intense sadness: Should the DSM-IV approach be revised? *The American Journal of Psychiatry, 165*, 1373–1375.

Suggested Resources

Eisenhruch, M. (1991) From post-traumatic stress disorder to cultural bereavement: diagnosis of southeast Asian refugees. Available at: http://www.dinarte.es/salud-mental/pdfs/Eisenbruch-From%20PTSD%20to%20cultural%20bereavement.pdf

Berlin Wall

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The Berlin Wall was a 96 mile wall that was erected on August 13, 1961, and stood as a concrete barrier until November 10, 1989. The wall was built by the German Democratic Republic and was meant to separate West Berlin from Eastern Germany.

After World War II, Germany was divided into four sectors. The United States, Great Britain, France, and the Former Soviet Union each controlled a sector. The sectors controlled by the United States, Great Britain, and France joined to form The Federal Republic of Germany, or West Germany. The sector controlled by the Former Soviet Union became The General Democratic Republic of East Germany and was a communist state. The division of the two sectors was coined the "Iron Curtain" by Winston Churchill.

The capital of Germany, Berlin, was similarly subdivided into four sectors. The United States, Great Britain, and France joined their sectors to form West Berlin. The sector held by the Former Soviet Union, East Berlin, became the capital of East Germany. Like East Germany, East Berlin was under Communist rule. Due to restrictions imposed by the communist regime, many East Germans immigrated to West Germany where they were afforded more freedom, better economic choices, and a better standard of living.

From 1949 to 1961, large numbers of East Germans immigrated by merely crossing from East Berlin into West Berlin. Once in West Berlin, the immigrants were permitted to move in West Germany or other Western European counties. Many of these individuals were professionals or skilled workers. To stop this egress, the German Democratic Republic built the Berlin Wall ("the Wall").

The Wall went through several versions. The first version of the Wall, consisting of 96 miles of barbed wire and guards, was essentially raised overnight. A more effective barrier was built in 1962. At that time, a second fence, which was built parallel to the first fence and was up to 100 yards further into East Germany, was constructed. The second fence was made up of barbed wire and concrete blocks. The buildings between the two fences were demolished to create an empty space that became known as the "death strip." This area was covered with raked gravel and provided guards a clear field of fire. In 1965, a third version was erected using a concrete wall and steel girders. The final version of the Wall began in 1975. It was officially named "Stützwandelement UL 12.11" (retaining wall element UL 12.11) and it was constructed of 45,000 concrete segments that were 12 ft. high and 4 ft. wide. The top was lined with smooth pipe that made it more difficult to scale the fence. The Wall was reinforced with methods that included mesh fencing, signal fencing, minefields, anti-vehicle trenches, barbed wire, dogs, over 300 watchtowers, and 20 bunkers.

The wall effectively separated families and friends. Those who lived in East Berlin no longer had contact with residents of West Berlin. Additionally, after the Wall was built, many people in West Berlin no longer had access to their jobs in East Berlin. There were only seven places along the Wall where one could access checkpoints and cross the border between East and West Berlin. The checkpoints were mainly utilized by officials and those who obtained a permit allowing passage. Checkpoint "Charlie," was located on the border between East and West Berlin at Friedrichstrasse and became infamous being used mainly by Allied personnel and Westerners.

Despite the obvious dangers, there were escape attempts. At first, escapes were attempted, and made, by climbing over the wall or jumping from apartments that were built along the wall. Further fortifications, coupled with the interdiction imposed by East Germany on its citizens near the Wall, made escape by these routes more difficult. Despite these restrictions, some of the East Berliners continued to try to scale the Wall, use underground tunnels, drive vehicles at the barrier, fly over the wall, and, on one occasion, fly in a hot air balloon.

It is estimated that over 5,000 people escaped over the wall into West Berlin. According to a collaborative project of the Berlin Wall Memorial and the Center for Contemporary History Potsdam entitled "The Dead at the Berlin Wall 1961–1989," at least 136 people were killed at the Berlin Wall between 1961 and 1989. Among the 136 people who died there were 98 refugees from the German Democratic Republic, 30 citizens from East Berlin and West Berlin who were not trying to flee, and 8 were border guards. Moreover, at least 251 passengers died either during, or after, checks at boarder crossings in Berlin.

The fall of the Wall began when Hungary raised its border restrictions in August of 1989. This allowed East Germans to escape to the West. As a result, the German Democratic Republic prohibited travel to Hungary to its citizens. A similar event occurred in Czechoslovakia. Additionally, protests broke out in East Germany. On November 9, 1989, Gunter Schabowski, a spokesperson for the East German government, declared, at a press conference, that visas would be freely granted to those wanting to travel outside or leave the country. This announcement resulted in thousand of East Berliners rushing to checkpoints of the Wall and ultimately crossing into West Berlin where they were met by residents of the West Berlin. The following weekend, the East German government announced the opening of ten new checkpoints. By December 23, 1989, East Germans and West German citizens could cross the border without any visa requirement. The "fall" of the Wall was met with a celebratory atmosphere on both of its sides. The Berlin Wall was officially dismantled on June 13, 1990, and Germany was reunified the same year. Short sections of the Berlin Wall have been permitted to stand as a memorial.

Related Topics

- ► Germany
- ► Poverty
- ► Social integration
- ► Violence

Suggested Readings

Buckley, W. (2004). *The fall of the Berlin wall*. Hoboken: Wiley.

Funder, A. (2004). *Stasiland: Stories from behind the Berlin wall*. London: Granta.

Rottman, G. (2008). *The Berlin wall and the inner-German border 1961–1989*. New York: Osprey.

Taylor, F. (2008). *The Berlin wall: A world divided, 1961–1989.* New York: Harper Perennial.

Wyden, P. (1991). *The wall: The inside story of divided Berlin.* New York: Simon & Schuster.

Suggested Resources

Berlin.de. Retrieved April 29, 2011, from http://www.berlin.de/mauer/index.en.html

Times Online. Retrieved April 29, 2011, from http://www.timesonline.co.uk/tol/system/topicRoot/The_Berlin_Wall/

Betel Nut

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The betel nut (more commonly known as the areca nut) is a seed of the areca catechu palm, a tree similar in shape to a coconut tree and found in the rainforests and moist lands of the Pacific Islands, Southeast Asia, and east Africa. The nut is commonly combined with a betel leaf and lime paste to form paan, a stimulant chew rooted in tradition and customs in Asia and Africa. Globally, it is the fourth most widely used drug after nicotine, ethanol, and caffeine. Studies have emerged about its carcinogenic effects and its associations with oral diseases.

The betel nut itself has a wood-like consistency, which can be chewed on its own or combined with a betel leaf. The main active ingredient is an alkaloid called arecoline and is responsible for its effects on the human body. The main effects are on the parasympathetic nervous system, mainly on nicotinic and muscarinic receptors. Because of its CNS stimulating effects, betel nut is used in a manner similar to the western use of tobacco or caffeine. Chewing the nut stimulates salivary flow, thereby aiding digestion. Betel nut also has been used as an appetite stimulant. It has been reported that betel nut chewing produces feelings of well-being, euphoria, heightened alertness, sweating, salivation, a hot sensation in the body, and increased capacity to work.

Studies have shown that the betel nut, even when chewed alone, has been associated with oral submucous fibrosis, a debilitating condition of the oral cavity that can lead to marked rigidity and inability to open the mouth and is considered to be precancerous. When betel nut is combined with the constituents of paan, there is a higher incidence of leukoplakia (a precancerous oral lesion) and squamous cell carcinoma of the mouth.

Related Topics

► Paan

Suggested Readings

Boyland, E. (1968). The possible carcinogenic action of alkaloids of tobacco and betel nut. *Planta Medica, 16*, 13–23.

Chu, N. S. (2001). Effects of betel nut chew on the central nervous system and autonomic nervous system. *Journal of Biomedical Science, 8*(3), 229–36.

Jacob, B. J., Straif, K., Thomas, G., et al. (2004). Betel quid without tobacco as a risk factor for oral precancers. *Oral Oncology, 40*(7), 697–704.

Lord, G. A., Lim, C. K., Warnakulasuriya, S., & Peters, T. J. (2002). Chemical and analytical aspects of areca nut. *Addiction Biology, 7*, 99–102.

McCallum, C. A. (1982). Hazards of betel nut chewing. *JAMA, 247*, 2715.

Suggested Resources

Medline. http://www.nlm.nih.gov/medlineplus/druginfo/natural/patient-betelnut.html

WHO. http://www.who.int/mediacentre/news/releases/2003/priarc/en/

Bigamy

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The practice of being married to one person while lawfully remaining married to another individual at one point in time is referred to as bigamy. If divorce has taken place or the marriage has been nullified, bigamy is not committed. Bigamy and polygamy are often confused with one another. Bigamy is the practice of being married to two women at the same time, hence the prefix “bi-.” Polygamy is the practice of being married to many women at the same time, hence the prefix "poly-." Bigamy has been the bane of law enforcement officials' for centuries in many locales around the world. It is one of the hardest crimes to recognize and is usually practiced by discreet parties.

During the eighteenth and nineteenth centuries, bigamy became a con artist's way of acquiring a mass amount of assets and funds. Partners of bigamists involved in these schemes were often oblivious to the criminal activity taking place in their "counterfeit" marriages; some were eventually murdered by their partners. George Joseph Smith, notoriously known as the Brides in the Bath Murderer, was executed on August 13, 1915 for the murder of three of his wives, to whom he was bigamously married. Smith murdered his wives for money, killing them by strategically drowning them in the bathtub. Smith had many wives, and to this day the exact number is not known. One of his wives, Caroline Thornhill Smith testified against him at the trial, exposing their marriage as one where Smith prevailed upon Caroline to steal from her employer.

Another famously known bigamist is Sigmund Engel, the "Lover of 1001 Women." Although the previous number is exaggerated, Engel bigamously married over 200 times, by far the largest record of bigamous marriages to date. Engel carried on his criminal ways over a period of 50 years, amassing over $6 million from his victims' savings and assets. His bigamist lifestyle was exposed in 1949, when a woman by the name of Reseda Corrigan brought charges of bigamy and fraud against him. Engel would usually swindle his women by informing them that he was going out to buy luggage for their honeymoon after he had cleaned out their accounts, ultimately disappearing and abandoning the marriage. On November 9, 1949, Engel was sentenced to 2–10 years in prison, where he eventually died.

As recently as 2007 a man by the name of Darrell Leach was convicted in Ohio of being bigamously married to three different women. He was ordered to pay a $500 fine and was given a year of probation after the judge instructed him to straighten out his marriages.

Serial bigamists have a sense of invincibility, giving them the idea that as long as they are clever, they will not get caught. Bigamy is outlawed in many countries, yet it is still widely practiced today. For individuals that come from a nation where bigamy is accepted and live in a country where it is not accepted, life can be very difficult. Depending on the level of punishment, the individual may risk committing bigamy.

Bigamy has caused several concerns in the area of immigration. For instance, if an individual desires to immigrate to another country but is currently married, they may leave their spouse behind and immigrate to the new country, claiming they are single. Eventually, they may get married to a citizen of the new country in order to gain citizenship, making the new marriage a fraud. Problems like these have caused immigration bureaus to closely monitor visa and citizenship applications for what could potentially be illegal marriages for residency and citizenship purposes. Other difficulties arise for individuals who are migrating from a country that permits multiple wives to a country in which bigamy and polygamy are illegal. The destination country will generally not allow the individual to immigrate with him more than one wife, creating difficulties within the larger family.

Related Topics

- ► Illegal immigration
- ► Marriage

Suggested Resources

http://women.timesonline.co.uk/tol/life_and_style/women/families/article1848488.ece

http://www.acluutah.org/bigamystatute.htm

http://www.ncga.state.nc.us/EnactedLegislation/Statutes/PDF/ByArticle/Chapter_14/Article_26.pdf

Birth Control

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One of the greatest achievements of medical research is considered to be birth control methods. Concerns for controlling the reproductive behavior have been present in history since the use of *coitus interruptus* or other natural methods such as the calendar method, the basal body charting or the temperature method, the cervical mucus, etc. Abortion itself had been described as a method of controlling child bearing. All of these methods had one major inconvenience: a low rate of success in preventing the pregnancy. This is why several other methods had been developed, with a better rate of success and higher safety, such as the condom, birth control pills, intrauterine devices, hormonal implants, surgical sterilization (vasectomy and tubal ligature), spermicides, diaphragms, etc.

Immigrants' birth control must be discussed in relation to several issues that may have an impact both on the choice to control their own childbearing, as well as on the acceptability of the methods, such as access to health care, socioeconomic status, cultural, religious and traditional factors, political and demographic factors.

Immigrants' access to health care may be limited by their illegal status, their low income, their uninsured status, and/or their cultural and religious beliefs. When discussing birth control, access to health care is crucial for several reasons. First, there are many types of birth control methods – from natural to intrauterine devices and to sterilization. Choosing the appropriate method is a decision in which method-specific counseling, i.e., providing appropriate information about the methods, instructions, conditions, safety, risks, possible complications and side effects, costs, etc., plays an important role. Beside the role of providing information, the counseling also provides follow-up case management that should encourage the patient to discuss: side effects, further advice, or modification of contraception method. Second, some of the birth control methods considered to carry a higher risk of serious complications (like intrauterine devices, oral contraceptives) should be used only on condition of health care access. Third, before choosing the birth control method, each patient should benefit from a medical examination. The medical condition of the patient, the patient's age, and the patient's sexual behavior should be closely examined in order to prescribe the appropriate method and to prevent method-specific risks.

In this context, immigrants' access to health care plays a very important role in the safety and effectiveness of the birth control process. Any limitations to health care access, regardless of the reason, may have serious consequences for immigrants' health.

Immigrants' low socioeconomic status may have a twofold impact: On one hand, immigrants' low income may limit access to medical care and to an adequate and appropriate birth control method, and on the other hand, the low income may be an important reason for reducing the number of children in a family by means of birth control. Though birth control methods were created for all women, there are major access disparities between social classes. Upper-class women are privileged because they have access to information, education and can buy any available method. Women of lower socioeconomic status, who may be, less educated and poor, do not have the same access to information or to affordable birth control methods. As an example, several studies of Friedlander et al. concluded that during the 1950s, immigrant women from North African and Asian countries in Israel experienced a fertility decline, due to their poor socioeconomic status. The low income had been considered the first determinant that contributed to this decline. The economic explanation points out the costs of having a child that leads to direct and indirect expenses which a low income could not cover. Other studies support the idea that low income does not produce the fertility decline alone, but acts in addition to other important factors, such as the cultural ones.

Culture, religion, and traditions of immigrants may influence the birth control basically at the level of the fertility behavior. The literature speaks about two main models that synthesize the influence of sociocultural factors on the fertility behavior.

The first one is the *adaptation model* according to which birth control behavior is the result of couple's adaptation to the society's changes. An example of the adaptation model is the decline of Mormon fertility in the USA in the nineteenth century, as the adaptation to the "decreasing ability of the Church of Jesus Christ of Latter-day Saints to maintain an economic, political, educational and religious separation from the national system." As a result, a large number of women practiced spacing behavior between pregnancies.

The second one is *the innovation-diffusion model.* According to this model, the diffusion of scientific innovation and people's attitudes toward these innovations may have an important impact on the reproductive behavior. This impact differs with the immigrants' country of origin, because it is filtered through different cultural factors.

Cultural and traditional influence upon fertility behavior is also reflected in the role of the decision-making person in the family. For example, though Asian and African immigrant women desired a smaller family than their husbands, the male gender power determined a higher rate of fertility or clandestine abortions. Religion may influence the birth control behavior based on the acceptability of some birth control methods and on the aspect of the bond between marital sexuality and procreation. Most of the religions consider that procreation is an act of love within the marital union. From this perspective, there are conservative societies such as the Israeli Jews; in 2000, only 2.8% of births had been attributed to never-married women.

Political and demographic strategies may influence the fertility behavior in the society. For example, in Romania, before 1989, abortion and birth control methods had been prohibited as part of the demographic strategy. Today, in China, the number of children allowed per family is limited by law at only one.

The promoter of the American birth control movement was Margaret Sanger, an Irish immigrant woman. She wanted to promote fertility control rights among all women. However, the manipulation of her ideas led to eugenics, which actually aimed to reduce the number of people who were considered to be socially undesirable: poor minorities, less educated, immigrants, etc.

Related Topics

- ► Cross-cultural health
- ► Family planning
- ► Fertility
- ► Health beliefs
- ► Health care utilization
- ► Health insurance
- ► Pregnancy
- ► Prenatal health promotion
- ► Reproductive health

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Birth Defects

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According to the March of Dimes, there are about 120,000 babies born with birth defects each year in the USA. Worldwide the numbers are much larger, estimated to be 7.9 million per year with a higher prevalence in developing compared to developed countries. Many of these conditions are either preventable, can be ameliorated or treated.

Several studies of immigrants to the USA have found that children born to native- and foreign-born mothers have a different prevalence of birth defects. The study of differences in the prevalence of birth defects is complicated by the large number of type of birth defects. If comparisons are made regarding individual types of birth defects, cleft palate and neural tube defects, for example, the pattern might be, and often is, quite different for each. Thus, birth defects are a heterogeneous set of conditions that may be caused by different genetic or environmental factors.

Few studies have focused on narrow classes of birth defects (although these also have subclassifications within the broader classification). One study focused on two types of oral cleft defects in newborns in Texas. This study found that US- and foreign-born Hispanic mothers did not differ relative to non-Hispanic White mothers for one type of cleft, but that the Hispanic mothers, regardless of place of birth, were less likely to have babies with another type of cleft.

A case-control study compared Mexican immigrants and White non-Hispanics for neural tube defects in California. This study found that recent Mexican immigrant mothers had a seven times higher risk of giving birth to babies with these defects. Another study looked at three types of cardiovascular (heart and circulatory system) defects in children born in Texas. One of these types of defects was more common in counties along the border with Mexico, and the authors suggested that this might be due to environmental exposures.

More recent studies have looked at a larger range of birth defects in the Hispanic population and considered maternal place of birth. A study of Hispanic women giving birth in New York State considered a dozen major organ system defects and a similar number of specific defects, and broke the term "Hispanics" down by nationality: Puerto Rican, Mexican, and a mix of other countries of origin. Although the analysis was somewhat complex, the overall finding was that foreign-born mothers were at lower risk of delivering babies with birth defects, both overall and for some of the specific organ systems and types of defects.

The most recent study, a case-control design, considered 29 specific birth defects from the National Birth Defects Prevention Study, which collected data from ten states in the USA. This study sought to identify associations between mothers being US- or foreign-born and having children with birth defects. Different associations were found for different birth defects, with some more likely to be found in babies of foreign-born mothers and others more likely for US-born mothers. For most types of defects examined, there was no statistical difference based on the place of birth of the mother. However, there were differences between mothers from Central America/Mexico and other countries of origin. The authors suggest that their findings might be due to culture, behavior, or diagnosis of birth defects.

Overall, the picture for a relationship of immigration, measured usually by country of birth of the mother, and birth defects is not entirely clear and needs further research. The large number of types and subtypes of birth defects makes these analyses particularly difficult.

Related Topics

- ► Birth weight paradox
- ► Chemical exposure
- ► Child development
- ► Child health and mortality
- ► Environmental health
- ► Pediatrics
- ► Pregnancy
- ► Prenatal health promotion
- ► Reproductive health
- ► Vitamins

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Birth Weight

► Birth weight paradox

Birth Weight Paradox

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The birth weight paradox is a subset of the more broadly defined epidemiologic paradox. The epidemiologic paradox describes a set of research findings showing that some groups of Hispanic immigrants, particularly of Mexican origin, have paradoxically good health and mortality outcomes in the USA, given their socioeconomic disadvantage relative to other major US racial and ethnic groups. This paradox has been most clearly documented in patterns of infant mortality and birth weight, a major risk factor for infant mortality as well as for health and developmental problems in childhood and beyond. Vital statistics data from 2006 show that the rate of low birth weight (<2,500 g) among Mexican American births was 6.6%, compared to 7.3% among non-Hispanic White births and 14% among non-Hispanic Black births. This pattern corresponds closely to rates of infant mortality documented in National Center for Health Statistics linked birth-death files, which, for 2005, show an infant mortality rate of 5.5 deaths/1,000 live births among Mexican-origin women, compared to a rate of 5.8 among non-Hispanic Whites and 13.6 among non-Hispanic Blacks.

The low rate of low birth weight among Mexican American infants is due to the fact that there are fewer small, preterm (<37 weeks gestation) births in this population, as there is a slightly higher rate of preterm deliveries to Mexican-origin women, compared to non-Hispanic White women. Preterm Mexican American infants are, on average, heavier than non-Hispanic White infants, but there is a crossover in mean weight at term, which is reflected in the fact that non-Hispanic White infants are, across all gestational ages, heavier than Mexican American infants. Errors in recorded gestational ages impede analytical focus on gestational age as a measure of infant health.

Social explanations for the birth weight paradox include data issues, cultural protection, and migrant health selectivity. Data issues include, most importantly, the selective return migration of sickly migrants to their countries of origin where their deaths go unrecorded in US vital statistics, which may downwardly bias postneonatal infant mortality and adult mortality rates. However, this bias is irrelevant to birth weight, which is recorded on birth certificates for all infants born in the USA. The cultural protection argument primarily involves health behaviors: immigrant mothers are less likely to use tobacco, alcohol, and drugs than other mothers. They may also be protected by familism, a cultural orientation emphasizing the group over the individual, which highly values mothers and children as well as kin and co-ethnic social support. Migrant health selectivity is the idea that, because of the costs, risks, and challenges associated with migration, migrants are a select group in terms of health and a number of unmeasured characteristics that may influence health, such as a strong sense of personal efficacy. Selectivity is supported by patterns of infant mortality, which are lower among immigrants in comparison to their native-born counterparts across all racial and ethnic groups, as well as by a study using pooled origin–destination data from Puerto Rico, which showed that migrants to the mainland have a lower risk of infant mortality than nonmigrants on the island.

Some research questions whether this good health at birth persists into childhood. Mexican American children are at a higher risk of some health and developmental problems than non-Hispanic White children. Scholars have suggested that the paradox may deteriorate over time due to a process of unhealthy acculturation, due to regression to the mean, or due to cumulative exposure to deleterious social conditions for Hispanic immigrants and their descendents in the US context.

Related Topics

► Acculturation

Suggested Readings

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Bisexual

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A bisexual is an individual who has sexual interest, physical or romantic attraction to or desire for both members of the same sex (homosexual orientation) and members of the opposite sex (heterosexual orientation). Bisexual orientation is one of the three main categories of sexual orientation, along with heterosexual and homosexual. Research indicates that sexual orientation is influenced by a combination of biological (genetic), environmental (including fraternal birth order, specific prenatal hormone exposure, and prenatal stress on the mother), cognitive, and cultural variables in interaction, leading to different types of bisexuality. A bisexual may be more attracted to one sex, attracted equally to both, or find people's sex unimportant. A bisexual may have erotic, affectionate, or romantic feelings for, or fantasies of experiences with, both men and women without having ever acted on them. The strength of their attractions to men and women may vary over time.

Some clinical surveys suggest there are a significant number of bisexual persons in terms of desires and practice. Sigmund Freud maintained that bisexuality was a normal part of development and every person has the ability to become bisexual at some time in his or her life. Based upon research in the 1940s and 1950s, Alfred Kinsey posited that individuals exhibiting strict heterosexual and homosexual behaviors be considered as end points along a continuum ("0" and "6," respectively, on the Kinsey scale), with those falling in between considered bisexual to varying degrees. People at "3" on the scale were about equally attracted to men and women.

The term "bisexual" frequently conjures misconceptions and false ideologies. Bisexual identity is frequently linked in research, health, and social contexts with homosexual identity, minimizing bisexuality as a separate and genuine orientation. Bisexual women and men face stigma from both outside and inside gay and lesbian communities, creating a sense of disenfranchisement and invisibility, not "fitting into" either homosexual or heterosexual communities. Coming out has been identified as particularly unsettling for bisexuals, and health care providers are often confused or make false assumptions about bisexuals' sexual practices or histories. Some bisexual persons are committed to forming their own communities, culture, and political movements, while others may merge into either homosexual or heterosexual society.

Bisexuality has been observed in various human societies throughout recorded history, although the term did not originate until the nineteenth century. Tolerance of homosexual behavior increased in many societies in the late twentieth century, and the number of people identifying as bisexual correspondingly increased. Even so, both bisexuality and homosexuality continue to challenge ingrained cultural concepts of sexuality, gender identity, and traditional family relationships and structures. An openly bisexual or homosexual life style remains unacceptable in many parts of the world, vilified and shamed by family members, neighbors, or society. In the last decades of the twentieth century, several regional and global cities emerged as cultural centers for lesbian, gay, bisexual, and transgender (LGBT) communities, including London, New York, San Francisco, Sydney, Sao Paolo, Johannesburg, and other Western European, American, and Canadian cities. These serve as destinations for millions of LGBT visitors and migrants, some of whom choose to make their homes there to escape from constricting, wearisome, economically depressed, conflict-ridden, traumatic, oppressive, or discriminatory conditions in their country of origin. The goal for many is to fulfill a desire, and likely a psychological need, to explore their sexual identity or live an openly LGBT life style, which would not be possible at home, or to find sexual or romantic partnerships. Studies, including gay and bisexual male immigrants in London and Mexican immigrants to the USA, described the phenomenon of international relocation of people driven to move, in whole or part, by issues of sexuality, as "sexual migration." For many, the move is unfortunately sometimes opportunistic and poorly planned, resulting in cultural shock and, particularly for those with limited language skills, overwhelming economic uncertainty; restricted job options, such as temporary and menial work and sometimes prostitution; and/or dependence on benefits. The result may be a loss of individuals' control over basic aspects of their lives and future, sometimes leading to risk taking with their health. Engagement in HIV risk behaviors has frequently been reported by gay and bisexual men after migration to another country.

Unlike other immigrants, LGBT individuals face specific and varying challenges from immigration laws that unfairly discriminate against them, leaving their lives and status often precarious and endangered, and in fear of deportation. At present, LGBT immigration advocates are at the epicenter of the heated national policy debate in the USA surrounding immigration, pushing for inclusion of LGBT people, families, and partners, and creating a history of LGBT immigration case law and policy to ensure justice for LGBT immigrants. Since 1994, persecution based on sexual orientation has been grounds for asylum for LGBT immigrants in the USA. Rarely used until recently, more immigrants from the Middle East, Africa, Latin America, and the Caribbean are now seeking asylum on the basis of sexual orientation to escape rape, persecution, violence, and threats of death from places where homosexuality is either outlawed or shunned. Applicants for asylum are required to apply within the first year of arrival in the USA, but may be allowed to apply later if within a reasonable time frame and under extraordinary circumstances, or if conditions in his or her native country have changed such that the person may be harmed upon return based on those changes.

Related Topics

- ► Acquired immune deficiency syndrome
- ► Asylum
- ► Homosexuality
- ► Immigrant visa status
- ► Legal services
- ► Marginalization
- ► Refugee

Suggested Readings

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Blacks

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The commonly used racial term "Black" has been used to describe people of African descent. Among other labels, African Americans have been given a slew of names to represent their supposedly diverse nature, such as Nigger, Colored, Negro, and African American. The term "Black," derived from the Latin word "niger," bestows the label of distinct membership to a racial group. It is not only a racial characteristic essential for identity but symbolically embodies degradation and negativity. Blacks have been subject not only to overt discriminatory action but to a structured institutional system that actively and passively exercises discrimination. Blacks have been subdued to a stereotypical legacy and are presently struggling with its negative backlash of effects. Blacks – and their social significance – are linked with race, racism, science, and politics.

The Emergence of Race and Biology

Within the field of natural philosophy emerged the concept of race. Racial classifications served as a way for prominent thinkers during the seventeenth and eighteenth centuries to describe the division of people. Immanuel Kant, a famous German philosopher of the eighteenth century was the first to establish a consistent concept describing the diversity between races with his theory of race. He defined race as deviations that were preserved over many generations, which were the result of migration and interbreeding. All people belonged to a single line of descent, one human species which comprised different races. According to Kant there were four distinct races, the White race, the Negro race, the Hun race, and the Hindu race. The Negro race was considered to possess a particular essence of laziness and indolence. Blacks were thought to have essences, or inborn qualities, which made them an uncivilized race subject to inferiority. Their characteristics such as facial and cranial measures were linked with mental capacity and morality. Kant used skin color and physical characteristics to determine inherited characteristics. He believed that intellect and skin color were inextricable and related to racial essences. Race was a predictor of intelligence and morality, a biological construct that entailed environmental underpinnings. The concept of race created a hierarchy of racial stratification in which science was used to validate European ideals. It was during this time the traditions and physical characteristics of Whites were proposed to be superior to those of non-Whites, especially Blacks.

Separating racial meaning from its scientific justifications means extracting the innate characteristics of race from its attributed structure of racial hierarchy. Many scientists have used phenotypic traits to try to prove unambiguous distinctions between the races. However, these traits, such as skin color and blood type, are highly varied within racial groups and provide no empirical evidence to support a biological racial theory. Common racial groups such as "Blacks," "Whites," or "Asians" are in fact large social groups, which do not constitute a race, and in fact, have no real biological foundation because they lack scientific referents. Therefore, the "Black" race is a social construction which possesses a strong social and political reality. Scientists and researchers have long tried to associate racial essence with disease, blood type, and body structure. For instance, the disease sickle cell anemia is known to affect a large majority of Blacks. This led the scientific community to believe that race was a determining factor for the disease. However, research has shown that sickle cell anemia is a genetic disease in which the abnormal shape of red blood cells that lack hemoglobin is a defense mechanism that protects the individual against malaria. In fact, sickle cell anemia is seen in areas where there is a high incidence of malaria; therefore the disease is not based on racial identity but geographical location.

A theory such as the legendary "one-drop-rule" supports the idea of racial essences. Due to the fear of racial mixing, Whites sought to make clear rigid distinctions between races and created a formal rule which socially classified anyone with any African ancestry as Black. A single drop of Black blood gave racially mixed persons subordinate racial status. This was adopted politically and also used to discourage racial mixing, or miscegenation. This historical idea of inherited racial essence supports racial labeling. Labeling is key to racial identification because it has two main parts, collective and individual. Collective labeling is how others assign labels to an individual, and individualistic labeling is how labels are adopted by the individual in order to self-identify. These racial labels not only represent ones' identification, but the history of its effects as well. Racial labels tend to accompany expectations, or those anticipated behaviors that are related to a particular racial identity. Therefore, socially constructed racial ascriptions sustain innate biological distinctions.

Usage and Changes of Racial Labeling

Upon arrival to the United States in the 1600s, the term "Africans" was frequently used as the racial label for newly acquired slaves from Africa; this word served as a sense of dignity and racial inclusivity among slaves. Soon after, a movement to change the racial term from "African" to "Colored" became apparent. The new label demonstrated the anticipation of slaves wanting to be associated with emancipated slaves and free White Americans. As the institution of slavery continued to grow during the 1800s, racial epithets began to surface as well. These racial terms served to keep the morale of the slave to a minimum, while maintaining dependency and servitude at a high level. Black slaves were portrayed as irrational, idle, promiscuous, and in need of governance. The depiction of Black men and women was in accordance with slavery's progression and outcome; these images changed as slavery grew stronger and as it weakened. Black slave women were portrayed in a combination of derogatory images, for instance, a Black woman who was seen to be a temptress and erotic was known to be a "Jezebel," a biblical term used to portray sexual prowess. The image of the "Mammy" portrayed a loyal slave who raised the slave master's children and possessed no sexuality. She was an obedient and stable southern icon, possessing no gentleness or beauty, a direct contrast to White women. These depictions of Black women were contradictory; however, both images possessed the common theme of Black female slaves being incapable of motherhood. The image of Black slave men was that of the "Sambo," a simple, irresponsible Black man, who surrounded himself with games, food, and laughter. The Sambo and Mammy caricatures served as slavery defenses, illustrating the decency of slavery and the benefits it served for slaves' well-being. During the Antebellum Era (1800–1860s), these caricatures followed the political current.

The Jim Crow Era (1875–1965) was a period during which racial slurs and laws against Blacks caused them to suffer disproportionately, and formalized economic, social, educational, and political segregation. It is believed that the term "Jim Crow" originated from an exaggerated slave dance in which White performers in blackface, Blackface Minstrels, portrayed the myth of happy slaves. The minstrels' vernacular and performance were assumed by the broader White society to be an accurate portrayal of Blacks. During the slave emancipation and the Reconstruction Era (1865–1877) political debate began to drastically change and shape new Black caricatures. The "Zip Coon" caricature emerged primarily out of the North, and symbolized a failed Black freedman who was unaccustomed and unable to adapt to a life absent of subjugation. The "Black menace" and the "Black brute" caricatures emerged as a symbol that portrayed newly released slaves as unmanageable, irate, animalistic, and prone to violence. These images posed a threat to White society and especially White women. In 1915, the film *Birth of a Nation* by D.W. Griffith was released. The film plays on the myth of deviant Black behavior, is set during the Civil War, and encourages Southern White supremacy. In the film, emancipation of slaves brought destruction to the south and showed Blacks rioting, committing violent acts and raping White women. Attempting to restore order, a group of vigilante White men known as the Klu Klux Klan (KKK) rose up to defend White societal order. This popular film created racial tension, especially in the South. It made Whites fear emancipation and its effects on Black pride, group solidarity, independence, and progression.

Following emancipation, Blacks were no longer legally subjected to servitude yet, racial oppression was rampant. Blacks were subjected by discriminatory laws and use of derogatory language. The term "Nigger" was derived from the Northern English word "Neger" which was derived from a Spanish word "Negro" meaning Black. The term "Nigger" became a racial slur because users knowingly mispronounced it as a sign of disrespect. By the early 1800s, the term "Nigger" had become a recognized racial epithet.

Even though slavery was abolished in 1865 through the Thirteenth Amendment, the legacy and impact of racial labels on Black people can still be seen. Racial labels such as Negro and Afro/African American share a historical and contemporary perspective which are both derogatory as well as a sign of strength and solidarity. There has been a generational change in Black racial identity to form and retain Black status and consciousness. Group status and advancement in society and politics provokes changes in racial terminology, therefore producing an evolution of racial labels. The adopted racial label "Colored" used during the nineteenth century was the dominant label accepted by both Blacks and Whites. It was an inclusive term, describing all types of Blacks including those of mixed race and those with full Black lineage. It in many ways lacked specific group membership, however, it possessed group dignity. Late in the nineteenth century, influential Black leaders such as Booker T. Washington and W.E.B. Dubois moved to replace the term "Colored" with "Negro." Booker T. Washington was a prominent public figure, educator, and political leader who advocated for Black civil rights and education. He gained the approval and financial support of many Whites while advocating race integration for the progression and betterment of Blacks. He believed that Blacks could gain social acceptance through hard work, gaining prosperity, and by seeking education. W.E.B. Dubois, author, historian, and civil rights activist, was a prominent figure during the early 1900s. His key concern was for the positive development of Black people. He believed that the small group of Black elites also known as the "talented tenth" would work to positively increase the social standing of Black people by leading them in the right direction. He also campaigned for the political representation of Blacks to achieve civil rights. Although Dubois opposed Booker T. Washington's integrationist ideas, they both focused heavily on the positive attributes of African American society, social progression, and political power. During the twentieth century "Negro" gained great acceptance and was proposed by many influential Black leaders. The term was highly favored due to its grammatical versatility and strength. Despite some opposition due to its derogatory use by Whites, it portrayed not only social strength but political growth as well. By the 1930s the expression "Negro" had become associated with racial progress, Black aspiration, militancy, defiance, and assertion of racial honor.

As the Civil Rights Movement began to materialize, so did a new racial label. During the late 1950s and early 1960s the term "Negro" was considered a vestige of slavery, servitude, and complacency. The new label "Black" was promoted to symbolize power, militancy, and racial separation. The term was preferred and promoted by many Black radical groups who encouraged progression of the Black race. Stokely Carmichael, a Black activist during this time was a strong proponent of the racial label "Black." His involvement in the Student Nonviolent Coordinating Committee (SNCC) and the Black Panther Party made him an influential organizer and civil rights advocate in the Black community. The racial label "Black" was considered to provide balance against the term "White" and emphasize racial separatism. It also was an identifier that was absent of pathology and inferiority. The label marked a time of self-improvement and activism. During this time the racial label "Black" produced great controversy, often seen as derogatory and conflicting with modern symbolism of the American lexicon which associated the word black with evil, destruction, and undesirable traits. But these negative connotations were confronted directly with strong Black political messages such as "Black is beautiful" and "Black and I'm proud," which turned it into a symbol of encouragement and positivity. With help from the Black Social Movement throughout the 1970s and early 1980s, "Black" became a highly favored racial label.

In the late 1980s, a new movement emerged and Ramona Edelin, President of the National Urban Coalition proposed to replace "Black" with "African American." Many were in favor of this, including civil rights activist Jesse Jackson. Since other ethnic groups such as Chinese Americans and Jewish Americans had a recognized source of lineage, it was felt that reference to a historical culture was necessary for Blacks as well. This cultural label replaced the race characteristic and debunked the myth of an inherent essence seen in previous racial labels. The main goals of the newly acquired race label were to identify with Black heritage and the native motherland of Africa, to positively improve public attitudes toward Black individuals and to promote dignity and self-esteem. The term "African American" was used to draw parallels with other cultural groups and rise to their level of social progress and ethnic tolerance. The term was to heighten the global presence and competitiveness of Blacks as well as connote equality with and inclusion into mainstream society. Just as there was enthusiasm for the label, there was also controversy. Many opposed this change because it was seen as a distraction to other issues that were disproportionally affecting African Americans such as poverty and limited access to education; others felt the term to be too inclusive and that the ties made to Africa were simply a delusion. Linguistically, the hyphenated term increased the use of negative "back to Africa" sentiments and other racial epithets. Despite opposition, the new racial term “African American” gained endorsement quickly. It is worth noting that many of these racial labels are still used today, in both mainstream and the Black communities. However, it is not of great importance as to which term is currently being used; it is the uniqueness and course of the term changes that are most relevant. The use of these racial identifiers has developed strength and guidance for social, psychological, and political liberation.

The Resurfacing of “Nigger”

While continuing to gain leverage in society, the resurfacing of the term “Nigger” specifically as used by Blacks has proven to be an even larger progressive step toward inclusion as well as a step back toward subordination. Full of political and linguistic complexity, the word “Nigger” contemporarily changed to “Nigga” has adopted multiple meanings; it has been used as a sign of endearment or affection, for identifying a person who is Black, for negatively associating someone with Black qualities, and for expressing deep disapproval. Its versatile usage has found its way into American popular culture through hip-hop, comedy, and even film. Supporters of the word find it to be liberating and a source of great pride and unity. Opponents find this contemporary usage insulting, disrespectful, and detrimental to the future of Blacks, as it makes the word acceptable for use by everyone and diminishes its historical importance. It has become an unwritten rule that the term “Nigga” is a collective expression only to be used within the Black community. Tension and disapproval still arises if the word is used by Whites and others who do not identify as Black. This strong racial distinction concerning the word “Nigga” serves as entitlement for Blacks, making them sole heirs of the term that was once used to derogatorily distinguish Blacks as an inferior and shameful race.

Impact of Racism and Racial Labeling

The psychological impact of derogatory or other common words for group classification can be detrimental. The words used to describe Blacks can injure one’s self-respect and self-esteem by provoking psychological responses such as humiliation, isolation, self-doubt, self-hatred, and ambivalence about self-worth and identity. Since many of these racial labels were used to negatively portray Blacks and discredit their status, merit, and dignity, the negativity that stems from these terms may become the “truth” in the minds of Black people. The image of blackness has always been a difficult reality to face. The subtle acceptance of defeat and inferiority has proven to be damaging to Black character. Echoes of a previously enslaved mind into the present can perpetuate itself across generations in the form of persistent rage, frustration, and the willingness to overcompensate. However, underlying these symptoms are feelings of hopelessness and despair, which is evidence of psychological damage and incapability. Even children recognize racial differences and cultural attitudes, and apply these differences to how they view themselves. Children carry these racial burdens with them into adulthood, establishing a mind frame of inadequacy and challenging the development of a positive self-image and racial inclusivity. The impacts of racial discrimination can leave traces of physical and psychological distress which perpetuate systemic oppression. Changing the racial labels through which one identifies as being Black may instill group pride and increase self-esteem within a racial group whose ancestral ties were stripped when they arrived as slaves. The change of racial labels has the possibility of breaking the vicious cycle of oppression.

Present Racial Disparities

The social and economic position of Blacks has improved immensely in the United States. However, there is still quite a disparity as it pertains to healthcare, employment, and education. While only constituting 13% of the population, Blacks account for about half of all HIV/AIDS cases and AIDS is the leading cause of death in HIV/AIDS as compared to other racial/ethnic groups. Blacks also have high rates of diabetes, a debilitating disease which affects the body’s use of blood sugar. Diabetes currently affects 13% of the Black population over the age of 20. Unemployment rates for Blacks have soared to about 15%; nearly twice the unemployment rate for Whites and far exceeding the national unemployment rate. The educational opportunities available to low income Black communities are limited, and only 42% of Black students complete college as compared to 60% of their White counterparts. Despite the improvements seen for the Black community, there is still a need to fight for stronger political stability and social acceptance to eradicate the racial disparities. Institutionalized racism, an invisible structure of discrimination that is heavily embedded into society's morals but is not supported by overt law and action, still impedes advancement of the Black population.

Immigrants

It is important for immigrants to acknowledge that there are many different races and behind each race there is a social legacy that is incorporated into each racial identity. Blacks and how they are perceived relates closely to their economic, legal, social and political positions. Blacks have often demonstrated strength and perseverance to withstand social pressures. Blacks, like many other immigrant groups who arrive in the United States have an identity and consciousness that is highly significant. Blacks and immigrants continue to experience assimilation difficulties. The Black experience has been heavily shaped by racism and White superiority. The strong public emphasis on race in the USA is in its own right unique. Unlike other countries such as Brazil, Colombia and many other Latin American countries, racial distinctions are less rigid, although discrimination may be equally prevalent. Due to the fact that Blackness varies depending on particular countries, those immigrants with dark skin do not qualify racially as Black. However, their dark skin is still associated with inferiority. Their skin tone still has a political element and can have a negative effect on economic status, employment, and educational opportunities. This discrimination based on skin tone is known as colorism.

American immigration history displays its close relationship with race and politics. The influx of immigrants during the late 1800s and early 1900s was historically relevant both to the United States and to the creation of whiteness. Immigrants during these times were seen as outsiders, not fully aligned with American ideals. The increase of European immigrants from Ireland and Italy provoked fear of a future decline in the White race; the mixture of races posed a threat to the existing "White" American life and predicted a future of weakness and demise. Many of these immigrants were perceived as having undesirable traits innately different from Whites. For instance, Irish and Italian Americans were considered savages, innately prone to criminality. They were seen as unfit to participate in American political life. These immigrants would need more than their White skin to fully assimilate – they would need to show how distinct they were from non-Whites. A close relationship to non-Whites was a violation of a social racial code which resulted in condemnation. Immigrants who were thought to be equivalent to non-Whites gave mainstream Whites valid reasons for discrediting and discriminating against them. They had to distance themselves from non-Whites in every way in order to solidify their racial distinctiveness. So in order to assimilate into a White-dominated culture, one must side with White Americans and equally degrade non-Whites, especially Blacks who were considered the lowest of the racial groups. The assimilation of immigrants soon prompted whiteness to be redefined as variegated. Whiteness is an exclusive and exclusionary racial category, in which non-Whites have no access to its privileges.

Immigration today is still influenced by racial views that involve the biological conception of race which is often supported by public policy. Immigrants may have a hard time assimilating into new cultures because they are viewed as inferior and lacking in rationality. The xenophobic fears of some sectors of American society have fueled the proposal of racist policies, which effect immigration and race relations.

Related Topics

- ▶ Acculturation
- ▶ Africa
- ▶ Discrimination
- ▶ Ethnic identity
- ▶ Health determinants
- ▶ Identity
- ▶ Multiculturalism
- ▶ Racism
- ▶ Stigma

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Centers for Disease Control and Prevention. *HIV among African Americans fact sheet.* http://www.cdc.gov/hiv/topics/aa/resources/factsheets/pdf/aa.pdf

Ferris State University. The Jim Crow Museum. http://www.ferris.edu/jimcrow/

National Association for the Advancement of Colored People. *African Americans and education fact sheet.* http://naacp.com/advocacy/education/African_Americans_and_Education_092809.pdf

Blood Cholesterol

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Of the estimated 214 million migrants in the world today, the USA has the largest number of international migrants. The dynamic concept of migration has evolved and gradually changed over time, leading to significant challenges to the existing political and healthcare systems of developed countries.

These challenges, which are often incongruous with the immigrant's vision and traditional values, range from poor access to quality preventive care to lack of understanding of the healthcare system. Despite the concept of the "healthy migrant effect," these barriers have predisposed immigrants to practice behaviors that lead to the early development of disease and disease risk factors like elevated cholesterol.

Cholesterol and triglycerides are substances in the bloodstream required for physiological functions such as metabolism, cell membrane permeability, and hormone synthesis. High cholesterol and triglycerides, broadly termed "hyperlipidemia," are important risk factors for cardiovascular events. Hyperlipidemia is defined biochemically as elevated bad cholesterol (LDL-cholesterol), low good cholesterol (HDL-cholesterol), and elevated triglycerides (TG). Hyperlipidemia can cause myocardial infarction ("heart attack"), stroke, and peripheral arterial disease. Hyperlipidemia shares a common disease risk factor and treatment strategy with a more epidemiologically concerning condition, cardiometabolic syndrome (CMS).

The age-adjusted prevalence of CMS among immigrants ranges from 26.9 to 38.2%, with rates increasing in women with age greater than in men. The rate of CMS among immigrants is higher than the rate for US-born adults, which ranges from 18 to 32%. Among Asian Indian immigrants in the USA, the prevalence of elevated LDL-cholesterol (LDL-C) is 41.4%, low HDL-cholesterol (HDL-C) is 26.4%, and hypertriglyceridemia is 42.3%.

The etiology of hyperlipidemia is subdivided into primary and secondary causes. Primary causes, which are more common among children, include genetic mutations that lead to underproduction, overproduction, or defective clearance of cholesterol and triglycerides. Secondary causes are related to lifestyle factors that include physical inactivity, poor dietary habits, smoking, alcohol abuse, and use of certain drugs. Chronic medical conditions like diabetes and chronic kidney disease also cause hyperlipidemia.

For most individuals, hyperlipidemia is a preventable metabolic risk factor. Drug treatment, considering both direct and indirect costs, may be challenging and not sustainable for immigrants if priorities are considered for thriving in a foreign land. The high and slow rate of decline of death rates from cardiac diseases among immigrants is a major public health issue. In order to address this issue effectively and produce change, a sensitive and culturally based treatment program tailored to the needs of the individual is necessary.

CMS is a cluster of physical conditions and metabolic abnormalities. They commonly occur together, which increases the risk for cardiovascular disease and diabetes. The American Heart Association criteria for CMS include elevated waist circumference (≥102 cm in men and ≥88 cm in women), elevated TG (≥150 mg/dL), reduced HDL-C (≤40 mg/dL in men and ≤50 mg/dL in women), elevated blood pressure (≥130 mmHg systolic or ≥85 mmHg diastolic), and elevated fasting glucose (≥100 mg/dL). Any three of the five constitute the diagnosis of CMS.

An important step in the pathogenesis of CMS, insulin resistance, is also characteristic of familial combined hyperlipidemia (FCH). Insulin resistance is associated with increased TG levels, low HDL-C, small dense low-density lipoprotein, and increased apolipoprotein B.

Immigrants are a growing group of people with high risk of cardiovascular disease and a tendency toward unhealthy behaviors. These risk factors and behaviors include poor dietary habits, obesity, smoking, and physical inactivity. These factors are not attributed to rapid Westernization, but to time since immigration, acculturation, and assimilation. This is concerning because immigrants may have a prevalence of risk factors that, over time, may surpass those of nonimmigrants.

Cardiometabolic risk factors vary among immigrant populations, especially in those of different ethnic backgrounds. For instance, the rate of obesity among immigrants to the USA approaches those of born in the USA if they have lived here for more than 15 years. This is in contrast with immigrants to Spain, where length of residence is not associated with obesity.

Physical activity plays a significant role in prevention of obesity and other chronic diseases. Physical inactivity contributes to higher cardiovascular risk and is prevalent in immigrant populations, especially those from South Asia. Lack of physical activity has been correlated with cultural beliefs, values, and low socioeconomic status. For example, some immigrants perceive people with bigger size and frame as being more healthy and prosperous than those who are thin, which is perceived as a reflection of impoverishment.

Immigrants are vulnerable to various degrees of food insecurity that occurs if there is no sustainable access to healthy food. In the USA, the root of food insecurity is poverty, which leads to poor health conditions and bad eating behavior. Food insecurity among low-income immigrants is associated with hyperlipidemia, obesity, and other cardiovascular risk factors.

Post-migration dietary changes can lead to both better and worse health outcomes. Based on a systematic review of dietary patterns of ethnic groups in Europe, age and generation were the two major factors responsible for dietary changes, with older generations maintaining consumption of staple foods rich in carbohydrates, while the younger generation is accultured to the Westernized diet and processed foods, which are often high in fats and low in carbohydrates. Other factors contributing to higher body mass index (BMI) are lack of exercise, genetic predisposition, and disadvantaged socio-economic status.

Smoking is an important risk factor for low HDL-C, though the prevalence is lower than in the nonimmigrant population, and it varies across subpopulations of immigrants. Cigarette smoking has a direct dose response. Smoking more than 11–20 cigarettes per day alters the lipid profile through nicotine-induced lipolysis and the development of hyperinsulinemia among smokers.

Lastly, psychosocial and socioeconomic factors have been implicated as important risk contributors in some studies. The role of these factors may have added impact in the escalating rate of chronic medical conditions among immigrants.

With continuing unhealthy behavior, hyperlipidemia establishes itself in the immigrant population and continues as an important cardiometabolic risk factor. Risk reduction strategies such as lifestyle modifications and prescribed medications are important to reduce morbidity and mortality associated with hyperlipidemia and CMS, regardless of migration status.

Prevention of hyperlipidemia requires a comprehensive approach that incorporates therapeutic lifestyle changes and risk-modifying strategies tailored to the values and beliefs of the immigrants using translated and culturally-relevant educational tools. In general, guidelines to manage hyperlipidemia and cardiometabolic risk factors share similar features (Table 1).

Blood Cholesterol. Table 1 Profile of immigrant and management of hyperlipidemia in CMS

Immigrant's profile	Recommendations
No lifestyle or metabolic risk factors	1. Optimal physical activity and diet to keep BMI <25 kg/m^2 2. Diet rich with complex carbohydrates, reduced saturated fats, and high intake of fruits and vegetables 3. Smoking cessation
Obesity with or without sedentary lifestyle	1. Physical activity with regular moderate intensity. At least 30 min of continuous or intermittent 5 day/week to reduce body weight by 10% until BMI is <25 kg/m^2 2. Dietary fat should be unsaturated with reduced trans fat and simple sugars. Total fat intake must be 25–35% of total calories 3. Smoking cessation
Low HDL-C and high TG	1. Physical activity with regular moderate intensity. At least 30 min of continuous or intermittent 5 day/week to reduce body weight by 10% until BMI is <25 kg/m^2 2. Dietary fat should be unsaturated with reduced trans fat and simple sugars. Total fat intake must be 25–35% of total calories 3. Adding fibric acid or niacin 4. Smoking cessation
Elevated LDL-C	1. Physical activity with regular moderate intensity. At least 30 min of continuous or intermittent 5 day/week to reduce body weight by 10% until BMI is <25 kg/m^2 2. Dietary fat should be unsaturated with reduced trans fat and simple sugars. Total fat intake must be 25–35% of total calories 3. Add LDL-C lowering drugs depending on number of CVD risk factors. If patient has high CVD risk factors, the LDL-C goal is <100 mg/dL. If moderate risk, LDL-C goal is <130 mg/dL. If low risk, the LDL-C is <160 mg/dL 4. Smoking cessation

BMI body mass index, *CVD* cardiovascular disease, *HDL-C* high-density lipoprotein cholesterol, *LDL-C* low-density lipoprotein cholesterol, *TG* triglycerides, *CMS* cardiometabolic syndrome
Source: Grundy et al. (2005)

Physical activity and weight reduction have a significant role in the management of hyperlipidemia and CMS by improving lipid profile and insulin sensitivity. Following the goals and recommendations of the American Heart Association on modifying lifestyle risk factors, physical activity that involves at least 30 min of moderate-intensity aerobic activity, like brisk walking, preferably daily, is recommended. For those at high risk for or with established cardiovascular disease, a medically supervised program is advised. Reduction of 7–10% of body weight from baseline within one year or until BMI of <25 kg/m^2 is desirable.

Barriers to implementing physical activity are particularly great for low-income immigrants. Physicians must promote physical activity and improve their knowledge through multiple channels with realistic goals in order to increase their participation and improve self-management behavior.

Similarly, diet management and smoking cessation are also important factors to address. Diet management through the assessment of dietary patterns, nutrition education, and personalized dietary regimens that consider food preferences are effective strategies that can alter unhealthy dietary acculturation. The recommended diets are focused on consumption of complex rather than simple carbohydrates using polyunsaturated and monounsaturated rather than saturated and trans fats and increasing consumption of fruits and vegetables. Immigrant-directed dietary regimens may have better compliance and an increased chance of improving dietary habits.

The most important class of drugs to treat hyperlipidemia are HMG-CoA reductase inhibitors ("statins"), niacin, and fibric acids. These may be used alone or in combination. These drugs, thought to have a significant lipid-lowering effect in Whites, have been found to produce ethnically based differential responses. This is an important issue when selecting appropriate drugs to treat hyperlipidemia. In addition, fibric acid is more effective than statins in the treatment of the lipid profile associated with cardiometabolic syndrome characterized by low HDL-C and high TG.

Risk stratification using a number of CVD risk factors, with LDL-C as the main target, guides clinical care providers when initiating an optimal treatment strategy, whether lifestyle therapies or lipid-lowering drugs are indicated. CVD risk factors are established atherosclerotic CVD, diabetes, metabolic syndrome, smoking, or 10-year risk for coronary heart disease of 10–20%. If the patient has one CVD risk factor, treatment is targeted for LDL-C <160 mg/dL. If more than two risk factors are present, targeted LDL-C must be <130 mg/dL. If there is coronary heart disease or a coronary heart disease risk equivalent, the targeted LDL-C is <100 mg/dL. Though there is no goal for low HDL-C, lifestyle therapies or adding fibric acid or niacin can increase it.

In cases in which elevation of cholesterol is related to family history or genetic disorder, like familial hypercholesterolemia, counseling and screening are an important part of management. If the underlying cause is due to a medical condition, such as diabetes or chronic kidney disease, control of glycemia through lifestyle modification and use of lipid-lowering drugs improves disease outcome.

Smoking cessation through the use of drugs like bupropion and community- or clinic-based counseling is a challenging task and requires an intensive and comprehensive approach. Recommended strategies that employ a combination of pharmacotherapy, counseling, and behavioral modification offer a higher chance of quitting.

Migrant population–based interventions must be implemented over an extended period with supervision to support the program. These interventions should be low cost, accessible, and implementable as large community-based programs.

Immigrants' health differs from that of nonimmigrants, whether their condition improves or deteriorates as a result of assimilation and acculturation to their new environment. Clinicians must increase their awareness of immigrants' higher health risks compared with nonimmigrants.

Hyperlipidemia is not an isolated disease risk factor but part of a spectrum of factors that synergistically work to cause disease. With immigrants' heterogeneity and differential exposure to behavioral and environmental factors at various stages of their lives, a comprehensive approach is mandatory. With a wide range of effective strategies available, future research must focus on longitudinal studies and the conduct of evidence-based, ethnic-specific community interventions on health promotion and disease prevention.

These tasks can be very challenging. Following the principles of theory of planned behavior and reasoned action, immigrants have various behavioral beliefs. Modifying the value attached to it through education and frequent follow-up will motivate them to comply until they fit in with the healthcare systems. This will improve their perception of the ease or difficulty of behavior performance, because immigrants have different healthcare needs and outcomes.

In addition, highlighting the importance of examining health risk behaviors by immigrant status is a mounting interest among policymakers, as their proportion in terms of overall population continues to increase along with the cost of care.

Related Topics

- ► Cardiovascular disease
- ► Food insecurity
- ► Health disparities
- ► Health literacy
- ► Health status
- ► Risk factors for disease
- ► Tobacco use

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Suggested Resources

American Heart Association. http://www.americanheart.org.

WebMD. Cholesterol management health center. http://www.webMD.com.

Blood Glucose

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Levels of blood glucose in the human body are regulated by insulin, a hormone secreted by the beta cells of the pancreas. Insulin facilitates the transport of glucose across cell membranes. When the regulation by insulin fails and glucose transport across cell membranes is impaired, the result is hyperglycemia: high blood glucose levels. Hyperglycemia is a common effect of undiagnosed or uncontrolled diabetes, a chronic disease caused by a lack of insulin activity. This lack of insulin activity may have two causes: The pancreas does not produce enough insulin or the body is not able to effectively use the available insulin, also known as insulin resistance. There are two major types of diabetes: Type 1 diabetes is mainly caused by a decline in insulin secretion by the pancreas and type 2 diabetes mainly by insulin resistance.

High levels of blood glucose can over time lead to serious damage to the body's systems especially to the blood vessels and nerves. Patients with diabetes have a high risk of microvascular (small vessel), peripheral vascular (blood vessels in the extremities), or cardiovascular disease. Half of all patients with diabetes eventually die of cardiovascular disease, primarily coronary heart disease and stroke. Other common consequences of diabetes are damage to the eyes, eventually resulting in visual impairment or blindness, kidney failure, neuropathy (nerve damage), and gangrene foot.

Diabetes is a rapidly spreading global health problem. Currently, over 220 million persons worldwide are estimated to have diabetes and this number is expected to have doubled by the year 2030. People with a sedentary lifestyle resulting in excess body weight and low levels of physical activity are at higher risk of developing diabetes. Furthermore, a low socioeconomic position, high age, and ethnicity are important determinants of diabetes. Particularly, migrants to Western societies have an increased risk of diabetes. This has been clearly demonstrated for South Asian and African migrants to the USA or the UK, who have a far higher (two- to fourfold) risk of having diabetes than the indigenous White population. In the USA, studies have also shown relatively high prevalence rates for diabetes among American Indians and Hispanic ethnic minorities. In the Netherlands, relatively high risk levels for diabetes have also been shown among migrants from South Asian and African ethnic origin. Compared to the Dutch ethnic population, diabetes prevalence rates are two- to fourfold higher among South Asian Surinamese and African Surinamese migrants. Interestingly, two large Mediterranean groups in the Netherlands, namely Turkish and Moroccan migrants, also show relatively high diabetes prevalence rates.

In Europe, migrants from Turkey and Morocco are among the largest ethnic minority groups. Turkish migrants mainly live in Germany and the Netherlands.

Migrants from Morocco mainly reside in France, Belgium, and the Netherlands. The first wave of migrants from Turkey and Morocco came to the Netherlands in the late 1960s, mainly as labor migrants. Nowadays, in Amsterdam, the Netherlands, Turkish and Moroccan migrants account for around 5% and 9% of the total population, respectively. Because of the relatively high immigration figure and high birth rate in these groups, their numbers are expected to rise in the coming years.

A recent population-based survey performed by the Public Health Service of Amsterdam and the Dutch National Institute of Public Health and the Environment among the Amsterdam adult population (18 years and older) has shown two to almost three times higher diabetes prevalence rates among Turkish (5.6%) and Moroccan (8.0%) migrants as compared to the indigenous Dutch population (3.1%). Although differences in demographic factors, such as age, sex, and socioeconomic status, and lifestyle-related factors, such as physical activity, body mass index, and waist-to-hip ratio, are shown to be of influence, they can only explain part of these ethnic differences. Furthermore, as is seen among migrants from South Asian or African origin, the typical age of onset of diabetes is lower among Turkish and Moroccan migrant groups, respectively, one and two decades younger than in the Dutch indigenous population. When taking into account the fact that these migrants are relatively young, ethnic differences in diabetes risk are expected to in fact be even higher.

Lifestyle-related determinants such as excess body weight and a lack of physical activity are important risk factors in developing diabetes. Primary prevention targeting on these lifestyle factors is crucial in all ethnic groups. However, migrants often have a higher risk of being overweight, and therefore, a special focus should be on them. Taking into account the lower age of onset of diabetes in many migrant groups, screening for diabetes among these migrants should start at an earlier age, preferably before the age of 45 years.

Since the number of migrants in countries such as the Netherlands is increasing and their age is expected to rise, it is of crucial importance to develop interventions targeting ethnic minority groups aimed at the prevention and/or early detection of diabetes.

Related Topics

- ► Cardiovascular disease
- ► Cardiovascular risk factors
- ► Diabetes mellitus
- ► Metabolic syndrome
- ► Obesity

Suggested Readings

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Blood Pressure

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Blood pressure is the pressure exerted on blood vessels by blood circulating in the body. It has two phases: systole and diastole – systole occurs when the cardiac muscles contract and pump blood through the body's arteries, and diastole occurs when the cardiac muscles relax between heartbeats. Blood pressure is therefore measured using both systolic and diastolic readings with millimeters of mercury (mmHg) as the unit of measurement. Normal blood pressure levels in adults are below 120 systolic and 80 diastolic mmHg. Adults with blood pressure measurements between 120 and 139 systolic or 80 and 89 diastolic mmHg are said to be prehypertensive, while those with blood pressure readings of at least 140 systolic or 90 diastolic mmHg suffer from hypertension (high blood pressure). Hypertension is an important risk factor for cardiovascular disease, kidney disease, and mortality, but is often manageable with the use of antihypertensive medications and lifestyle alterations, such as increased physical activity and a low-sodium diet. Approximately 90–95% of hypertension is referred to as *essential* hypertension, meaning the causes of the condition are unknown; the remaining proportion of high blood pressure cases are labeled *secondary* hypertension and are linked to a specific cause, such as stress, smoking or obesity.

The opposite of hypertension is “hypotension” or abnormally low blood pressure (defined as blood pressure below 90 systolic or 60 diastolic mmHg). However, hypotension is less prevalent (as we report in the next section) and less often studied than high blood pressure. When it does occur hypotension can lead to depression, increase the risk of falls as a result of increased dizziness, and in severe cases it may lead to organ failure and brain damage.

Hyper- and Hypotension Prevalence in the United States by Nativity

Analysis of the National Health and Nutrition Examination Survey (NHANES) data for 2005–2008 indicate that the prevalence rate of hypertension (according to blood pressure measurements, self-reports of hypertension diagnosis, and whether respondents were currently taking antihypertensive medication) in the adult U.S. population was approximately 28%. This rate was considerably higher among adults 70 years of age and older (55%). Separated by nativity, these data suggest that 29% of U.S.-born adults had hypertension and 22% of foreign-born adults did. This hypertension nativity difference reverses, however, as the populations age – while both U.S.- and foreign-born adults were at increased risk of hypertension the older they were, 54% of U.S.-born adults over the age of 70 were hypertensive compared with 64% of foreign-born adults in this age group. Although we were unable to identify any studies that have investigated the prevalence or sources of hypotension by nativity in the United States, 2005–2008 NHANES data suggest that 17% of U.S.- and 21% of foreign-born adults were hypotensive.

Hypertension Awareness and Management

Not all U.S.-born adults who have hypertension are managing or even aware of the condition, partly because high blood pressure is not always accompanied by obvious symptoms. For example, 34% of U.S.-born and 20% of foreign-born adults who have hypertension report that a health professional has never informed them of this diagnosis. One implication, of course, is that U.S.-born individuals have a higher prevalence of hypertension than typically reported and are less aware and potentially less likely to be in control of their blood pressure. Furthermore, among adults who have been diagnosed with hypertension, it is estimated that approximately 75%, regardless of nativity, were taking antihypertensive medication. Unfortunately, little research exists on blood pressure management and medication compliance among foreign-born residents of the United States. Studies that have been conducted – mostly among international Mexican and Chinese migrants – convey three messages: (1) migrants are less likely to be screened for blood pressure than nonmigrants; (2) migrants, especially those who have been in the United States for less time, are less likely to maintain medication compliance when prescribed antihypertensive medications; and (3) more research is needed to understand the determinants of blood pressure awareness, management, and control among the foreign born.

Ethnoracial and Nativity Differences in Blood Pressure

Racial differences in blood pressure have been well documented in the United States, with non-Hispanic Black adults consistently demonstrating a higher prevalence of hypertension and lower rates of blood pressure screening and medication compliance than non-Hispanic Whites. However, the 2005–2008 NHANES data indicate that non-Hispanic U.S.-born

Black adults actually had a lower prevalence of hypertension (31%) than non-Hispanic U.S.-born Whites (38%). This ethnoracial minority advantage disappears around the age of 50 though, and as the population ages non-Hispanic U.S.-born Black hypertension rates begin to exceed those of non-Hispanic U.S.-born Whites. Consequently, it appears that differences in hypertension rates exist not only by nativity in the United States, but also within foreign-born populations by age and race. Such heterogeneity between and among ethnoracial-nativity groups intimates that researchers need to be careful when comparing various subpopulations residing in the United States, and at the very least age-standardize data before presenting statistics comparatively. The evidence to date regarding blood pressure (and in particular hypertension) among specific migrant groups, in the United States or elsewhere, is relatively scant. Initial studies have tended to focus either on Latinos as a whole or on Mexicans – who constituted the largest legal and unauthorized foreign-born populations in the United States as of 2008.

In general, foreign-born Mexican residents of the USA appear to have lower rates of hypertension than U.S.-born populations regardless of race or ethnicity. For example, according to the 2005–2008 NHANES data, the hypertension prevalence rate among foreign-born Mexicans is 15.8%. In line with the immigrant selectivity hypothesis, one study also found that foreign-born Mexican residents of the USA had the lowest rates of hypertension when compared with U.S.-born Mexicans and those living in Mexico. However, some evidence suggests that foreign-born Mexican residents of the United States are also less likely to obtain blood pressure screening than U.S.-born Mexican Americans and non-Hispanic U.S.-born Whites.

When looking specifically at other Latin American groups, the story seems less consistent; a few studies have found darker-skinned Latino populations, such as those from the Dominican Republic, to exhibit hypertension prevalence rates more similar to those found among non-Hispanic U.S.-born Blacks, and that Central American migrants fall somewhere in between Mexican and Dominican migrants. The NHANES data suggest that immigrants from Spanish-speaking countries other than Mexico have a hypertension prevalence rate of 27.3% – notably higher than foreign-born Mexicans but still slightly lower than U.S. adults viewed collectively. However, among Latino migrants with hypertension, Mexicans appear less likely to be in control of their blood pressure after having been diagnosed (66% taking medication) than other Spanish-speaking migrants (78% taking medication). In terms of race, migrants who characterize themselves as White are more likely to suffer from hypertension (28.7%) than those who self-identify as Black (27.1%) or Latino (20.2%).

Only a few studies have looked at other non-Hispanic migrant groups, and again foreign-born Asians (usually including Arabs and Persians) and foreign-born Africans tend to be considered as single subpopulations rather than separated by place of birth. Still, existing research indicates that foreign-born Asians have the lowest rates of hypertension. One study using 1993–1994 National Health Interview Survey (NHIS) data found only 8.9% of Asian immigrant adults to be hypertensive. In contrast, U.S.-born Asians in the same study had a prevalence of 19.9%, higher than the non-Hispanic White prevalence of 17.5%. Another study looking at adult immigrants in the United States from all over the world found that foreign-born Europeans had the highest hypertension prevalence rates, followed by Latinos, Africans, and finally Asian and Middle Eastern immigrants. A household study of Arab immigrants in Michigan, published in 2008, found a hypertension prevalence rate of 18% and another survey of foreign-born African physicians and nurses found that the African migrants had a lower rate of hypertension than the African-American comparison group.

Hypertension and the Acculturation Hypothesis

Although immigrant groups in the United States appear healthier than their U.S.-born counterparts with respect to hypertension, research on acculturation – often measured by English-language proficiency or duration in the United States – suggests that immigrant health declines across a variety of outcomes the longer they reside in the United States. The limited research on hypertension and acculturation is inconsistent on this point, with some studies finding time in the United States to be associated with greater hypertension prevalence and others reporting no association. Comparisons between the findings are often difficult, as data and acculturation measures employed vary from study to study.

For example, one study using the Multiethnic Study of Atherosclerosis (MESA) data included Latino immigrants aged 45–84 and measured acculturation with two variables: language spoken at home and proportion of life spent in the United States. A second study employed the 2005 New York City Community Health Survey data, including U.S.- and foreign-born Latinos, as well as non-Hispanic Blacks and Whites, and examined differences between immigrants who had been in the United States for more than 4 years and more recent immigrants. Another study utilizing NHIS data looked at all foreign-born residents and the relationship between hypertension and length of time in the United States measured according to three categories: less than 10 years, 10 to less than 15 years, and 15 years or more. The first study found that those respondents who spoke Spanish at home and had been in the United States for a smaller proportion of their lives had higher systolic blood pressure, while the second study found a positive relationship between length of residence in the United States and hypertension. The third study reported no association between hypertension and having lived in the United States for 15 or more years. Thus, the dynamics of the migration process and their influence on blood pressure remain unclear.

Individual and Sociogeographic Determinants of Hypertension

Beyond the migration experience itself, there are a variety of risk factors for high blood pressure. Most research has honed in on individual genetic, physiological, and lifestyle factors, but there is increasing evidence pointing to the importance of sociogeographic factors as well. Age is the foremost risk factor for developing high blood pressure – the prevalence of hypertension increases considerably beyond the age of 50. According to the NHANES data, the prevalence rate of hypertension in foreign-born adults ages 50 and over in the United States is 45.6% (48.9% for U.S.-born), and that for adults between ages 18 and 49 is only 9.9% (14.5% for U.S.-born). Having a family history of high blood pressure is also a serious risk factor for developing hypertension.

Many of the remaining risk factors for hypertension are more modifiable than age or family history. Lifestyle factors, or health behaviors in particular, are often implicated in cases of high blood pressure and adjusting these factors may be required in order to control hypertension. For example, smoking, a high-sodium or high-fat diet, lack of physical activity, and alcohol or drug abuse are risk factors for hypertension. While some non-U.S.- born groups are less likely to engage in such habits, others may be more likely to do so depending on the environment from which they migrated as well as their current environment.

In China, for example, more than 60% of the male population smokes compared to 23% of U.S.-born men, and this habit may increase the probability that Chinese migrants in the United States will smoke. Foreign-born Mexicans in the USA are often employed in manual labor jobs in which they engage in employment-related physical activity on a daily basis when they arrive, and this may buffer against hypertension. Studies of Brazilian and Dominican migrants in the United States have found both groups to be less likely to engage in harmful behaviors compared to the U.S. population as a whole, but Brazilian migrants are healthier than Dominicans across various metrics. Thus, not all migrants engage in behaviors likely to contribute to hypertension, but consistent with the acculturation hypothesis, evidence suggests that the longer migrants reside in the United States, the more likely they are to emulate relatively unhealthy habits of the U.S.-born population.

Finally, there are sociogeographic factors that may influence the probability of experiencing hypertension, many of which pertain especially to immigrants in the United States. Specifically, a large proportion of the foreign-born population in the United States is from Latin America, and Latino migrants tend to be of lower socioeconomic status and to live in more residentially segregated neighborhoods than their U.S.-born counterparts. Some migrants are unauthorized to reside in the USA, and each of these circumstances separately and together may induce stress and anxiety. Stress is a multifarious risk factor for high blood pressure, and if chronic, may predispose individuals not only to hypertension but to a host of concordant health problems, such as cardiovascular and metabolic diseases.

Legal and unauthorized migrant populations also have less access to health insurance and medical care than U.S.-born residents. A study using the NHIS data for 1998–2003 found that foreign-born residents of the United States were far less likely to have access to health insurance than U.S.-born individuals – 26 versus 11%. Among the foreign-born, Latino immigrants were least likely to have insurance, with 37% of the population lacking access to care. A second study suggests that approximately half of all legal and a full two-thirds of unauthorized Latino migrants in California lacked access to health insurance between 1993 and 2001. Without access to insurance, people are less likely to obtain preventive care, such as blood pressure screening, and less likely to successfully manage hypertension once diagnosed.

With the foreign-born population comprising a substantial and increasing proportion of the United States population, and generations of their U.S.-born children growing in number, it is important to gain a clearer understanding of the risks of hypertension (and hypotension) among these immigrants and the factors explaining these risks. While research that currently exists offers a useful starting point, further work is necessary to elucidate the differences in risk and prevalence among the many foreign-born population groups in the United States.

Related Topics

- ▶ Acculturation
- ▶ Cardiovascular disease
- ▶ Cardiovascular risk factors
- ▶ Healthy immigrant
- ▶ Hypertension
- ▶ Obesity
- ▶ Racial disparities

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Body Image

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Practitioners should be aware of several body image-related issues when dealing with immigrants. One's body image can be defined as the way an individual perceives himself or herself and is often complicated by the process of immigration insofar as immigrants may perceive themselves according to the cultural standards of both their native and receiving countries. It appears that the longer immigrants remain in their nonnative land, and the more immigrants absorb the culture's attitudes toward body image, the more susceptible immigrants are to certain body ideals and pitfalls of the dominant culture. The major issues a practitioner should consider with respect to body image include unhealthy dieting, media images of thin and fit women, the impact of media on body image distortions and body dissatisfaction, eating unhealthy comfort foods, obesity, and, increasingly, eroticized White bodies.

In contrast with the numerous mental and physical health issues modern immigrants face as a result of poor body image, historically, this has not always been the case. In the wake of Europe's mass exodus after World War II, many individuals immigrated to the USA and other European safe havens in the hopes of achieving physical safety and health. While immigrant health and positive body image may be partially attributed to the new feminine ideal of the 1940s and 1950s (led by buxom actresses such as Marilyn Monroe, Lauren Bacall, and Marlene Dietrich), it can also be attributed to Holocaust survivors who promoted the new ideal. The new ideal hailed curves and large breasts, and Holocaust survivors who had been deprived of food and drink for numerous years latched onto such voluptuous images.

Because today's immigrants leave one set of stressors in their native land, only to arrive to an entirely new set of stressors and limited opportunities in receiving countries, poor eating and inadequate self-care dominate today's immigrant culture. In the USA, Latino individuals provide insight into this phenomenon, which essentially manifests itself in several ways, including unhealthy dieting, overeating comfort foods, and vacillating between the ideals of their native countries and Western ideals. Nonphysically active Latina women living in the USA concerned with health maintenance and body image have expressed grievances over the thin American ideal in contrast to the curvaceous Latin ideals. At issue for these immigrants is the desire to preserve their cultural pride in feminine curves versus the desire to assimilate into a receiving culture that tends toward an ideal of thin actresses and supermodels without curves.

As a consequence of mixed media and cultural messages, many Latinas are at risk of developing mixed feelings toward healthy eating and physical activity. Overeating affects many immigrants whose comfort food in their native lands was deep-fried. Many developed countries have incorporated significant amounts of ethnic food into their common cuisine, and while this multicultural phenomenon is progress in the sense that just about anyone can get a burrito or chop suey anytime, day or night, this phenomenon indeed puts immigrants at risk. Specifically, those immigrants who are overworked and stressed may find that the easiest and most comforting meal often consists of fast food that vaguely resembles food from home.

Mixed feelings regarding Western ideals of thinness extend beyond Latinos in America. As immigrant women in Australia and Canada acculturate, they may eventually experience a shifting of their weight-related values, and at the extreme can develop disordered eating. It appears that the longer immigrant individuals live in societies steeped in Western ideals, the higher the risk is that they will develop disordered eating. This trend rebuts previously accepted notions that factors for disordered eating are restricted to non-Hispanic White females in Western societies, and, instead, posits the notion that self-assessment increases as women take on less traditional female roles and become more competitive in the workplace. As such, it can be important for practitioners to speak with clients and instill in them the value of preserving one's cultural heritage and the ways in which their respective heritage values the female figure.

Many immigrants also struggle with feelings of inferiority due to skin color. A closely held belief emerging, almost transcontinentally, is the belief that lighter skinned individuals are better situated and fare better than darker skinned individuals, regardless of race/ethnicity. This tension is presently playing itself out in Asia and increasingly among Asian, Jamaican, and Indian immigrants who see skin bleaching as a means to upward mobility. The perceived need for skin bleaching stems from the idea that white skin is both noble and aristocratic, while dark skin is a result of manual labor and agrarian living. Because of the inherently racist undertones, US marketing corporations that promote skin-bleaching products are careful to designate products as "brightening, not whitening products." But, the so-called sensitivity seems insincere in light of numerous reports of mercury poisoning in China. Mercury is an active ingredient in many bleaching products and, the higher the mercury content, the better results a bleaching product has. The problem, of course, is that mercury is toxic and can cause psychosis, kidney failure, and injure the nervous system. While various countries have regulations to prevent harmful products from entering the market, immigrants whose receiving countries do not have such safeguards run the risk of bringing in or importing harmful products and jeopardizing their health in an effort to fit in and get ahead.

The lasting impact of body image distortion and body dissatisfaction on immigrants remains to be seen, but should the current trends continue to dominate, Western ideals of stick-thin models and pale skin will likely prevail at the expense of healthier ideals such as those prevalent in Latino and Mediterranean cultures.

Related Topics

- ▶ Body shape
- ▶ Depression
- ▶ Disordered eating
- ▶ Gender roles
- ▶ Migrant farmworkers
- ▶ Multiculturalism
- ▶ Nutrition
- ▶ Obesity
- ▶ Percent body fat
- ▶ Psychological acculturation
- ▶ Social stress

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Body Mass Index

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Body Mass Index or BMI is a simple way to measure body fat based on a person's height and weight. It is often used to determine a person's health and fitness status. It is also used to screen for weight categories that serve as indicators for potential health risks. BMI was originally developed by the Belgian statistician, Adolphe Quetelet, between 1830 and 1850. The mathematical formula to calculate BMI is Weight (in kilograms) Height (in meters)^2. The standards are the same for men and women.

According to the National Institutes of Health, BMI classifies weight as follows:

- Below 18.5: Underweight
- 18.5–24.9: Normal weight
- 25–29.9: Overweight
- 30 and over: Obese

There are over 1 billion overweight adults in the world and at least 300 million of those are obese. Obesity has clearly become a global epidemic. Overweight and obesity are major risk factors for serious diseases such as type II diabetes, heart disease, hypertension, stroke, and cancer. Over the last 20 years, there has been a dramatic increase in the obesity rates in the United States. Rates are especially high for non-Whites. The CDC reported African-Americans had a 51% higher prevalence of obesity and Hispanics had 21% higher obesity prevalence compared with Whites between 2006 and 2008.

A large study conducted in Canada over a 12-year period revealed that non-White immigrants to the country had a lower BMI than native born Canadians. Although the immigrants did have a rise in their BMI over time, they remained lower than their native counterparts. Immigrants to the United States are also at risk for increased BMI and obesity. Studies show many immigrant groups have significant weight gain associated with their length of residence in the United

States. Among the different ethnic groups, higher BMI scores were strongest among Hispanics with longer time of residence in the United States. This often results as immigrants adopt an unhealthy sedentary lifestyle and an American diet of fast food and snacks. In another study of hotel workers in Hawaii, BMI of immigrants from the Pacific Islands and Philippines was actually greater than the BMI of White natives.

Body mass index is the generally accepted method of determining a person's body fat based on the individual's height and weight. The National Institutes of Health categorizes overall health and risk of developing health-related problems based upon the BMI. Some immigrants to the United States are at risk of increased BMI and obesity the longer they reside in the country. Although BMI varies among ethnic and immigrant groups, there has been an overall rise in BMI demonstrating the rise in obesity internationally.

Related Topics

► Obesity

Suggested Readings

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Body Shape

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Body shape is a complex topic and greatly impacted by the world around us, as well as our own internal thoughts and perceptions. The ideal body shape or image is a construct an individual believes is what they should look like. This may or may not match their actual appearance. Perceived body shape may also be distorted or accurate. Thin anorexic patients perceive themselves as fat and try to avoid eating to gain weight, even when detrimental to their health. Conversely, some obese persons have grown up in families where being overweight is the norm and not believed to be problematic. The medicalization of obesity has also impacted how persons feel about themselves and their shape. This chapter will discuss a range of influences on immigrant shape.

A range of body shape consequences can occur after immigration. Young Asian immigrants are at risk for anorexia, bulimia, or disordered eating while older immigrants who lose their former eating habits and exercise patterns gain more weight over the years than the amount generally expected in peers living in their homeland. Immigrants to the USA find themselves adapting to many changes: less exercise, more processed foods, increased portion sizes, and an abundance of energy dense foods bringing weight gain and higher body mass index. Immigrants who reside in the United States for 15 or more years are much more likely to be obese than new immigrants who have lived in the USA less than a year. Although immigrants may come with healthier habits, these gradually diminish the longer they remain. Women in particular, who move to the USA by the age of 20 or younger, are more vulnerable than those who immigrate over the age of 20. When immigrants go to a physician for care they are less likely to discuss weight, exercise, or diet with their doctor and therefore, not as likely to receive advice about their body shape or weight management.

Several studies report daughters born in the USA of Asian and Hispanic immigrants reportedly have more dissatisfaction with their bodies and are more likely to exhibit disordered eating than White US females of the same age. Even if young women recognize overprotection as a reflection of caring, it remains a risk factor for the development of abnormal eating patterns. Over-protection and conflicts, particularly with mother, are associated with higher scores on eating disorder assessments aimed at detecting anorexia and bulimia. The same has been found in Great Britain when comparing second-generation female British Asian college women to White college women.

Income, education, gender, and birthplace in the USA, or birthplace in another country can impact body mass index (BMI) but in somewhat complex patterns. For example, higher education is more predictive that US-born females can maintain a healthy weight, but that is not necessarily valid for immigrants living in the USA. Although true for women, it is inconsistent for immigrant males. The country of origin also impacts (BMI) and shape. Adult immigrants may come to the USA with lower rates of obesity, but acculturate to diet changes and inactivity leading to larger body shape. Puerto Ricans and Cubans are susceptible to increased body mass the longer they live in the USA. In a study without controls, Mexican immigrant women believed that physical activity provides health benefits but are still unlikely to exercise. First generation Hispanic adolescents as a group are more likely to become obese after moving to the USA than are US-born Hispanic adolescents.

Foreign immigrant families are likely to have lower income, less maternal education, and live in isolated immigrant sections of cities where the primary language is not English. Higher socioeconomic level is more protective against obesity for White nonimmigrants than immigrants. Nonetheless, looking at large populations of all socioeconomic levels, obesity remains higher in White US-born individuals than immigrants.

Native Alaskan women are content with larger body shapes than White Alaskan women. However, as Native Alaskan women move, acculturate, and spend more time in urban areas, they are more likely to adapt the Western ideal.

Studies in Sweden demonstrate that multiple immigrant groups by nationality are susceptible to obesity. Socioeconomic level, education, occupation, and social network all impact rates of obesity in immigrants to Sweden. The stress of immigration and acculturation is believed to lead to increases in unhealthy behaviors that lead to obesity. However, risks of physical inactivity were less important in males from southern European or Finland currently living in Sweden.

Even without immigrating to another country and culture, younger women in third world regions may be influenced by thin actresses coming to make movies in their nations.

In summary, immigration and multiple other factors influence how individuals perceive their weight and body shape. Conflicting values, gender, ethnicity, religion, availability of fast food, and willingness to exercise can impact both body shape and commitment to choices.

Related Topics

- ▶ Acculturation
- ▶ Dietary patterns
- ▶ Fitness
- ▶ Obesity
- ▶ Percent body fat
- ▶ Pregnancy

Suggested Readings

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Suggested Resources

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www.dailymail.co.uk/..../Trinny-Susannah-reveal-12womens-body-types

www.immigrationandhealthinitiative.org/immigration

www.informaword.com/index/915180021.pdf

Border

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A "border" typically refers to a clearly demarcated, geopolitically defined boundary. Borders are primarily established for the purpose of territorial control and characteristically have defensive security measures in place to contain or limit the entry or exit of various things into a region. Crossing a border usually requires complying with laws and standards set forth by its founding governing entity. For example, the presentation of a passport is required protocol for entry into most foreign countries. Worldwide, border disputes are commonplace and generally tied to power struggles over resources, regional jurisdiction, or cultural clashes. Past and present efforts to regulate borders include the construction of a number of controversial, heavily supervised physical barriers, such as the Berlin Wall, the Korean Demilitarized Zone (DMZ), the US–Mexico border wall, the Great Wall of China, and the Israeli West Bank barrier.

Globalization, the intensified interdependence and interconnection between nations, has had an integral role in shaping modern border policy and directive. For instance, border relations have been profoundly altered by increasingly liberalized international trade restrictions. The North American Free Trade Agreement (NAFTA), a trilateral trade agreement implemented in 1994 that encourages import and export between the USA, Canada, and Mexico, is an example of policy that has generated noticeable ripple effects in the political, economic, and social climate of the US–Mexico frontier. Although NAFTA is responsible for dramatic economic growth in these nations, critics assert there have also been negative ramifications. For example, the explosion of the export industry triggered by NAFTA led to a significant rise in *maquiladoras*, or foreign-owned factories found along the Mexican side of the border. Maquiladoras are frequently depicted as unsafe to work in, with laborers working long hours and receiving low wages and little to no benefits. These factories have also been blamed for exacerbating serious environmental problems and posing additional threats to the health of the workers exposed to them.

US–Mexico Border

The US–Mexico border, the most frequently crossed international border in the world, stretches 1,969 miles from the Pacific coast cities of San Diego, CA, and Tijuana, Baja California, to the Gulf of Mexico and the cities of Brownsville, TX, and Matamoros, Tamaulipas. In total, there are 48 US counties in four states and 39 municipalities in six Mexican states that line the border. Approximately 12 million individuals reside in this region, the predominant portion of whom live in 14 pairs of sister cities. The US state with the largest section of the border is Texas, which hosts four of the six highest traffic crossing areas. US government figures from 2006 declare 250 million individuals legally crossed into the USA from Mexico by land at various ports of entry. Current statistics indicate there are between 11 and 12 million illegal immigrants living in the USA, the largest portion of whom are Mexican born. However, recent data reveal a decline in subsequent years of both legal and illegal immigration from Mexico, a trend that some researchers suggest is primarily the result of the struggling US labor market and economy.

National security concerns over the permeability of the border, coupled with a volatile sociopolitical debate over the effects of illegal immigration in the USA have intensified the management of this nearly 2,000-mile border. The majority of more than 20,000 US Border Patrol agents are stationed along this border. A controversial fence, which runs intermittently along the border and is still being erected in some areas, was constructed to deter persons trying to gain illegal entry into the country as well as control the flow of drugs and other illegal goods. Although proponents of the fence believe that it has been effective in reducing the number of arrests relating to illegal entry, critics perceive the barrier as detrimental to the physical and social environment, and ultimately as an ineffective long-term deterrent to illegal crossing. Human rights groups are concerned with the number of immigrants, both confirmed and presumed, who have died in their attempts to cross the border. These deaths are mostly attributed to dehydration and heat stroke from crossing in areas with harsh natural conditions, such as the Sonoran Desert in Arizona.

Colonias

The passage of NAFTA also initiated a sizeable increase in the number of *colonias*, or poor, unincorporated settlements found along the US–Mexico border that developed in response to the need by low-wage workers for inexpensive housing. The largest US colonia population currently resides in Texas, where approximately 400,000 individuals live in over 2,000 colonias. Because housing in colonias is obtained informally, it is often constructed of substandard materials and lacking in adequate infrastructure such as plumbing and electricity. Colonias characteristically have unpaved roads and problems with animal control. One of the greatest health threats to colonia residents is accessibility to potable water. Consequently, exposure to and prevalence of infectious diseases such as hepatitis A, dysentery, cholera, and salmonella are considerably higher in these communities. Improper waste disposal by colonia residents has also engendered concerns about the creation of environmental hazards and contamination of the larger ecosystem. In addition to higher incidence of infectious disease, current research in the Lower Rio Grande Valley (LRGV) region of Texas reveals that colonia residents and surrounding border populations also have high rates of obesity and chronic disease such as diabetes.

In comparison to the rest of the state and the nation, colonias have higher rates of poverty and unemployment, lower levels of education and literacy, and an increased number of individuals who are uninsured or underinsured. Lower levels of acculturation (e.g., solely speaking Spanish), an inability to acquire transportation to clinical sites, educational inequities in health knowledge and lack of awareness about available programs, a general distrust of government entities and perhaps having an undocumented citizen status are just some of the barriers faced by colonia residents in accessing traditional US health care. Delayed treatment or going undiagnosed is also of great concern for the mental health of colonia residents and others in border populations.

Conclusion

As discussed, borders impact the lives of citizens in physical, economic, and social ways. The US–Mexico border is a frontier of special concern, as residents in close proximity to the border on both sides often experience critical health disparities. Attention to health literacy, and improvements in overall infrastructure will likely enhance the quality of life for citizens living in these regions.

Related Topics

- ► Border health
- ► Illegal immigration
- ► Irregular immigration
- ► Labor migration
- ► Maquiladora
- ► U.S.–Mexico border

Suggested Resources

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Border Health

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Border health is a broad term that is characterized by the health care markets, regulatory environments, health laws, environmental factors and health care consumer and individual behaviors (risk and protective) that shape the health of immigrant and other populations living in the region intersected by the geopolitical boundaries of two or more nations. In the 2009 book, *Condiciones de salud en la frontera norte de México* (Health conditions in the northern border of Mexico), Salgado de Snyder provides a comprehensive description of border health in the context of the Mexico–USA border, emphasizing the dynamic and interdisciplinary nature of border health as field for understanding the health priorities and challenges faced by nations with mutual interest in improving health outcomes of migrant and transnational populations.

This definition serves as a foundation to understand immigrant and border-dwelling communities in a global context as evidenced by the recent formalization of cross-border health policies among member nations of the European Union and bordering nations in Latin America. In a global context, historical, regional, and societal factors influence the health of populations living in a border region, particularly those populations that migrate to and from the cojoined countries. A socio-ecological approach provides a useful framework to describe *environmental factors* (e.g., defining a border region, laws, policies, health service infrastructure), *interpersonal factors* (e.g., population mobility and disease exposures), and *individual factors* (e.g., health knowledge, perceptions, and practices) that influence health outcomes and characterize border health. We draw on examples from the USA border with Mexico, bordering nations in South East Asia and South America, and discussions between EU member states about issues relevant to providing cross-border health care in Europe.

Environmental Factors

Defining a Border Region

Although desirable from a comparative standpoint, a strictly geographic definition of the boundaries that determine a border region generally, and border health more specifically, is elusive. Simple metrics of distance from the political boundary may not explain the influence on the health of populations near borders that can be exerted at state, municipal, or national and international levels. The extent to which the health of border inhabitants and immigrants who cross borders is influenced by their proximity to a border region will depend on: regional, occupational, or environmental health risks or protective factors; the availability of and access to desirable health resources on either side of the border; the connectivity between the nations (e.g., roads, bridges, pedestrian crossing points); the regulation of a political border; how porous the region is to unregulated crossing; the ability to cross and costs that may be associated with crossing (e.g., visas); the perceived benefit of crossing or desire to cross among border inhabitants; and the physical distance of residents from the geopolitical border that can moderate cross-border care-seeking activities (e.g., distance lived from the border may be prohibitive to crossing for routine health care). A more global conceptualization of border health may refer to population or environmental health in border counties or municipalities, border states, and even border countries. To this effect, EU member States and border countries in Latin America are formulating health policies that will better define and improve coordination of care for immigrant and binational populations (those who routinely work, visit, and purchase goods and services, including health care, on both sides of the border).

Policies and Laws

Decisions on regulation of who can enter the respective border country to consume health care, or regulation of goods (e.g., medications) that can be introduced into a country are dictated by national security and other interests or perceived threats of the potential for “undesirable” individuals or unregulated goods to enter. In regions where there are political arrangements for free flow of populations (e.g., EU member states), environmental factors that determine mobility may be different than between nations whose borders are more protected from population mobility. For neighboring countries in vastly different stages of economic development and relative per-capita wealth, a more developed neighboring nation may be concerned with the immigration from the lesser developed nation where it is perceived that these individuals would take advantage of a public good such as health care or fear that foreign individuals might work at jobs that would otherwise be held by that country's citizens. Policies governing the cross-border flow of individuals may be further dictated by the political climate and sentiments expressed by the general public toward the potential immigrant or foreign visitor, including racism and xenophobia.

Border health can be influenced by national laws, policies, and political decisions made thousands of miles from the border region, by government representatives who may be unfamiliar with the local reality or needs of border populations, or whose national interests supersede those of its border inhabitants. For example, the US Food and Drug Administration along with the US Customs and Border Protection set policies governing conditions under which medications can be crossed from Mexico to the USA, as well as the type and quantity of medications that can be brought into the USA. The policy is enforced by another federal agency, the US Customs and Border Patrol, whose agents may have discretionary power in the application of certain policies. Border health can also be influenced by health policies operating on each side of the border and the extent to which the health care delivery system from one nation can influence or interact with that of the other. In the State of California, USA, for example, the 1998 amendment to the Knox-Keene Health Care Service Planning Act of 1975 (Senate Bill 1658) was the first state legislation in the USA to allow Mexican health maintenance organizations (HMOs) to offer USA populations health insurance that covers receipt of health care in Mexico. A 2007 amendment to the law required the reporting of certain diseases and health conditions to the California health officer. This type of unilateral legislation can impact the health of residents on both sides of the border, where the worker covered by insurance in one country may have health care access for members of their family living in the neighboring country. Similar considerations, such as care for temporary visitors or workers and quality assurance of medical services are currently being discussed by EU member states. The global health care market is also experiencing growth in private insurance companies that make transnational arrangements with health care providers in regions such as the USA–Mexico border, South East Asia, and China for a network of cross-border care provision.

Health Service Infrastructure

Formal and informal sectors of the health economy in a border region provide care to border inhabitants. The formal health care infrastructure includes hospitals (both public and private); public or private clinics that provide immunizations and disease testing [e.g., testing for human immunodeficiency virus and other sexually transmitted infections, and tuberculosis (TB)]; and an array of public and private agencies that provide out-patient care and other health services. Healthcare delivery from the informal sector may include provision of medications and health advisement from pharmacists, herbalists, traditional healers, and providers of alternative treatments or therapies. Persons living in a border region may access formal and informal health care services on both sides of the border, complementing care that is unobtainable or unaffordable on one side with care available on the other side of the border. Examples include USA residents crossing to Mexico border to obtain medications, dental care, and surgeries at a reduced cost, or to access traditional medicine or traditional healers. When there are significant differences in cost and availability of health care services and medical therapies between bordering nations, health care consumers, who can cross the border and are comfortable doing so, will cross for care. In the absence of care coordination between clinicians or health care systems, the opportunity for fragmented patient care, duplication of services and disease surveillance data, and potential medication interactions increases. The benefits of cross-border coordination of patient care could include improved patient health outcomes, reduced redundant use of health care resources, and improved regional management of chronic and infectious diseases. An example of cross-border coordination includes a TB care program administered by the San Diego County Department of Health and Human Services, California that links USA patients with active TB and their contacts who travel between the USA and Mexico with a Mexican health care provider who can assist with continuity of TB care. The program contributes to improved regional and binational health by helping patients adhere to and complete their TB therapies and avoid development of multi-drug resistant strains.

Interpersonal Factors

Cross-Border Mobility

To the extent that the border between two nations serves as a conduit for migration or is crossed by persons who lead binational lives (e.g., work, live, or purchase goods and services on both sides of the border), cross-border immigration and population mobility is an important component of border health. Persons who are able to cross to and from a neighboring nation may do so to access health care services. As mentioned earlier, border-dwelling populations may exhibit a variety of cross-border health care utilization practices depending on their ability to cross and the availability of services that they may desire or have access to in the neighboring country. Reasons for crossing a border to access health care may be driven by considerations such as preference, availability, and lower relative cost of health care. Individuals who live on one side of a border and work on the other side may access care on one or both sides. This behavior has been reported in numerous studies with residents living in the US–Mexico border region, in the border shared by Thailand and Myanmar and among residents of European member nations. Cross-border mobility and immigration can also be driven by economic factors (e.g., persons who cross daily from one side to the other for work or shopping), political factors (e.g., visas and other government-granted permissions for some members of the population to cross at will), forced migration, repatriation (i.e., deportation) of persons who are in the country undocumented, or individual factors (e.g., crossing to visit family).

Individual Factors

Individual health behavior may change depending on the side of the border the behavior takes place. For example, persons who choose to cross a national border for sexual tourism and engage in behavior that may place them at risk for acquisition of HIV or other sexually transmitted infection (STI) or risk that they may transmit HIV or an STI to an uninfected person (e.g., sex without condoms with a partner with unknown HIV/STI status and sharing contaminated needles or injection drug paraphernalia among injection drug users). Unprotected sex and needle sharing among injection drug users who cross a border and participate in these behaviors on the other side may increase the potential for greater number of HIV cases in a border region. This risk activity adds to the public health burden of screening, diagnosing, and caring for individuals and immigrant populations living in the neighboring country or of both countries. In another example, availability of prescription medications in a neighboring country next to a country with more costly and highly regulated sale of prescriptions may also drive border crossing behavior. The purchase of prescription or other medications may contribute to promotion of health if affordability and accessibility to medications favor better health outcomes. To the contrary, the purchase of medications without proper clinical guidance can undermine public health if, for example, patients consume antibiotics without a prescription or supervision and generate resistant bacterial strains. When populations frequently engage in binational medication purchase and consumption, public health policies regulating access to medications, and the effective enforcement of these policies, are critical to public health efforts in border regions and beyond. For example, to mitigate the potential for patient antibiotic self-medication in the wake of the H1N1 viral epidemic in 2009, in June of 2010, the Mexican government–imposed restrictions on the pharmacy sale of antibiotics, requiring that all antibiotics be sold only with a provider prescription.

A discussion of border health would be incomplete without consideration of gender and how health outcomes and experiences surrounding health and illness may be different for men and women in a border context. For example, there are distinct gender differences in the populations affected by TB in San Diego, California. In 2010, an epidemiologic study conducted by Rodwell and colleagues in the San Diego, California region bordering Mexico found that the profile of persons most affected by TB included males of Latino ethnicity, aged 30–49 years, and who are injection drug users. Other research in border health includes improved understanding gender-related disparities in health for women in the USA–Mexico border region (e.g., cancer and diabetes). Attention to gender differences in the health of border residents can allow for improved targeting of public health resources on both sides to reduce gender disparities in health.

Border Health Research

Research with communities in border regions should strive to meaningfully consider influences that may come from either side of the border to impact the health issue under investigation. Using both quantitative and qualitative research methods to capture the breadth and depth of binational issues that impact health, researchers should take into account the day-to-day experiences of consumers as well as the perspectives of professionals delivering care. In a border context, this would necessitate inclusion of populations that cross back and forth as well as border-dwelling immigrant populations that have relocated to the other side of the border and do not cross. A comprehensive border health research agenda should also include understanding of border community assets and resources that may provide creative avenues for resolving health issues (e.g., community clinics with novel care delivery models that successfully serve underserved, binational populations). Given that individuals residing in border regions frequently cross borders to work, one avenue might include fostering public health and private sector partnerships to improve the health of workers.

Public Health Surveillance and Epidemiology

Current data from border regions clearly indicates that from an epidemiological perspective, border populations are different in many ways when compared with non-border populations. As indicated by Weinberg and colleagues in 2003, border populations should be viewed as one population, instead of two, because diseases are able to make seamless transitions from one nation to another. Recent border health studies indicate that health problems and disease profiles in border regions may differ substantially from non-border regions in the same country or may parallel one another, but vary in the type of population affected. Rodwell and colleagues illustrate an example of this phenomenon through the study of TB in the San Diego-Tijuana region, where TB prevalence is higher both in Tijuana and San Diego than in the interior of each respective country. In the USA, TB disproportionately affects residents of Mexican-origin, who also have worse TB health outcomes than other San Diego residents. The Southeast Asian border between Thailand and Myanmar experiences similar problems. Both nations are considered high-burden TB countries and both face substantial public health challenges in addressing TB and HIV in the border region. The burden of TB in one Thai province is carried by persons from Myanmar, including immigrants and refugees and Myanmar residents and refugees who cross to Thailand for health care or work.

Binational and transnational coordination of disease surveillance activities in many border regions is fraught with challenges due to differences in disease classifications, laboratory tests and metrics, passive and active disease surveillance infrastructure, and reporting requirements. Unilateral approaches to cross-border disease surveillance include the aforementioned Knox-Keen Act that allows for insurance health care coverage of US residents in Mexico. Amended in 2007, the Knox-Keen Act now requires Mexican doctors to provide information to the local US health officer on diseases that are reportable in the State of California (S.1658) and the standards for disease reporting in Mexico continue as per national policy. From a regional health perspective, however, it is unclear whether this type of unilateral legislation would promote duplicate reporting of new cases, such as a confirmed positive HIV test detected in the Mexican border city of Tijuana that is reported both to the centralized Mexican surveillance system and to California's HIV surveillance system. Another polemic involves surveillance of diseases among populations that seek health care on both sides of a border. In many border regions it is common for patients to seek health care services on both sides, including testing for HIV or other reportable diseases, underscoring the importance of a coordinated approach to epidemiological surveillance and public health cooperation between border nations.

The Future of Border Health

The future of border health includes two important elements that will favor the health of populations living in border regions: better systems for electronic transmission of health information and movement toward regional cooperative health agreements. Technological innovations and improved capacity to transmit and share health information electronically is a rapidly growing field. Although public health tends to fall behind in the adoption of new technologies, the "e-health" movement is already being explored among border nations in the USA, Mexico, Asia, and the Pacific. Use of e-health in cross-border health care services can include referrals for care, continuing education for clinicians and other health practitioners, cross-border communication between health care providers, surveillance, medical records, and international travel for the sole purpose of seeking health care (i.e., medical tourism).

Cooperative cross-border or pan-border surveillance and health coordination initiatives are emerging from many regions throughout the world and will also favor the health of border-dwelling populations. The role of binational health organizations or organizations that represent public health interests from two or more countries can serve as a platform to bring together clinicians, researchers, and other public health practitioners to move border health agendas forward. Border health dialogue should include the representation of non-government agencies as well as government-sponsored agencies. Examples of cross-border coordination agencies and initiatives include the US–Mexico Border Health Commission, the US Center for Disease Control and Prevention's Early Warning Infectious Disease Surveillance Program; the Euro-Mediterranean consortium "Impact of migration on HIV and TB epidemiology in the Mediterranean Area"; the 2010 border health plan implemented jointly by Bolivia, Chile and Peru, and European Commission collaboration among member nations to improve cross-border care. These activities will ultimately lead to improved regional surveillance data and to better management of infectious and chronic diseases in border regions throughout the world. The challenges of promoting coordinated border health are many, and include issues of national sovereignty, differing laws regarding the practice of medicine and licensure of practitioners, and clinician perceptions of the quality of care delivery provided in the neighboring country where their patients may seek care. Political and social will to address these issues is critical, as the benefits of coordinated care, improved patient health outcomes and improved epidemiologic surveillance data are measurable, desirable, and make better use of health resources on both sides of a border.

Related Topics

- ► Border
- ► Cultural competence
- ► Guest worker
- ► Health services research
- ► Healthy immigrant
- ► Migrant farmworkers

Suggested Readings

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Bracero Program

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The Bracero ("Strong Arm") program was the impetus for large-scale legal and illegal migration between Mexico and the USA. For 22 years (1942–1964), 4.6 million legal contracts were signed with Mexican workers for temporary agricultural work in the USA, making it the largest US contract labor program in history.

Concerned by impending labor shortages for the fall harvest due to conscription for World War II, California farmers asked the US and Mexican governments in the spring of 1942 to allow Mexicans to work seasonally on US farms. Coupled with Mexico's burden of an excess number of unemployed laborers, serious labor negotiations ensued between the USA and Mexico. Even as US farm labor reformers protested that the only shortage was in reasonable wages and working conditions and not workers, the two governments moved forward and signed a bilateral agreement in 1942 for the importation of temporary contract laborers from Mexico to the USA. Desperate for cash work, Mexican workers were willing to take jobs at wages derided by most Americans. Only agricultural workers from Mexico, not urban residents, could participate and prospective candidates often were required to show calloused hands as proof of experience as farm laborers. As part of the processing, Braceros were fingerprinted and disinfected with DDT before being allowed to enter the USA.

The Bracero program was relatively small during the war years, peaking in 1944 at 62,000, less than 2% of the four million US hired agricultural workers. The initial agreement expired in 1947, but the program continued through a variety of laws and administrative agreements until 1964. As the first agreement ended in 1947, many Mexican workers began to migrate into the USA illegally, which was tolerated. If caught, they were legalized by being taken to the border, issued documentation, and returned to the farm from which they were taken; this process was pejoratively called "drying out the wetbacks." With no penalties for farmers who knowingly hired illegal workers, the number of illegal workers soon exceeded the number of legally admitted Braceros. Texas received no Braceros due to racial discrimination and relied upon illegal workers for manual labor, flagrantly violating a 1948 agreement when the Border Patrol welcomed migrant workers across the Rio Grande despite Mexican threats to close the border. US President Truman and the Mexican government supported a 1951 US government commission recommendation to impose fines on US employers who knowingly hired illegal workers, but Congress did not. The 1952 Immigration and Nationality Act that made harboring illegal aliens a felony specified that employing an illegal alien was not "harboring."

One argument for Braceros was that allowing Mexicans to enter legally would reduce illegal migration. This was proven wrong since 4.6 million Braceros were legally admitted to the USA between 1942 and 1964, while 4.9 million illegal Mexicans were apprehended in the USA during the same time frame; both numbers double-count individuals who entered the USA several times. Subsequent to a new Bracero agreement, the Immigration and Naturalization Service launched "Operation Wetback" in June 1954, removing 1.1 million Mexicans, including US-born and therefore US citizen children of Braceros. The US Department of Labor relaxed regulations on Bracero housing, wages, and food charges in the mid-1950s, leading more farmers to hire legal Braceros, whose admissions peaked at 445,200 in 1956.

The Braceros significantly affected the business and culture of farming in the USA, and set the stage for subsequent patterns of Mexico–US migration. The availability of low-cost Braceros permitted the expansion of a labor-intensive agriculture to meet the growing demand for fruits and vegetables. This resulted in a demand-pull for Mexican workers, creating and sustaining circular migration patterns of Mexicans into the USA, linking US farm jobs to rural Mexican villages that became dependent on money earned in the USA. Facing competition from Braceros, US farm workers left the agricultural industry for other labor markets with better wages and working conditions, leading to farm labor shortages that subsequently brought more Braceros whose share of the workforce in major California agricultural commodities soon exceeded 50%. Even legal Braceros confronted competition from illegal workers willing to take an even lower wage, and farm wages as a percentage of manufacturing wages fell in the 1950s.

In November 1960, CBS aired a television documentary, "Harvest of Shame," about the Bracero Program, convincing US President Kennedy that Braceros were "adversely affecting the wages, working conditions, and employment opportunities of our own agricultural workers." President Kennedy ordered enforcement of Bracero regulations. While farmers lobbied heavily to preserve the program, Congress ended the Bracero program on December 31, 1964.

The end of the Bracero program prompted several changes in US agriculture: (1) many farmers joined or formed associations ("super labor contractors") to recruit and supervise fewer US workers, increasing worker earnings; (2) successful unionization, prompted by a strike against grape growers in the fall of 1965 by the National Farm Workers Association led by Cesar Chavez, winning a 40% wage increase for grape pickers largely because no Braceros were available; and (3) new impetus to illegal migration, increasing steadily since 1965 using established patterns, fostered by socioeconomic conditions in Mexico, including unemployment, large disparities in income distribution, and discrimination toward the rural sector in allocating government funds.

Related Topics

- ► Farmworkers
- ► Illegal immigration
- ► Irregular immigration
- ► Labor migration
- ► Migrant day laborers
- ► Migrant farmworkers
- ► U.S.–Mexico border

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Brain Death

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Traditionally, and prior to 1970s, the only criterion to validate death was the irreversible cessation of cardiopulmonary function. It was believed that persons who suffered cardiopulmonary arrest immediately lost brain function and this event would predict permanent nonfunctioning of the organism as a whole, therefore serving adequately as a criterion for death.

In 1968, the Harvard Medical School Ad Hoc Committee decided that brain death should be accepted as the definition of death. The first country to adopt brain death as a legal definition (or indicator) of death was Finland in 1971. In the USA, Kansas enacted a similar law earlier, but the agreement has been later signed by virtually all the leading authorities on the subject in the USA in 1981 (31 states having adopted the Uniform Determination of Death Act that was first proposed in

1981). It became a consensus view of the American Academy of Neurology in 1995.

Brain death is defined as the irreversible cessation of all the functions of the entire brain, including the brainstem. If the brain can be viewed simplistically as consisting of two parts – the cerebral hemispheres (higher centers) and the brainstem (lower centers) – brain death is defined as the destruction of the entire brain, both the cerebral hemispheres and the brainstem. In contrast, in the permanent vegetative state, the cerebral hemispheres are damaged extensively and permanently, but the brainstem is relatively intact. Thus, anencephaly, in which there is no higher brain present, is generally not considered brain death, though it is certainly an irreversible condition in which it may be appropriate to withdraw life support.

The diagnosis of brain death needs to be rigorous, in order to be certain that the condition is irreversible. The patient has no response to command, verbal, visual, or otherwise. A brain-dead individual has no clinical evidence of brain function upon physical examination. This includes no response to pain, no cranial nerve reflexes (pupillary reflex – fixed pupils, oculocephalic reflex, corneal reflex, no response to the caloric reflex test) and no spontaneous respirations. A confirmatory examination (e.g., brainstem auditory evoked response, transcranial Doppler, sensory evoked potential, computed tomography angiogram, magnetic resonance angiogram) must document complete and irreversible loss of brain function including brainstem function.

The EEG exams must show complete absence of brain function (it is usually flat). It is important to distinguish between brain death and states that may mimic brain death (e.g., barbiturate intoxication, alcohol intoxication, sedative overdose, hypothermia, hypoglycemia, coma or chronic vegetative states). Medical conditions that could cause an error in the examinations listed above should be excluded.

As most of the social concepts are with moral implications, brain death has been both accepted and rejected.

For immigrants' health, matters regarding life and death are paramount. More than for anybody else, their own cultural values are at stake, shaping their own decision and the moral acceptability of the host-country medical decisions as well. Many immigrants may accept brain death because, like Lisa Cahill, their belief is that *"life fails to constitute a sufficient condition for the fulfillment of human value in either the presence of gross suffering or the absence of consciousness."*

On the contrary, others have strongly opposed the brain death, considering that Harvard criteria perceive the patient as she is "...already decapitated because the brain has already been destroyed. And even if the heart is able to beat all the time and the patient has no ability to breath independently she is considered dead."

From all the cultural values that have a strong impact on the acceptability of the brain death, religion is one of the dominant factors. According to Islamic tradition (that shapes the life of many Asian and Middle Eastern immigrants), life and death are controlled by God. There is no right to die, since only God can decide when someone will die. Moreover, death is considered to have occurred when the soul has left the body, but this exact moment cannot be known with certainty. The Muslim population in the USA is very diverse; the cultural background of different Muslim groups might influence the way in which they respond to illness or other life crises. For example, some Muslims may perceive a sudden death as a sign of punishment, or a test from God. Moreover, when an immigrant Muslim family moves to a larger non-Muslim society, they may adopt certain elements of their new cultural environment.

However, one aspect that is usually the same for all Muslims, regardless of country of origin, is in relation to the practices surrounding death and dying. Traditionally, many Muslims have agreed with the cardiopulmonary definition of death. Even if the concept of brain death was accepted by many Muslims, not all Muslim countries accept now brain death criteria.

According to the Iranian perspective, as long as the heart is beating, the skin is warm, and the patient is actually looking "alive" (even if he/she is artificially ventilated), it is hard to accept that being brain dead means being dead. It is a moral duty to seek medical help, if needed, and continuous life support (no matter if the patient shows irreversible signs of brain death) is viewed as an obligation, not an option. Generally, the concept of options and patient's autonomy is foreign to traditional Iranian culture. Given the necessity of informed consent in the USA, and taking also into account that informed consent is the essence of a liberal society, dealing with a dying Muslim immigrant patient in the USA signifies a complex exchange of cultural, social, and religious values. In Iranian culture, it is rude to go directly to the point and explain, for instance, that a loved one is “almost” dead and thus a potential donor for organs. There is a need of very sensitive dialogue about the terminal stage of a patient’s disease.

Some Eastern cultures are patriarchic and authoritarian, with great emphasis placed on deference to elders and suppression of personal interests for the good of the family. Immigrant Muslims may often hold these views because of societal norms. Thus, when talking about Muslims’ concept about brain death, one has to understand that we retrieve selected information that comes from their representatives (usually male heads of the families). Brain death is not human death, but the family definition of death.

Many Japanese, especially lay people at the bedside of a family member, may not accept brain death, thinking that brain death should not be considered human death, as long as the brain-dead patient’s body is still warm and moist. Brain death is an “invisible death” that conflicts with everyday intuition. The Japanese criteria for brain death could test only the cessation of the brain’s observable functions, not the actual death of all brain cells. If some brain cells remained alive after the determination of brain death (which is unknown, since an electroencephalogram cannot detect the activities of cells deep inside the brain), some inner consciousness might exist inside the patient’s brain.

For Japanese people, the core site or physical location of personhood is associated with the heart, not the brain. A patient is considered “alive” until the heart stops beating. It should be noted that a “clinical” brain death diagnosis is to be distinguished from a “legal” brain death diagnosis. The clinical diagnosis is a tentative one. The determination does not require an apnea test (the test to see whether breathing has stopped) since such a test might be detrimental to the patient’s body. Physicians are not allowed to reach a legal diagnosis of brain death (including an apnea test) on the patient unless the patient has a donor card, and has agreed to brain death and organ donation (and designated the names of transplantable organs on the donor card).

Other Asian immigrants, like Korean or Korean–American families, also maintain a strong degree of adherence to religious beliefs relating to life and death concepts (including brain death). For them, traditional values dictate that a patient die at home, meaning that basically they will never agree with the Harvard criteria.

One multicultural society, composed of a multitude of immigrants, is Israel, where, beside the native-born Jewish and Muslim citizens, live many people from former ex-Soviet Union, other Eastern European countries, Ethiopia, and South America. In Israel, according to Brain Death/Respiratory Law of 2008, the time of death of a person is determined to be when there is brain/respiratory death or cardiac/respiratory death. Among the reasons why the cadaveric donation rate is very low in Israel is the public’s difficulty in accepting brain death. There has been a decades-long controversy among primarily Orthodox Jewish legal authorities over whether to accept brain death. Many authorities in Israel argue that the traditional definition has always included cardiac death in addition to absence of respiration. This religious opposition is the reason for the clause in the law that allows families to request continuation of the treatment. Notwithstanding the law’s existence, Israel did not adopt one legal definition of death, but left it up to the individual as to how to define death.

In conclusion, brain death is a medical concept and a legal issue with a tremendous moral and social impact. Life and death decision making is a process during which many stakeholders share different views, options, feelings, and uncertainties. When such a sensitive issue arises in immigrants’ lives, more than for anybody else, their cultures, traditions, and values will interact with those held by the host country. Sometimes such an interaction will ease the family’s pathway toward acceptance of the fact that their loved ones’ life is coming to an end, but sometimes will transform the dying process into an unbearable journey. Being very hard to judge one side or another, we may say that respecting the cultural values and, most of all, the individual’s values is the only way in which brain death may equal the human death.

Related Topics

- ► Community
- ► Family
- ► Family reunification
- ► Religion, religiosity, and spirituality

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Brain Drain

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Human capital is a concept often used by economists to define all the attributes that persons come to possess by natural inheritance or by attending schools, building an education, and lifelong learning through trainings and courses. It is as much an aggregate of knowledge, skills, experience, and competencies as it is an amalgam of personal qualities and values that a person holds. Economically, investing in human capital means creating the premises for economic growth, for social development, and better living standards. Sustainable growth requires an analysis of the costs and benefits of investing in human resources. Access to medical care, education, training, and other resources provides the means for individuals to reach their potential, both physically and mentally. Such an individual will soon incorporate into the human capital by performing labor in order to produce value, especially economic value.

Individual efforts to enhance its potential on the labor market must be sustained within a State by policies aimed at promoting access to education and continuous efforts to improve the quality of it, but also ensure that the human capital will be absorbed by the labor market. Creating jobs must be a priority and the highly skilled should be compensated according to their training and education.

Globalization and the integration of economies have not only increased international trade, but stimulated people mobility. A healthy economy and sound governing ensure the attractiveness of the labor market. A State's inability to provide the opportunities that the highly skilled require in order to fully exercise their potential encourages them to seek other labor markets that are more likely and able to satisfy their need for a bigger income and better working conditions. If such a phenomenon happens at a large scale, it is called *human capital flight* or *brain drain.*

Brain Drain Causes

One of the first uses of the term brain drain was in the 1950s regarding the influx of scientists belonging to the Soviet bloc into the United States. Over the years, the concept came to define the general movement of higher educated individuals that left developing countries and settled in developed ones.

The brain drain phenomenon can be easily confused with the migration process, but the two are not identical, even though they share some common factors that influence the decision to leave a country. Migration is a general process that includes many types of individuals' movements from one country to another, whereas brain drain focuses on highly skilled individuals that decide to emigrate. In other words, brain drain is in fact a migration process, but the main characteristic that separates it from other types of migration is that the individuals leaving a country are educated and the impact on the destination country is mostly positive while the impact on the country of origin may be positive or negative.

Highly skilled persons will more likely find a work place easily and will provide the destination country with the human capital it needs, and at the same time they will probably send part of their income to the origin country. Brain drain supplies countries rich in capital with the labor force they need and also provides origin countries with part of the capital it lacks.

Whether highly trained people are employed in sciences or arts, their behavior is influenced by similar motivations. Commonly, human capital flight is determined by a conflict, lack of opportunities, socioeconomical struggles, or political instability. However, the prospect that the destination country will offer a real income increase over an expected period is the main reason of the highly skilled individuals' migration.

The Impact of Human Capital Flight on Countries' Socioeconomical Environment

The brain drain phenomenon seems to be directed from the developing countries toward the developed ones, richer in resources, and with more possibilities of absorbing the influx of human capital. It also can be argued that the degree of the brain drain, place of origin, and final destination can affect a country's development negatively. Developing countries will be disproportionately affected by the brain drain, as many university graduates leave those countries and important sectors like education and health remain to face a lack of personnel. These are crucial human resources for the country of origin and the individuals might end up employed in another area of the industry than that in which they trained. Migration flows are a key factor to a country's economic, social, and cultural environment. Human capital is, among the other productivity factors, essential to the growth and development of an economy.

It is arguable that the origin countries do not benefit in any way from the brain drain phenomenon. This type of migration increased in the last couple of decades, thus offering a prospect of return to higher education. Such a prospect encourages developing countries' population to seek attending colleges and faculties.

For most developing countries, the highly educated individuals represent a scarce economic resource. Usually, the education these individuals receive is financed by the State from the public finances. The State's effort of encouraging higher education and adjustment to the necessities of the labor market are sabotaged and the investment in people's skills does not produce positive results. Furthermore, the migration of the highly skilled people will affect the society, as the investment made in the individual will not be returned and the competencies, education, and skills will not be used to produce value in the country of origin.

A significant impact of brain drain on the receiving countries is the performance in the labor market. This is determined by the education the highly skilled migrants have obtained and in which country. Most of the migrants within a brain drain process are very well educated and possess great valuable skills. However, once they arrive in a new country, due to either cultural differences or economic conditions, some of these highly skilled individuals might find employment in other areas than the ones they have expertise in. Globalization increased the number and the frequency of the brain drain flows and, as a result, the persons seeking employment might be facing a saturated labor market.

The variation of highly skilled migrants' placement on the labor market can be explained by the cultural baggage an individual carries when leaving the country of origin. Social, personal, and taught values and experience guide a person to make decisions and increase or decrease their capacity of adapting to a new setting. However, the sociopolitical and economical situation in a country influences the decision of the highly skilled persons to emigrate. The most affected countries as a result of this event are the smaller countries with a weak or underdeveloped economy, that lose an educated and needed human capital.

Another aspect worth considering is the selection of the destination country. Aspects like distance, openness to immigrants, standard of life, language, and facilities for foreigners to adapt are usually considered.

Circulation of the Human Capital

Over the last decades, migration patterns changed and new models developed, which caused changes in public policy. The perception of the brain drain phenomenon improved and the movement of highly skilled individuals came to be seen as natural, a process which should not be subjected to restrictive public policies. Instead of being a brain drain, this type of mobility is more and more referred to as the brain circulation. This implies that public policy must suffer changes that would reflect that the migration of the highly skilled could be and, in fact, is a process that can benefit a state and should not be stopped.

The worldwide human capital transfer was in general considered to cause prejudice to the country of origin. Brain drain is a negative external phenomenon with consequences for the population left behind to continue living in the origin country. In addition, it leads to an increase in the disparities between developing and developed countries and to an unjust human resources allocation. In recent years, the perspective on brain drain is influenced by a shift in global economy models. A knowledge based economy concept has surfaced and it promotes the significance and contribution of human capital to the development of economy.

The impact of the brain drain effects was considered for many years to be negative for the origin country, which suffered a loss of essential economy resources. It was one-way migration of the highly skilled from the developing countries to the developed ones. On the other hand, if brain drain is caused by the impossibility of accessing the labor market in the country of origin, it can be argued that a positive effect occurs: avoidance of brain waste.

Significant changes in the context that fosters migration, such as the improvement of transportation, an increase in international commerce, cooperation, and the development of intercultural relations, determine characteristic transformation in the brain drain phenomenon. This process is not necessarily permanent and is multi-directional, affecting not only the origin, but the host country as well. Contact with the country of origin is less likely to be suppressed, as there are many means of communication accessible to almost anyone.

The brain circulation approach recognizes that there can be compensatory mechanisms to the loss of highly skilled human resources in the developing countries. Fostering international cooperation among scientists, the transfer of technology from developed countries to the developing ones are some of the measures that counterbalance the negative effects of the brain loss.

Related Topics

- ▶ Chain migration
- ▶ Discrimination
- ▶ Eastern Europe
- ▶ Ethnic enclaves

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Brain Fag

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The syndrome known as "brain fag" was first described in 1960 by Canadian cultural psychiatrist Raymond Prince, following his field experience in Nigeria, Africa. Yap later reviewed the literature on what were thought to be "peculiar" disorders from the perspective of comparative psychiatry and suggested the term "atypical, culture-bound, psychogenic psychosis." He later suggested using the term "culture-bound, reactive syndrome" in order to encompass various psychopathologies or atypical syndromes that were observed in specific cultures and that occurred as the result of psychological reactions. The following year, he revised the term to "culture-bound syndrome." Although often referred to as a culture-bound syndrome, brain fag has also been characterized as a somatic idiom of distress and as a folk illness.

Brain fag syndrome has been associated with intellectual impairment in the form of cerebral memory loss and poor concentration, visual disturbance in the form of blocked vision, and somatic complaints described as burning feelings in one's head. It is most frequently observed in equatorial regions of Africa and has been reported to occur in Nigeria, Uganda, Liberia, Côte d'Ivoire, and Malawi. The syndrome has been characterized as a very common, minor psychiatric disorder and is thought to occur most frequently among secondary and university students and other "brain workers," such as teachers and government clerks.

Patients often attribute their illness to fatigue of the brain due to excessive mental work. Others in their environment may report that the illness is a form of bewitchment, brought about by the ill person's individualistic educational achievement and abandonment of communal responsibility. In contrast, several scholars have suggested that the syndrome is a response to the stress and pressure that some students experience as the result of family pressures. Not uncommonly, one of the brighter children in a family is supported financially by family members in order to attend school. In turn, that individual is held responsible for the other family members when the need arises. This expectation places great stress on the student to succeed.

Prince, however, attributed the syndrome to childrearing practices such as late weaning, mothers' prolonged close contact with the child, late toilet training, and group life in polygamous and extended families. He theorized that the placement in a Western-type school environment of such a child may bring about the child's breakdown and regression to an earlier state of dependence on the mother. The syndrome has, accordingly, been interpreted as "an unconscious rejection of the superimposed Western educational system."

Depending upon the specific locale, it may be difficult for immigrant patients who believe that they are suffering from brain fag to locate a physician who is familiar with the illness. Brain fag, like other diagnoses that appear to be specific to specific cultures, is difficult to fit within a single diagnostic category, such as might be found in the *Diagnostic and Statistical Manual (DSM-IV-TR)* that is currently in use in the USA for the diagnosis of psychiatric disorders. If the ethnocultural group in a particular geographic area is large, the individual may be able to locate a provider with whom he or she shares a common language and culture. However, the shared language and culture do not guarantee that the patient will receive culturally appropriate care because of differences in socioeconomic status and subcultural groups.

Related Topics

► Culture-specific diagnoses

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Brazil

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For most of its history, Brazil was a nation of immigrants, not emigrants. Beginning with the early Portuguese settlements in the 1500s through the late twentieth century, multiple waves of immigrants have arrived in Brazil. There were early Dutch and French settlements in Brazilian territory, in addition to continuous Portuguese colonization throughout the sixteenth to eighteenth centuries. Due to the decimation of the sparse indigenous populations, the majority of which either succumbed to European diseases, warfare, and forced labor or fled to the vast hinterlands of Brazil, Portuguese landowners did not have access to a ready supply of labor. To meet the agrarian labor needs of the new colony, the Portuguese imported approximately four million African slaves into Brazil between 1550 and 1850. The abolition of slavery occurred gradually and was not consummated until 1888. By then Brazil had established itself as a major coffee producer, and São Paulo had already put in place provincial policies to encourage immigration to meet the increasing labor needs of coffee cultivation. As a result, there was a clear surge in European immigration to Brazil in the post-abolition period. During the nineteenth and twentieth centuries, Brazil absorbed large numbers of immigrants arriving to work in agricultural and commerce. Portuguese, Italians, and Spanish immigrants were the largest groups contributing to Brazil's cultural melting pot; in the early twentieth century, significant numbers of Japanese, Lebanese, Syrian, German, and Jewish immigrants arrived; Koreans, Chinese, and Bolivians are more recent newcomers. Over time, through widespread ethnic/racial intermarriage and cultural cross-fertilization, these diverse immigrant groups and cultures have contributed to modern Brazilian culture and identity. Throughout its history, Brazil has been characterized as a nation of tremendous social/economic disparities with strongly embedded stratifications of social and economic class. Although racial/ethnic dividing lines are often blurred, there are racial/ethnic undertones to class stratifications based on social, economic, educational, and occupational levels. Brazilians speak Portuguese, and their language and culture are distinct from other Latin American populations.

It was not until the late twentieth century that Brazil became a major sending country. During the initial years of the military dictatorship in the 1960s, some Brazilian political exiles fled to Europe; Previously there had been small numbers of emigrants to major cultural centers such as New York, London, and Paris, but no large-scale out-migration. This situation changed in the late 1980s, when failed Brazilian economic policies, rampant inflation, and labor instability devastated the economic and social stability of middle-class Brazilians, many of whom were highly educated but unable to find or maintain stable well-remunerated employment in their fields. It was this chaotic economic context that fueled large-scale Brazilian emigration beginning in the late 1980s, as Brazilians left to seek jobs in United States, Japan, Europe, and Australia. For many middle-class Brazilians, the economic impetus to emigrate was also infused with a desire to explore other social, cultural, or educational experiences (e.g., learn another language, gain broader cultural experiences, or explore new opportunities).

At least initially, these new Brazilian immigrants often framed their migration as a temporary sojourn rather than a planned permanent settlement. In the United States, many entered on valid tourist or student visas and eventually overstayed their visas or obtained residency status. Very few Brazilians from the poorest classes emigrated, although some poor women did leave the country as domestic employees of Brazilian officials, diplomats, or multinational business executives. Thus, for many Brazilians, the immigration experience was one of downward social mobility. In the United States, and also in Europe, Australia, and Japan, many (although certainly not all) middle-class Brazilian immigrants engaged in low-skilled, low-wage jobs (e.g., domestic work, restaurant work such as waiting tables or dishwashing, landscaping, babysitting) that are considered totally off-limits to persons of middle-class stature in Brazil. Similarly, Brazilian immigrants in Japan also experienced negative social mobility and social and cultural discrimination. Beginning in the 1990s, due to domestic labor shortages, Japan began encouraged immigration of Brazilian *nikkejin* (Japanese descendents). Yet, these Japanese Brazilian immigrants were not recognized as full-fledged members of Japanese society.

In the United States, the fact that Brazilian immigrants tend to be urban, middle-class, and well educated distinguishes them from many Hispanic immigrants, who have a tendency to be of lower classes, less educated, and are often from rural areas of Mexico or Central America. Despite the distinctions, many Brazilian and Hispanic immigrants often share other characteristics (e.g., undocumented status, limited-English-proficient, working in low-level unskilled jobs). For Brazilian immigrants living in areas with large Hispanic populations, negotiating one's personal and public identity as either distinct from or associated with a Latino/Hispanic identity is often necessary. For middle-class Brazilian women, the immigration transition from a *dona de casa* (lady of the house) accustomed to having paid domestic workers in her own home, to being an *empregada* (paid domestic worker) in the homes of others, in addition to taking on the responsibilities of cooking, cleaning, and laundry in her own home, can involve significant social and personal identity transformations. The convergence of migration and domestic work and employment experiences create opportunities for more fluid, transnational perspectives on gender, class, and culture, but may also contribute to stress and health risks. Separation from family and traditional social networks are commonly expressed through *saudades*, a Portuguese word and cultural construct referring to an intense longing and yearning for that which is not present. For some Brazilians, economic and social transitions related to migration may be a source of stress, family discord, or embarrassment; others may consider their migration experiences as contributing to and enhancing their personal growth and development. The price of economic migration is often higher than anticipated, as work is not necessarily easy to come by and is often arduous and socially isolating. Many endure the stress and social hardships in hopes of eventually accumulating funds to return to Brazil to pursue other dreams.

When immigration is a planned or semi-planned process, Brazilians tend to engage in some type of premigration health practices, either as part of formal migration procedures or to validate their positive health status or prevent untoward future expenses for medical and dental care abroad. Documented occupational health issues among Brazilian immigrant domestic workers include physical stress and exertion, muscular-skeletal problems, infectious diseases, and respiratory and dermatological problems from exposure to household cleaning agents. Among Brazilians with a temporary, sojourner mentality whose lives are focused on work, the practice of putting personal health care needs on hold is common. Delays in seeking care may also be related to lack of information and concerns about the costs of professional care, in terms of time and money. Brazilian immigrants report reliance on informal social networks to access information and health care resources; those who have experienced feelings of being discounted, blamed, not understood or acknowledged by US health care personnel may be less eager to seek further care or follow-up. There is widespread recognition of transnational medication practices among Brazilian immigrants. These include self-medication with prescription drugs obtained in Brazil (e.g., antibiotics, birth control pills, pain medications, and compounded diet pills) or herbal remedies. Immigrants obtain these medications by bringing a stock of drugs with them, sharing with other immigrants, and asking relatives and friends to bring or send medications from Brazil.

Recommendations for practitioners caring for Brazilian immigrants include:

- Do not assume that a Brazilian patient speaks Spanish. Most do not, although some may have acquired knowledge of Spanish through contact with US Hispanic populations. Some Brazilians take offense at being classified as Hispanics; although they are South Americans and Latinos, the general preference is to identify as Brazilian.
- A Brazilian's current occupation may not reflect previous educational, occupational, or socioeconomic status. Explore with Brazilian immigrants how their immigration and occupational transitions have influenced their health practices in order to uncover possible sources of stress and personal coping strategies and explore how perceptions of immigration and occupational transitions may have influenced personal health practices.
- Review correct use of oral contraceptives with Brazilian women, who may have obtained birth control pills in Brazil without a prescription.
- When conducting a health history or performing a tuberculin skin test (PPD), inquire about a Brazilian patient's history of BCG vaccination; carefully explain the implications of a positive tuberculin skin test following BCG vaccination. Because BCG vaccination is routine in Brazil, tuberculin skin tests are not used as a diagnostic or screening tool. Brazilians may perceive providers as insensitive or domineering in their approach to immigrants with positive tuberculin skin tests.
- Among Brazilian immigrants, screen for diseases that are endemic in Brazil but less common in the United States (e.g., malaria, Hansen's disease, Dengue fever, Chagas disease, intestinal parasites).

Related Topics

► Access to care
► Alternative and complementary medicine

- ▶ Birth control
- ▶ Gender role
- ▶ Identity
- ▶ Interpreter services
- ▶ Leprosy
- ▶ Malaria
- ▶ Stress
- ▶ Tuberculosis

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Suggested Resources

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Vida Verde Brazilian Women's Co-Op Environmentally Sound Cleaning. http://verdeamarelo.org/br/vidaverde/

Breast Cancer

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Breast cancer is a class of cancerous tumors originating in breast tissue. When such cancers remain within the ducts or lobules of the breast, they are called in situ. Upon diagnosis, almost all in situ breast cancers can be cured. When breast cancers spread to surrounding tissue, they are referred to as *invasive*. Upon diagnosis, the extent to which the cancerous cells have spread determines the stage and prognosis of the disease.

Breast cancer is the most common cancer in women worldwide; however, its incidence (i.e., number of new diagnoses per unit of the population, usually 100,000 people) varies greatly. The lowest incidence is observed in Africa, intermediate rates are observed in Eastern Europe and South America, and the highest (i.e., 4–6 times higher than the lowest) rates are observed in Western Europe and North America. Generally, emigrants from low-risk countries to high-risk countries experience an increase in their breast cancer risk. The estimated lifetime risk of developing breast cancer is currently one out of every eight U.S. women. Men can also develop breast cancer, but their risk is very low, i.e., less than 1% of all cases of breast cancer.

Classification

The presence of breast cancer can be detected via several techniques, such as mammography (X-ray), biopsy, estrogen and progesterone receptor test, and magnetic resonance imaging. Two main cancer classification systems are commonly used. One of them – developed by the American Joint Committee on Cancer – takes into account four factors: (1) size of the tumor; (2) spread within the breast and nearby tissue and organs; (3) spread to lymph nodes; and (4) spread to distant organs. Based on these fators, breast cancers can be classified in one of four stages, with "I" as an early stage and "IV" as the most advanced stage. This classification system is used primarily in the diagnostic context. Research with immigrant populations has indicated that the person's place of birth might be linked to the stage at diagnosis. For example, foreign-born Hispanic women in the U.S. might be less likely to be diagnosed with an early-stage breast cancer compared to Hispanic women born in the U.S.

The other cancer classification system was developed by the Surveillance, Epidemiology, and End Results (SEER) program. It assigns cancers to one of three stages: (1) local: when the tumors are confined to the breast; (2) regional: when the tumors have spread to surrounding tissue or nearby lymph nodes; and

(3) distant: when the tumors have spread to distant organs. This system is employed primarily in cancer registry reporting, public health research, and program planning.

There are cultural variations in women's approaches to breast cancer detection and follow-up, which are related to their level of acculturation (i.e., the process of adoption of the host country's language, behaviors, and norms), attitudes and beliefs about the causes of cancer, a sense of fatalism, body image concerns, and social norms.

Treatment and Worldwide Survival

Different types of treatment are available for patients with breast cancer, such as surgery, radiation therapy, chemotherapy, and hormone therapy. As with most other aspects of the disease, the type of treatment also varies by race and ethnicity owing to socioeconomic and cultural factors. Currently, for women with stage I or II breast cancer, standard primary care constitutes either breast-conserving surgery combined with radiotherapy or a total mastectomy (removal of the breast). However, there is evidence that immigrant and minority women might be less likely to receive adequate care than the native White women. Recent research reports show that breast-conserving surgery was performed about 15% less frequently among foreign-born compared to U.S.-born Hispanic women.

Similar to the incidence, breast cancer survival also displays important worldwide variation. Overall survival in North America, for example, is about 80% or higher, whereas survival in middle-income countries is about 60% and in low-income countries – about 40%. Scientists usually attribute the low survival rates in less developed countries to the lack of screening (i.e., programs aimed at the early detection of cancer) and the lack of adequate treatment facilities. Whereas the survival rate in the U.S. is among the highest in the world, all racial and ethnic groups are considered less likely than White women to survive for 5 years after breast cancer diagnosis. Generally, immigrant status appears to be associated with worse expected prognosis.

Risk Factors

Increased levels of ovarian hormones, especially estrogens, throughout one's lifetime have been associated with an increased breast cancer risk. Estrogen levels can be influenced by a number of genetic, biological, behavioral, and social factors, most of which are considered risk factors for breast cancer. Some of the most important risk factors are not easily modifiable, such as female sex, age >60 years, inherited genetic mutations, family history of breast cancer (e.g., in mother, sister), increased breast tissue density, older age (>30 years) at first full-term pregnancy, and late menopause (>55 years). Regarding age, research shows that Hispanic and Asian women typically develop breast cancer at younger ages (i.e., in their 50s) compared to native White women (i.e., in their 60s). International research studies have shown that there are also differences in breast tumor biology related to race and ethnicity. For example, breast tissue density, which is an important marker of breast cancer risk, varies by country. A study with Chinese immigrant women observed that a longer duration of residence in the U.S. could lead to higher breast tissue density.

There are additional, modifiable risk factors and they include use of combined estrogen-progestin menopausal hormones, alcohol consumption, avoidance of breastfeeding, and physical inactivity. Interestingly, obesity has been associated with a decreased risk of breast cancer in premenopausal women but an increased risk in postmenopausal women.

Socioeconomic Status as a Risk Factor

Socioeconomic status (SES) referes to one's position relative to other members of society based on education, occupation, and income. Generally, women of higher SES have higher breast cancer rates. In the U.S., the immigrant (foreign-born) population overall experiences decreased SES. Research shows that the SES gradient in breast cancer incidence is strong and increasing among Hispanic and Asian American women, but not among White or Black women, possibly as a result of health behavior changes following immigration.

Immigration as a Risk Factor

Between 1970 and 2005, the percentage of the foreign-born civilian non-institutionalized U.S. population more than doubled and currently constitutes over 12%. The foreign-born represent over two-thirds of the Asian population and over a third of the Hispanic population. Migrant studies frequently note that migration to a high-risk country, such as the U.S., might increase breast cancer risk. However, the immigrants' risk does not always lie between that in the native and the host countries, and there are both known and possibly yet unmeasured protective factors.

Generally, immigrants who have resided in the U.S. fewer than 10 years as well as those who have emigrated after the age of 20 have reduced breast cancer risk compared to longer-term immigrants or the native-born. A study with Hispanic immigrants in California showed that the third- or higher generation immigrants had at least four times higher risk of developing breast cancer compared to recent immigrants. Studies with Italian migrants, U.S. Hispanics, and internal migrants in California suggest that the timing of migration might be a stronger predictor of breast cancer risk than duration of residence.

Higher levels of acculturation (expressed in terms of duration of residence and language use in the host country) have been linked to fewer pregnancies, decreased duration of breastfeeding, and less healthy dietary patterns. In turn, more acculturated immigrants might be at increased risk for obesity but also might be more likely to utilize cancer screening owing to a reduction in structural barriers, and increased education and career opportunities.

A recent, comprehensive review of breast cancer incidence among immigrants worldwide confirmed the importance of potentially modifiable environmental and behavioral determinants of risk, acting both pre- and postmigration. Specifically, about a third of the available research studies highlighted the importance of early exposures (i.e., during the first two decades of life) such as diet and residential history. Among women originating from low-incidence areas and migrating as adults, the place of birth exerted a protective role, whereas breast cancer incidence was shown to increase among the younger migrants. Among women migrating from areas of high incidence to areas of low incidence, a negative effect of birthplace was also observed. About a fifth of the reviewed studies highlighted the importance of environmental and behavioral factors after migration, particularly the roles of diet modification, increasing SES, delay of childbirth, or avoidance of breastfeeding.

Prevention and Screening

Breast cancer prevention consists of minimizing one's risk of developing the disease. This can be achieved by decreasing the number of known risk factors, such as by avoiding postmenopausal weight gain, engaging in physical activity and in breast cancer screening. For women who are at average breast cancer risk, periodic breast self-exams are recommended after the age of 20; clinical breast exams every three years are recommended for those in their 20s and 30s; annual mammography is recommended after the age of 40. Recent national reports show that approximately 53% of non-Hispanic White women, 42% of Hispanic women, and 38% of Asian women report having a mammogram within the previous year.

A number of research studies dealing with diverse immigrant populations (e.g., Hispanic, Asian, Eastern European) have shown that the level of acculturation is associated with a greater number of clinical breast exams and mammograms. Recent national reports indicate that mammography use is about 25% higher among immigrants who have been in the U.S. more than 10 years, compared to those who have resided in the U.S. for a shorter period.

Researchers have identified many factors that prevent immigrant and minority women from engaging in breast cancer screening. Such factors include lack of health insurance, lack of transportation, impermissible work schedules, lack of understanding of the healthcare system, language difficulties, fear of cancer, fatalism, and culture-bound family dynamics. For example, in 2008 the proportion of the foreign-born population without health insurance was about two and one-half times that of the native-born population.

Future Directions

The ethnic and cultural diversity of the American society is more pronounced than ever before and global migration has diversified the populations of many other countries. Even though fitting a perfect breast cancer prevention model is not currently possible, by means of continued scientific research and informed public health efforts, all women could limit their exposure to the known risk factors and engage in proactive behaviors, thus promoting their overall health and decreasing their breast cancer susceptibility. The collection of comprehensive lifestyle information, such as dietary and physical activity practices, the development of measurement standards, and the inclusion of understudied populations are all on the migrant research agenda. In addition, due to heterogeneity in breast cancer risk among same-race women, the need for disaggregating racial data is critical.

Identifying and understanding differences in all aspects of breast cancer could help in developing culturally and linguistically appropriate interventions and improving outcomes. Theory- and evidence-based comprehensive prevention programs are needed for all immigrant populations in order to increase engagement in preventive behaviors as well as decrease the rates of late-stage diagnosis. Efforts at removing breast cancer screening barriers, for example, can be made at different levels. On the macro-level it is possible to conduct community needs assessments, employ trained community outreach workers, implement provider training for the provision of culturally sensitive care, and engage breast cancer survivors in educational and screening efforts. Possibilities on the micro-level include education initiatives regarding breast cancer signs and symptoms as well as navigation of the healthcare system, reduction of linguistic barriers, and empowerment strategies.

Related Topics

- ► Acculturation
- ► Breast cancer screening
- ► Breast self-examination
- ► Cancer health disparities
- ► Fatalism
- ► Mammography

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WHO. http://www.who.int/cancer/detection/breastcancer/en/index.html

Breast Cancer Screening

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Immigrant Health: Screening for Breast Cancer

Previous research has documented cancer incidence in immigrant populations in the United States to reflect those of their native country in first-generation immigrants with evolution to patterns seen in the USA in subsequent generations. However, immigrant women are often unaware of their own risk and that of their children and may also differ in philosophy regarding approaches to preventive screening compared to what is deemed "standard of care" in US culture. The number of new breast cancers diagnosed in 2010 is estimated at 207,090 or 28% of new cancers in women. Mammography, a type of x-ray evaluation, is an effective screening test for breast cancer prevention. Efforts to engage immigrant women in education about breast cancer screening and treatment programs remain a priority.

Screening for breast cancer in immigrant women represents a challenge on multiple levels. Often, there is misunderstanding and fear around health in the USA and barriers to effective communication with clinicians. Remennick has identified types of barriers to breast cancer screening as *structural* including issues related to health insurance, transportation, work/childcare demands, *organizational* including language barriers or health system navigation, *psychological* such as fear or denial and "fatalism" philosophy, and *sociocultural* such as the position of women in the native culture. Similar structural and organizational factors have been cited as contributors to health care disparities in all minority populations in the USA.

Health care disparities are frequently found in immigrant populations and may be related to low socioeconomic status and other determinants of health. Specifically, Gomez et al. recently reported disparities in breast cancer survival among Asian women in California and noted poorer survival among foreign-born Asians compared to US-born Asians. The factors influencing this notable finding likely represent a complicated interplay of health preferences, access to and types of interaction with the health care system, and disease-specific characteristics.

The concept of fatalism in which the individual believes that their fate is predetermined, or determined by something/someone outside of themselves, is more common in nonmainstream US cultures and may significantly influence health preferences. The attitude of "you control your own destiny" is often projected by health care providers in the USA, while many cultures prefer deference to a higher power for health outcomes. Acceptance of breast cancer screening by immigrant women, desire to know of a diagnosis of cancer, as well as compliance with treatment interventions may be affected by this philosophy. Often, native culture may introduce traditional and not Western medicine prevention options. This may be an additional barrier in obtaining recommended evidence-based screening. Additionally, many immigrant populations experience miscommunication with health care systems and providers due to language barriers. While trained interpreters are helpful in this situation, they are often not readily available.

Another barrier to obtaining breast cancer screening with mammography is the access to care when immigrants are noncitizens. One study showed that even after adjusting for age, education, family income, and marital status, noncitizens remained significantly less likely to report having a mammogram than US-born women (14% point difference; $P < 0.01$). Initiatives to diminish disparities in screening should prioritize improving access through culturally sensitive interventions to care for noncitizens.

Addressing known barriers to breast cancer screening is critical to effective care for immigrant women. This includes educational interventions which are often supported by public health agencies and targeted toward immigrant at risk communities for low health literacy and health numeracy (one's ability to use numeric information in the context of health care). Use of community leaders as advocates to decrease mistrust and encourage proactive preventive breast cancer screening in immigrant women has been successful. Others have found that automated reminders and registries that do not rely on individual recall or visits to a physician promote mammography completion.

Breast cancer is important for all women as it is the most common non-skin cancer in women, and the second deadliest. As women age, breast cancer becomes more prevalent. Statistically, the 1-year incidence is 1 in 800 in a 40-year-old woman, 1 in 400 in a 50-year-old woman, and 1 in 200 in a 60-year-old woman. Given the substantial increase in risk as women age, screening recommendations differ by age, yet clinicians and patients must also consider family history and previous history of breast biopsies as these factors may also contribute to increased risk.

Breast cancer screening recommendations in the US have changed in the last several years due to new studies. In 2009, the US Preventive Services Task Force (USPSTF), a group of health experts that reviews published research and makes recommendations about preventive health care, issued revised mammogram guidelines. According to the USPSTF, women who have screening mammograms die of breast cancer less frequently than do women who do not get mammograms. Those guidelines included the following: screening mammograms every 2 years beginning at age 50 and up to at least age 75 for women at average risk of breast cancer. Very few patients over age 75 were included in studies making recommendations unknown. Screening mammograms before age 50 is controversial and recommendations from USPTF state that mammograms should not be done routinely and should be based on a woman's values regarding the risks and benefits of mammography. These guidelines differ from those of the American Cancer Society (ACS). The ACS mammogram guidelines call for yearly mammogram screening beginning at age 40 for women at average risk of breast cancer. Screening mammograms can detect breast abnormalities early in women in their 40 s. Findings from a large study in Sweden of more than one million women in their 40 s who received screening mammograms showed a decrease in breast cancer deaths by 29%. And it is important to remember that most women who get breast cancer have no family history or other known risk factors for the disease. However, it is important to note the false-positive results are much more frequent in younger patients. Patient discussion with health care professionals about their values and preferences is essential.

The American Cancer Society recommends that some women – because of their family history, a genetic tendency, or certain other factors – be screened with a more sophisticated medical imaging technique (magnetic resonance imaging, MRI) in addition to mammograms. (The number of women who fall into this category is small: less than 2% of all the women in the USA.)

It is currently not recommended that doctors teach women to do breast self-exams. There are a few studies that show reduced risk of dying from breast cancer with this method of screening alone or in combination with mammograms. Potential harms may include false-positive results that lead to unneeded breast biopsies and accompanying anxiety and distress. However, physician/clinician clinical breast exam is recommended for women starting at age 40 and depending on different guidelines, from annually to every 3 years.

Related Topics

- ► Access to care
- ► Breast cancer
- ► Breast self-examination
- ► Cancer
- ► Fatalism
- ► Health barriers
- ► Mammography

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Breast Health

- ► Breast cancer
- ► Breast cancer screening
- ► Breast self-examination
- ► Mammography

Breast Self-Examination

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Breast Self-Examination (BSE) is a screening method performed by individual women on a monthly basis in order to detect early breast cancer. To conduct BSE, a woman may touch and look at each breast for possible lumps, distortions, or swelling. BSE was once considered as the best approach for woman to take control of her own health by finding the breast lump that may be cancerous yet in early stage. After the detection of any lumps, and if women seek breast cancer treatment accordingly, they may be diagnosed with breast cancer at an earlier stage.

An estimated 2.4 million women are living with breast cancer in the USA. Another 192,370 female breast cancer cases are estimated to be newly diagnosed in the USA in 2009. Breast cancer is the most common cause of cancer-related deaths among women worldwide. Breast cancer deaths are at 40,170 according to the most recent record published by the American Cancer Society, 2009.

Despite evidence supporting early detection such as performing BSE as the best approach to reduce breast cancer mortality, it continues to be underutilized by minority women, especially new immigrants. Data showed striking disparities in breast cancer outcomes among different ethnic groups in the USA, especially among ethnic minority women. As compared to women who are born in the USA, immigrant women who have less access to health care and use health care less than often are more likely to be diagnosed with breast cancer at a later stage. Although there is no research focusing specially on undocumented immigrant women in the USA, these women are even less likely to utilize preventive services such as breast cancer–screening services and treatment as compared to other immigrant women.

Breast cancer is also the number one cause of cancer-related mortality for a large group of both American-born and immigrant women, the Asian American and Pacific Islander (AAPI) women. As compared with new immigrants, Asian American women who immigrated to the USA at least a decade ago have an 80% higher risk of being diagnosed with breast cancer. For Asian women born in the USA, the breast cancer risk is similar to that of non-Hispanic White women.

Besides practicing BSE at a lower rate, only 48.5% of Asian and Pacific Islander women 50 years and older in the USA have had a mammogram or clinical breast examination within the last 2 years. This is the lowest rate of screening among all racial/ethnic groups. Immigrant women may also experience more barriers to practicing BSE such as modesty, a perception due to cultural training that touching one's own breasts is inappropriate, or a lack of resources to practice BSE correctly. Therefore, promoting BSE among immigrant women may be beneficial. When performed competently and with appropriate frequency, BSE has the advantage of being a user-friendly screening technique that may enhance the likelihood of early detection of breast cancer.

Controversial Aspects of BSE

Although BSE was once promoted heavily as a means of finding cancer at a more curable stage, large randomized controlled studies found that BSE was not effective in preventing death, and actually, may cause harm through needless biopsies and surgery. Therefore, BSE is no longer promoted as the best preventive approach a woman can take to prevent breast cancer by early self-detection. However, breast cancer advocacy organizations have continued to encourage women to practice BSE and provide training materials with a caution regarding newer research findings.

The controversy and debate of the effectiveness of BSE started after a research analysis was published in The Cochrane Library indicating women who practice BSE have the similar likelihood of dying of breast cancer when compared to women who do not practice BSE. This analysis merged data from two studies, one from Shanghai, China, and the other one from Russia with a total of 388,535 women conducted in 2002. In both studies, factory workers were trained to do BSE. Both studies found that women who were trained to perform BSE were not less likely to die of breast cancer, as compared to the women who did not receive the training. However, it is not clear if these women from other countries, their practice of BSE, and their health care systems are comparable to the US women's experience and the US health care system. Given the studies of immigrant women in the USA, it may be presumptive to suggest BSE is not effective in detecting breast cancer if it is practiced correctly and on a regular basis.

The Advantage of Practicing BSE

In comparison to clinical breast examination, mammography, ultrasound, and magnetic resonance imaging, BSE can be performed independently by women of any age in the comfort of their home. Several studies and reports indicate, however, that cultural barriers may discourage immigrant women of Asian descent from practicing BSE. Common barriers – such as dependence on medical professionals and forgetting – predicted older Chinese women's nonpractice of BSE. AAPI women with lower income and without private insurance were less likely to practice BSE. Newly immigrated Vietnamese women, especially those with a lower level of education, are less acculturated and less likely to learn about preventive screening and medicine compared to those who have lived in the USA for a longer period of time. Among Korean American women, acculturation, proportion of life spent in the USA, and English-language proficiency were significant factors in seeking cancer-screening tests. Lack of interest in BSE may be influenced by inaccurate beliefs regarding cancer, such as some Chinese immigrants' beliefs that all cancers are contagious, so why would they go out of their way of finding cancer by not knowing cancer is most curable when it is found early.

BSE has been described as a highly accessible method supporting early detection of breast cancer. However, the appealing notion that BSE is consumer driven and is independent of overcoming access-related barriers may assume a normative culture that does not apply to immigrant women.

Given the recent controversy and debate on the importance and necessity of practicing BSE, all women should know their risk of having breast cancer. This risk may include but not limited to family history of breast cancer, personal risk factors including cigarette smoking and sedentary life style, diet, or amount of exercises. Women who have an average risk of breast cancer should have mammogram every year starting at age 40 and practice BSE. Knowing how one's breasts look and feel is also an important aspect of BSE. If a woman thinks there is imbalance or feel something may be wrong, a physician's opinion should be obtained. For immigrant women, research shows that cultural and structural barriers may prevent them from obtaining other screening tests such as mammography and clinical breast exam. By promoting BSE immigrant women may gain the power to have some knowledge about their own body and seek care if they find anything unusual.

Related Topics

- ▶ Access to care
- ▶ Acculturation
- ▶ Breast cancer
- ▶ Breast cancer screening
- ▶ Cancer health disparities
- ▶ Health promotion

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Suggested Resources

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Susan G. Komen for the cure. http://ww5.komen.org/BreastCancer/BreastSelfAwareness.html

The Cochrane Library. http://www.mrw.interscience.wiley.com/cochrane/clsysrev/articles/CD003373/frame.html

www.dhss.mo.gov/BreastCervCancer/BSEbrochure.pdf

Breastfeeding

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The American Academy of Pediatrics and the National Association of Pediatric Nurse Practitioners in their policy statements support the tenet that breastfeeding is the physiologic norm for both mothers and children, and offers overwhelming benefits not available from substitutes for human milk to the infant and mother. This policy is also supported by the Association of Women's Health, Obstetric and Neonatal Nurses, the American College of Obstetricians and Gynecologists, The American Academy of Family Physicians, and the World Health Organization. Goals of the US national health policy statement *Healthy People 2010* included 75% of mothers initiating breastfeeding, with 50% of mothers' breastfeeding their infant at 6 months of age. In support of these opinions, state legislatures have enacted laws that specifically allow women to breastfeed in public, and have exempted breastfeeding from public indecency laws. In 2006, 74% of US mothers initiated breastfeeding, and 43% were breastfeeding at infant's 6 months of age.

In a 2006 study conducted in New York City with 4,207 Mexican Hispanics, non-Mexican Hispanics, and non-Hispanics mothers, an infant with a foreign-born parent was associated with a dramatic increase in the likelihood of breastfeeding. There was an 85% reduction in the odds of breastfeeding by mothers born in the USA compared to mothers foreign-born. The study showed that for every year of US residency there was a 4% decrease in the odds of breastfeeding. Similarly, another study in low-income mothers ($n=490$) of Mexican descent that showed that increased years in the USA were associated with decreased likelihood to initiate breastfeeding, and shorter duration of exclusive and any breastfeeding. Using cross-sectional data from 33,121 children aged zero to 5 years, immigrant women in each racial or ethnic group had higher breastfeeding initiation and greater duration rates compared to native-born women controlling for socioeconomic and demographic differences. In this study, higher acculturation rates in Hispanic and non-Hispanic women were associated with lower breastfeeding rates. Large data base statistics from the 2003 Canada Community Health Survey showed that 85% of all mothers attempted to breastfed, although many stopped within the first month, and less than half continued to breastfeed at least 6 months. Exclusive breastfeeding for 6 or more months was associated with mother's age, education, household income, and was more common among immigrant than non-immigrant women. Not surprisingly, the practice of breastfeeding has been associated with improved outcomes for infants of immigrant mothers whose families frequently experience low levels of food security. Breastfeeding has been found to be initiated by 83% of immigrants. Breastfed infants were less likely to be reported in fair/poor healthy, and were less likely to have had a history of hospitalization.

The role of acculturation in immigrant women and its impact on breastfeeding continues to be examined. A study that evaluated the impact of prenatal education on breastfeeding showed that measures of household income were significant and positively associated, and that maternal acculturation levels were negatively associated with breastfeeding. This is in conflict with an older study of 962 low-income immigrant women in New York City. When controlled for smoking, intent to work, age, social support, and attitudes toward breastfeeding, acculturation did not automatically lead to decreased breastfeeding in immigrant women, and rather higher acculturation levels led to increased likelihood of receiving support from family, friends, and health care providers. This social and emotional support increased intent and duration of breastfeeding.

The prenatal intent to breastfeed has shown to be predictive of action and duration of breastfeeding. Other factors associated with breastfeeding intention include previous experience, age, maternal parity, living with a partner, and education. However, having been breastfed as an infant, prior breastfeeding experience, or having a breastfeeding friend or relative outweighs other contributing variables. In interviews with 382 women, foreign-born women were significantly more likely to intent to breastfeed compared to US-born women. County of origin, and having breastfed a previous child were significant predictors of intent to breastfeed.

Some concern has been expressed between the US practice of rooming-in on the postpartum floor that fosters a new mother's independence as a caregiver to her newborn, versus a conflicting cultural practice of giving the new mother time to recuperate and being attended upon by her family. Some cultures feel that the postpartum period is the most vulnerable time of a woman's life and that rest is crucial for future emotional and physical well-being. The demands of establishing breastfeeding need to be combined with the cultural needs to be cared for by the new mother.

Breastfeeding in the United Kingdom has been studied and contrasts the English belief that breastfeeding is rarely done in public and is an activity that society requires to be hidden from view, to the African societal practice that the breast is readily available to the infant and women can nurse their infants without leaving the worksite. In traditional Somalia, an extended family provides the new mother with a 40-day lying-in period of nurturing. Older and more experienced family members provide maternal behaviors for the new mother to model. Migration is largely done for economic reasons with the anticipation of securing paid employment. Breastfeeding may become more challenging if the woman works outside the home. This employment affects traditional perspectives on breastfeeding.

In an interview study with 19 Vietnamese immigrant mothers it was demonstrated that migration changed traditional health practices normally given to the new mother that can last 1 month to 100 days. In their home country new mothers receive a series of prescribed rituals that include rest and traditional perfumed steam baths meant to restore the *heat* lost in the process of childbirth, and helps them transition into motherhood by an established rite of passage. The lack of receiving these rituals lead the mothers to feel that she would be vulnerable to *cold* illnesses. It is thought that breastfeeding requires *vital energy* that may not be replenished after childbirth if ritual practices are not received. In addition, immigration to a new country may prevent the new mother from receiving the traditional meals composed of herbs and special meats which are thought to help produce *fresh*, nourishing milk. New immigrant Vietnamese mothers stated that breast milk was the best nourishment for their infants but felt that their personal breast milk was not good because traditional rituals were not followed.

In another study with Chinese immigrant mothers ($n = 506$) in Australia examining the intention and duration of breastfeeding, findings showed that health care providers may have an influential role contributing to a tenfold greater chance of initiating and sustaining breastfeeding. Support of new mothers' partners also contributed to intent and duration of breastfeeding, but only to those mothers who delivered in Australia, not China. Mothers who delivered in China relied on their mothers and female relatives for support. Those who migrated needed to rely on their partners as their relatives were not in proximity. In this study and in a study in Kenya ($n=444$), women's education level was positively associated with duration of breastfeeding. Well-educated women are reading more about the benefits of breastfeeding and returning to the practice of breastfeeding. Another study finding that complements previous research shows that immigrant and non-immigrant women, whose postpartum hospital stay is longer because of delivery by cesarean section, have greater access to education instruction, and have more time to be guided toward successfully establishing breastfeeding.

Holistic and culturally competent health care includes the incorporation and value of beliefs, traditions, and rules of behavior among racial and ethnic groups of people. Lessons learned include the effectiveness of using prenatal interventions to increase the prevalence of exclusive breastfeeding among Latina and other immigrant mothers. Prenatal and postpartum education should encourage the continuance of ethnic maternal practices of breastfeeding, while supporting concepts of respect for culture, the importance of family, trust, and the development of personal health care provider–client relationships. Attention to any prenatal or postnatal ritual practices that are thought to be needed for the production of good maternal milk needs to be incorporated into the plan of care for expectant and new mothers. Immigrant mothers may be lacking in the amount of social support received in their new maternal role due to their new place of residence. Friends and family may be far away. In addition, immigrant mothers may receive less support from health care providers, possibly due to language differences, and less instruction may make them more vulnerable to free samples of breast milk substitutes. Programs that seek to promote breastfeeding need to compensate for this lack of support, and reinforce existing social networks. It is encouraging that in immigrants whose US-born female children become more educated and obtain a higher socioeconomic status, there is a greater return to breastfeeding.

Related Topics

- ▶ Acculturation
- ▶ Assimilation
- ▶ Child development
- ▶ Cross-cultural health
- ▶ First generation immigrants
- ▶ Health perception

Suggested Readings

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Buddhism

- ▶ Asia
- ▶ Asian Americans
- ▶ Cambodia
- ▶ Chinese
- ▶ India
- ▶ Japan
- ▶ Religion, religiosity, and spirituality

Built Environment

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The impact of the built environment on health has shifted from a focus on sanitation to the influence of man-made systems and structures on the health and well-being of communities. Of particular concern to public health practitioners is the role of the built environment in modifying, exacerbating, or protecting against health disparities. The poor, particularly those of minority status, are disproportionately exposed to the deleterious effects of the built environment, and face a corresponding increase in related disease morbidity and mortality. Among these groups, immigrant populations are of particular concern as they often are the vulnerable to exposure and, perhaps due to language and cultural barriers, may be disproportionately at risk.

Health and the Built Environment

Conceptualizations of the built environment have changed over time. Resting at the intersection of urban planning and public health, our understanding of the built environment has shifted with the parallel development of these two disciplines. Public health concerns over the built environment have often rested within the broader context of environmental health, and as such have historically been concerned primarily with preventing exposure to toxins and pollutants, often through zoning ordinances and regulation. However, as both fields have matured, the domain of environmental health has grown to encompass the broader health effects of the built environment.

The increased interest in the built environment has shadowed a general change in the structure of the built environment itself. In the early 1900s, densely populated urban spaces tended to be self-contained, walkable, and provided access to daily necessities, such as food stores and shops. However, with outward migration to suburban areas in the early 1960s, the construction of highway systems, and the enlargement of urban sprawl, the impact of the built environment on health has become increasingly more complex. The current scientific conceptualization of the built environment encompasses all human-modified structures and places such as homes, schools, workplaces, parks, industrial areas, farms, roads, and highways; essentially, the places where people live, work, and play. Despite the diversity of structures that fall under the term, the built environment can be examined through housing, transportation, and neighborhood which provide a useful lens to examine the impact of the built environment on health.

A significant body of literature has examined the impact of housing conditions on health. While the interactions between housing and health are complex, it is generally recognized that inadequate housing can expose residents to allergens, mold, lead, pests, and result in negative health outcomes from asthma and respiratory infections, and cardiovascular disease. Similarly, transportation has been linked to negative health outcomes. In areas with high traffic density and crowded streets, air pollution is a persistent concern. Like inadequate housing, air pollution is associated with respiratory and cardiovascular morbidity. Additionally, transportation issues can decrease physical safety by increasing motor vehicle and pedestrian accidents. Lack of appropriate or accessible transportation may prevent residents from access to crucial services such as health care facilities, exercise facilities, supermarkets, and recreational spaces, leading to negative health outcomes.

Neighborhood characteristics such as walk-ability, availability of green spaces such as parks and playgrounds, access to needed facilities such as schools, police, supermarkets, and hospitals all affect health. The obesogenic nature of the modern urban built environment is also of great concern to public health practitioners, policy makers, and researchers. The growth of urban sprawl and the increase in the number of miles Americans must travel daily have all led to a decrease in physical activity. Physical inactivity has long been known to be associated with an increased risk for many health conditions including diabetes, hypertension, colon cancer, and coronary heart disease. The literature indicates that elements of the built environment can serve to provide avenues for physical activity or to prevent productive physical activity. Neighborhood factors also influence how residents respond to and recuperate from adverse health events, either physical or mental. Finally, elements of the built environment can influence levels of social capital and social cohesion.

While the above research suggests that the built environment directly impacts human health, of greater importance is the mechanisms by which these factors aggregate toward disparities. In an effort to tease out the multiple interrelated factors that the built environment serves to ameliorate or exacerbate, *The Social Determinants of Health and Environmental Health Promotion* (*SDOH &EHP*) model demonstrates how features of the built environment interact with social, economic, and political processes to promote health inequities. Of note in this model is that the built environment serves as an intermediary between macro-level causes of health disparities (i.e., ideologies and historical conditions) and proximate factors that lead to the aforementioned negative health outcomes (i.e., stressors, and health behaviors). This framework serves as a useful tool in examining how the built environment contributes to health disparities among new immigrant populations.

Immigrant Health and the Built Environment

Immigration patterns in the United States have experienced significant changes over the past century. At the turn of the twentieth century, primarily European immigrants composed over 13% of the population. Subsequently, the proportion of foreign-born peoples in America declined to approximately 5% of the population in the 1940s as post-World War II immigration policies restricted the influx of immigrants. However, in 1965, federal legislation eased immigration quotas and opened immigration opportunities to other countries. The resultant immigrant boom in the 1980s and 1990s – a functional doubling of the foreign-born population of America – resulted in a very different demographic of immigrants. These "new immigrants" originated outside of the traditional European regions and instead hailed from Latin America, the Caribbean, Africa, and Asia.

The new immigrant communities flocked to urban centers, such as Boston, Chicago, New York, and San Francisco. Yet since land use, and consequently many features of the built environment, have always been political decisions, those lacking political voice (i.e., immigrants) are often clustered in the least desirable, and consequently least healthy, spaces. Consequently, many immigrant populations are vulnerable to excess disease morbidity due to the built environment.

The *SDOH & EHP* model provides insight into how environmental injustice can disproportionately affect immigrant populations in urban areas and otherwise. Persistent sociopolitical inequities can manifest themselves through the built environment and result in health disparities. For example, economic and historical conditions can push immigrant populations to reside in affordable yet substandard housing leading to the negative health outcomes.

Examining the morbidity rates experienced by immigrant populations provides a clue as to how the built environment might affect health. Physical characteristics of the built environment can affect rates of obesity. New immigrants generally have lower levels of obesity than their US-born counterparts; physical inactivity might account for this increase. However, the impact of physical environmental characteristics on physical activity is unclear. Some studies have found that the reasons for physical inactivity among this population concerned aspects of the built environment including transportation, lack of facilities, cost, and safety. Conversely, other studies have shown that social environmental factors such as knowing people who exercise and having a supportive family structure as well as level of acculturation has a much stronger effect on physical activity. It is also important to note that different immigrant groups may possess different concepts of what constitutes physical activity. Though immigrants might not engage in physical activity during their leisure time, their daily tasks and chores might be highly active. Yet, even in such cases the perception of the built environment might discourage leisure-time activity.

Another domain where the built environment may play a strong role is the area of mental health. Generally, immigrants have better overall mental health status than native-born residents, however this is not consistent among all subgroups, varies by psychiatric disorder, and changes with time spent in the United States. In a nationally representative survey, researchers have found that a perceived lack of neighborhood safety was positively associated with mental health outcomes such as depression, anxiety, and substance use disorders. Similarly, the built environment is thought to play a role in acculturative stress, as living environments can impact acculturation.

Finally, the built environment might be implicated in several other health outcomes of immigrants. Regarding asthma, studies have suggested that while some immigrants are less likely to develop symptoms of asthma than their US-born counterparts, asthma rates vary widely between racial and ethnic groups. Regarding violence, the social and physical context of the built environment has been linked to rates of youth violence. For example, easy access to alcohol and lack of role models in professional occupations have been associated with youth violence.

Related Topics

- ▶ Acculturation
- ▶ Acculturative stress
- ▶ Body mass index
- ▶ Border
- ▶ Chinatown
- ▶ Community
- ▶ Environmental exposure
- ▶ Ghetto
- ▶ Heat stroke
- ▶ Housing
- ▶ Obesity
- ▶ Violence

Suggested Readings

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Suggested Resources

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http://www.jointcenter.org/hpi/pages/place-matters

http://www.policylink.org/atf/cf/%7B97c6d565-bb43-406d-a6d5-eca3bbf35af0%7D/WHYPLACEMATTERS_FINAL.PDF

http://www.walklive.org/

Bureau of Immigration and Customs Enforcement

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The Bureau of Immigration and Customs Enforcement is the original name of the Immigration and Customs Enforcement (ICE). ICE, Customs and Border Protection (CBP), and United States Citizenship and Immigration Services (CIS) are the three organizations formed from the former Immigration and Naturalization Service (INS) when that agency was absorbed into the newly created Department of Homeland Security (DHS) in 2003.

For many years prior to 2003, critics of the INS complained that it was a dysfunctional agency, being charged with both enforcing the immigration laws and providing immigration benefits. The critics claimed that the enforcement mentality crept into adjudicating benefits, resulting in harsher standards than were required by the law. In addition, monies received by INS through increased fees originally designated to improve service often were appropriated for enforcement. With the formation of DHS, government officials took the opportunity to break the INS into component organizations with supposedly clearer missions.

Initially, there was a great deal of confusion as to which new agency had jurisdiction over various aspects of immigration law. Eventually, it became clear that ICE was responsible for the enforcement of the immigration laws within the United States. ICE officers are responsible for worksite visits, visiting jails and prisons, and otherwise looking for individuals in the United States in violation of the law. ICE officers also include the attorneys responsible for representing the government before the Executive Office for Immigration Review.

As the internal enforcer of the immigration laws, ICE is responsible for referring cases to the Executive Office for Immigration Review, Office of the Immigration Judges, commonly referred to as the Immigration Court. The Immigration Court can remove or deport an individual who was inadmissible when he/she applied for entry into the United States. An individual who (1) has a communicable disease of public health significance, (2) is an immigrant who has failed to have the required vaccinations, (3) has a physical or mental disorder that may pose or has posed a danger to the self or to others, or (4) is a drug abuser or addict, is inadmissible to the United States. Thus, if an individual, at the time of entry into the United States, was in one of these classes, ICE may place the person in removal proceedings, in some cases even if the individual entered the United States many years before.

One of the most active and growing sections in ICE is the fugitive unit. ICE officers in this unit are responsible for locating and removing individuals who have been ordered deported or removed but have not left the country. Although some are violent criminals, ICE has been criticized that many of those it targets have no criminal history. ICE has also been criticized for making collateral arrests of other individuals who happen to be present at a home or other location where ICE is looking for an individual.

ICE can make worksite raids of locations suspected of hiring a large number of illegal immigrants. In May 2008, ICE agents arrested over 400 individuals suspected of being in the United States illegally at a meat packing plant in Postville, Iowa. Individuals who used a social security number not their own were given a choice: be prosecuted under a federal identity theft statute and risk a 2-year prison sentence, or plead guilty to a lesser charge and face automatic deportation. One year later, the United States Supreme Court held that using someone else's social security number to obtain employment was not in and of itself sufficient to satisfy the identity theft statute. The Postville raid was criticized not only for ICE's treatment of those detained but also for its economic and psychological effect on the local community.

Related Topics

- ► Communicable disease of public health significance
- ► Illegal immigration
- ► Immigration and Naturalization Service
- ► Immigration status
- ► Undocumented

Suggested Resources

Bureau of Immigration and Customs Enforcement. http://www.ice.gov

CAM

► Alternative and complementary medicine

Cambodia

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The health of Cambodian immigrants cannot be separated from the political history and the impact of the Khmer Rouge whose rule saw the deaths of approximately 21% of the Cambodian population – 1.7 million people – between 1975 and 1979. A 2005 community survey of Cambodians who had immigrated to the USA before 1993 reported that 99% had experienced near-death due to starvation and 90% had a friend or family member murdered.

Background

Most Cambodians consider themselves to be Khmers and descendants of the Angkor Empire that was the dominant force in Southeast Asia for hundreds of years from the tenth to the thirteenth century. The empire declined over the next 500 years and the country was invaded and sacked by various neighbors, although a monarchy endured. In the nineteenth century, attacks from the west (Thai) and the east (Cham/modern-day Vietnamese) led to Cambodia seeking French protection and becoming a part of French Indochina. Vichy French Colonial administrators were allowed to maintain control of Cambodia during most of World War II, and unlike Vietnam there was little impact from the Japanese occupation. Cambodia gained independence from France in 1953 and remained a constitutional monarchy until open conflict with the communist (Maoist) Khmer Rouge began in 1970. Some scholars believe the US intervention in Cambodian politics supported an unpopular government that endorsed the US war effort in Vietnam, but made Cambodia more susceptible to the Khmer Rouge guerillas. Fighting continued until the Khmer Rouge gained control of the country in 1975 – at the same time the North Vietnamese gained control of South Vietnam and unified their country.

Khmer Rouge and Genocide

Within days of capturing the capital, Phnom Penh, the Khmer Rouge led by Pol Pot began to locate and kill military and political leaders, monks, teachers, doctors, scientists, lawyers, engineers, and anyone who wore glasses; these were all people thought to be contaminated by capitalism. Because ammunition was in short supply, the majority were killed by stakes or bludgeoned to death with iron bars after they had been forced to dig their own graves in what became popularly known as "The Killing Fields." Hundreds of thousands of people were known to have died in this manner based on excavated gravesites.

Based on large-scale "experiments" that Pol Pot had carried out on villages the Khmer Rouge had captured in previous years, he believed that society had to be radically destabilized to break all previous bonds and ensure absolute loyalty to the communist party. The campaign was called "Year Zero," a takeoff on the ideals of the French Revolution. To accomplish this, the cities and villages were emptied to become ghost towns and the population forced into the countryside despite signs of an oncoming famine in the wake of the civil war. The displacement campaign was organized to remove traditional bonds such as family, village ties,

Sana Loue & Martha Sajatovic (eds.), *Encyclopedia of Immigrant Health*, DOI 10.1007/978-1-4419-5659-0,

and faith in Buddhism. The farming practices proved to be poorly planned and executed due to the lack of expertise by the Khmer Rouge administrators. This led to an ongoing agricultural catastrophe, resulting in famine and starvation across the country.

The Khmer Rouge administration was an ally of the People's Republic of China. Cambodia was invaded by Vietnam (a client state of the Soviet Union) in 1978 and despite a limited Chinese invasion of Vietnam in 1979 to support their Cambodian allies, the capital Phnom Penh fell to the Vietnamese in the same year, ending the genocidal reign of the Khmer Rouge 4 years and almost 2 million lives after it began. During the 1980s, the Khmer Rouge operated as a guerilla movement from the jungles of Western Cambodia and sometimes across the Thai border. Ten years of ongoing civil war ended with a peace agreement in 1991 that was policed by 20,000 UN Peacekeepers, although sporadic fighting continued for 8 more years. The last remnants of the Khmer Rouge surrendered in 1999. Since the peace accords in 1991, there have been elections in 1993, 1998, 2003, and 2008 that have been generally peaceful – with the exception of a coup in 1997.

Despite increasing security and political stability, the scars of the Khmer Rouge linger on in many Cambodians' minds. There is almost no access to mental health resources within Cambodia. Posttraumatic stress disorder and other mental illnesses appear to have a high prevalence among the generation of Cambodians that survived as well as those that perpetrated the genocide and conflict.

Gang Rape

Because of the genocide of the 1970s and the conflict that followed, 50% of Cambodia's population is less than 21 years old. They tend to have limited education and skills training because most of the teachers were killed by the Khmer Rouge, schools were destroyed, and the following decades of conflict resulted in limited investment in an education infrastructure. Combined with the intentional destruction of Cambodian culture by the Khmer Rouge and the social structure that was lost with it, this has led to some challenging social trends. One is an increasing recognition of the widespread practice of "bauk," which translates to "plus" in Khmer. It is a practice of group sex that appears to be gang rape more often than not. The process involves a group of – up to a dozen – youths luring a woman, usually but not always, a prostitute to a room. The expressed sentiment is that they are paying "full price" so it is cheaper to split the cost. There appear to be no prosecutions for bauk despite it being well documented. One survey of 580 youths aged 13–28 in Cambodia reported that only 13% of men and 13% of women felt it was inherently wrong; 33% of men and 41% of women felt bauk was dangerous mostly because of STD transmission; 13% of men and 8% of women said gang rape was okay because the women were prostitutes and see "many men" anyway; and 13% of men and 17% of women said it was better to happen to prostitutes than "other women." Thirty-four percent of high-school students said they knew at least one person who had participated in bauk. Sixty percent of university students said they knew of someone who had participated. One trend noted anecdotally by women's-rights NGOs is that non-Khmer-speaking women (prostitutes or not) seem to be more common targets of bauk/gang rape, perhaps because their foreignness/otherness as immigrants appears to make it more acceptable to the men involved.

Trafficking

Another issue that comes along with a large population of unskilled Cambodian youths is unemployment and a susceptibility to human trafficking. Human trafficking is a form of exploitation that involves controlling and transporting people through the use of force, deception, or coercion. It is reported to be the third most profitable criminal activity in the world after drug and gun smuggling, and resulted in estimated worldwide profits of $31 Billion USD in 2008. Cambodian men, women, and children are trafficked for sexual and labor exploitation in Thailand, Malaysia, Macao, and Taiwan. The traffickers are reportedly organized crime syndicates, parents, relatives, friends, intimate partners, and neighbors. Cambodian men are trafficked into commercial fisheries, seafood-processing plants, and for farm, industrial, and construction labor. The trafficking of women commonly occurs for exploitation as sex workers.

It is also common to find Vietnamese and Chinese women trafficked into Cambodia working as prostitutes, commonly from ages 15 to 18. This is partly so not only because agents in both places act as way-stations to move the women on to industrialized nations, but also because within the local sex industry of each nation the foreign women are perceived to be more compliant and less resistant when they are in a strange country with an unfamiliar language, customs, and geography. In a foreign land they will be unaware of any resources to help them escape and may be subject to prosecution as illegal immigrants if they approach the police. Psychologically, they feel isolated and may see their captors as their only hope for survival. Even their employers or customers, who do not speak Khmer, may not realize that they are unwilling participants. In Cambodia, a local nongovernmental agency study found that 76% of trafficked children sent to Thailand came from families who owned land, 93% owned their own house and had no debt on the land or house, and 47% stated that their mother was the facilitator. Young Cambodian girls who are virgins are also highly sought after by traffickers, as clients will see them as being free from HIV or STDs. They are also thought to convey increased vigor to their male clients, an animist belief common throughout eastern Asia. Reports state that they are bought for a “week of use” and confined to a hotel or guesthouse room for the duration.

Landmines

Other residual effects from the conflicts include the remaining land mines and unexploded military ordinance that many of the different warring groups (US, Vietnamese, Royal Cambodian, Thai, Khmer Rouge, and other military forces) in Cambodia left behind. Cambodia is one of the most heavily mined areas in the world. In 2009, more than 10 years after the last of the Khmer Rouge surrendered, the Cambodian Mine Action Centre found and destroyed 19,511 mines and 133,164 artillery shells and bombs. It is estimated that two to four million mines remain. Cambodia has one amputee for every 290 people, one of the highest ratios in the world. This is especially tragic considering the youthful demographic of the population. UNICEF estimates that children account for half of landmine casualties in Cambodia. Many of these victims will not have access to modern prosthetics and will be at a severe disadvantage for work in a crowded labor market. They also have no access to physical medicine and rehabilitation specialists that amputees in developed countries would normally see. These victims also have unmet mental health needs and commonly express symptoms of PTSD and chronic depression.

Refugees

From 1975 to 1993, over 500,000 Cambodians fled into Thailand and another 100,000 entered Vietnam. At least 300,000 of those Cambodians permanently fled the region with more than 179,000 ending up in the USA, 50,000 in France, and 45,000 in Australia. Most of the refugees left Cambodia after the genocide because the Khmer Rouge would generally not allow the population to leave Cambodia. For instance, only 300 Cambodians arrived in the USA in 1977. After the fall of the Khmer Rouge from power in 1979 and as the Vietnamese came into Cambodia, a large amount of the Cambodian population made their way westward. In 1979, 6,000 Cambodian refugees entered the USA. A year later, 16,000 more refugees followed. The year 1981 saw the largest number of Cambodian refugees enter the USA, 27,100.

The Cambodian refugees who fled to Thailand overwhelmed resources at the border. In 1979, an international response led to the opening of several refugee camps within Thailand for some 160,000 refugees; another 350,000 lived in Thailand outside of the camps. Several hundred thousand returned to Cambodia after the arrival of United Nations Peacekeepers in the 1990s.

Gangs

Cambodian refugees resettled in the developing world have been associated with limited assimilation to their adopted culture and a higher rate of gang activity. This is thought to come from a series of factors: poor skills base on arrival, difficulty learning a language, familiarity with weapons, a higher rate of untreated mental illness and desensitization to violence, lack of parental guidance and role models, and settling in low-income/high-crime neighborhoods where some communities may have the need to band together to protect themselves. In Los Angeles 46% of Cambodians were found to be living below the poverty line as opposed to 27% of Vietnamese. Cambodians who have had negative experiences with the Khmer Rouge and then in refugee camps before arriving in the USA often show a fear of and distrust towards authority. This may make them less prone to cooperation and more likely to turn within their own community for support and perceived protection.

In the USA, gang-associated violence or misdemeanor crimes of suspected gang members can be a cause for deportation if immigrants have not achieved US citizenship, which many Cambodian immigrants in the USA have not. This had not been an issue in the past, as prior to 2001 there was not a treaty regulating deportation. The number of deportees is rising with several thousand pending return to Cambodia, despite the fact that many speak Khmer poorly or are not acclimatized to life in Cambodia. This is of concern to health care workers who treat suspected gang members or drug abusers who may be at risk for deportation.

Health Care in Cambodia

In addition to problems arising from the Khmer Rouge genocide and displacement, Cambodia faces problems that similar developing nations have to contend with, such as corruption, infectious diseases, poverty, and a significant lack of basic infrastructure. In developing countries, local economics determine illness exposure, and Cambodia is not an exception. Seventy-five percent of the country is engaged in agriculture and 35% of the population lives below a very marginal poverty line. Stability is beginning to pay off, however, the government-funded public health system is reportedly ineffectual, with up to 100% of the funds and equipment lost to corruption and diverted to private clinics – NGOs are stepping in to provide networks of clinic and birthing services.

Cultural Issues

Cambodian men are the traditional heads of household, but women have always had a role as "purse keepers" and masters of the household budget in Cambodia. After the genocide and years of war, in many households divorced, widowed, or separated women are accepted as the head. Age has traditionally been very important in Cambodian culture. Extended families often look to an older parent or grandparent for adjudication or structure and for Cambodian refugees; this can be stressful as the younger generation may be more likely to adapt to local customs. Younger members of refugee families may be expected to act as caregivers, translators, and transportation assistants for older family members requiring medical care. This can set up situations where health care is neglected, as older members feel they do not want to intrude or cannot ask younger members to help them access care.

Respect for the elderly is essential in a Cambodian family setting, and the oldest members should be greeted first and last in a family meeting. Communication can be very frustrating for Western-trained health care workers as it is unusual for older Cambodians to respond negatively or say "no." Synonyms for no may be a lack of response to the question, statements such as "it's ok" or "no problem," or even an unconvincing "yes." It is generally of little value to press directly for answers.

Emotion, including anger, frustration, or loud, cheerful, or overly familiar behavior, is often out of place and Cambodians, like Thai, prize equanimity in the face of distress and confrontation. Translators may have difficulty conveying tone or Western concepts in psychological or psychiatric assessment. It is important that health care providers address these challenges in communication; using a translator that is incompatible for gender, age, or other reasons will lead to false or limited information.

Children

Cambodians see compliments or unnecessary attention to children as bad luck. Cambodian society also sees corporal punishment as a common and acceptable method of feedback. Cambodians in Western society may be distressed at the lack of restraint and structure that schools provide and sometimes blame this for the high rate of gang involvement described above. Childhood immunizations are generally accepted.

Physical Touching

Greeting is by the *Sampeah* gesture, pressing the hands together and bowing the head. The bottom of the foot is considered unclean and should never be pointed at a Cambodian. Touching of the head is thought to impact the soul, and should be done only after obtaining permission during a physical examination.

Names and Language

The Khmer language places the family name ahead of a given name and both are used in many cases to show respect within a family and by strangers. Women usually keep their father's surname after marriage. Names of Cambodians in Western Arabic spelling are usually adaptations that were taken on arrival at refugee centers in Thailand or on arrival to their adopted country. Different family members may have slightly different spellings if they arrived separately. The Khmer language is not always as precise as Western languages in terms of medical symptoms. For instance, "Krun" is commonly translated as fever, but may actually refer to malaise, "hot and cold," or flushing. However, "Krun jang" usually refers to high fevers and rigors and is associated with malaria.

Traditional Medicine Practices

Although Cambodians are primarily Buddhist, there is an extensive range of animist and Chinese influences. Cupping, acupressure, acupuncture, massage, and traditional medications such as bark or animal products may be used for a variety of ailments. It is not uncommon to mix traditional therapies with alcohol. Spiritual practices are wide and varied; tattoos may be used for protection, amulets may be thought to convey healing powers or protection, and "Yuan," inscriptions over windows or doors, may be used for protection against spirits.

Cambodians may use a combination of traditional, spiritual, and complementary medicine practices and see no sense of exclusivity about them. It is common that they associate medications with symptoms of distress and stop the medications when the symptoms alleviate.

Mental Health

A report in the *Journal of the American Medical Association* stated that 62% of Cambodian refugees who came to America to escape the Khmer Rouge are suffering from posttraumatic stress disorder. Another 51% suffer from severe depression.

Mental illness in the Cambodian community is often only addressed indirectly and reluctantly. Animist influences suggest it is due to spirit possession and Buddhist influences suggest a role for bad karma from previous acts and shame, both leading to stigma within the community. Initial presentations for mental distress will often be to local Buddhist religious figures and traditional medicine practitioners. Only if these are unsuccessful will an attempt generally be made to engage Western practitioners. In a 1985 California survey conducted on the mental health of Southeast Asian refugees, 84% of Cambodian households had at least one member under a physician's care in comparison to 45% of Vietnamese households. This is thought to reflect psychiatric as well as psychosomatic issues from past traumatic experiences.

A number of case reports discuss specific PTSD symptoms surrounding episodes of cannibalism that were witnessed or experienced by child and adult survivors of the Khmer Rouge and the famine that resulted.

Culture-Bound Syndromes

"Koucharang," or "thinking too much illness," is associated with past trauma and symptoms of headaches, behavioral changes, and other somatic complaints.

"Khyol," or "wind illness," may also refer to dizziness and fever, but commonly describes a disturbance of balance that can be due to a variety of illnesses.

"Sore neck syndrome" may entail headaches, blurry vision, tinnitus, dizziness, and palpitations/shortness of breath. This is thought to be a manifestation of panic disorder.

Pregnancy and Childbirth

Traditionally childbirth was at home, but among refugees and in Cambodia this is switching to hospital-based midwives or birth attendants (chmop). There is often a strong preference for female attendants. Delivery is thought to leave women susceptible to cold. Cambodian women are anecdotally noted to be stoic during childbirth.

Infections

Cambodia is noted to have a very high burden of tuberculosis (TB) with 64% of the population infected and an average annual death rate from TB of 13,000 people. Cambodian refugees are at even higher risk of infection due to crowded conditions in some camps. Multidrug resistance is known within Cambodia and some refugees may have been partially treated due to being moved between camps in Thailand. Infections remain the leading cause of death and disability in Cambodia according to the World Health Organization.

The current HIV prevalence rate is estimated at 0.8% as of 2007. However 40–50% of the prostitutes in Cambodia are thought to be HIV positive, and Cambodian emigrants thought to have practiced prostitution should be tested for a range of sexually transmitted diseases including HIV, syphilis, gonorrhea, and chlamydia. Other infections seen in refugees and Cambodian immigrants include: amebiasis, angiostrongyliasis, anthrax, capillariasis, chikungunya, cholera, cryptococcosis, cryptosporidiosis, cysticercosis, dengue, Japanese encephalitis, filariasis, gnathostomiasis, helminthiasis, hepatitis B (15% of the population in some studies), leishmaniasis, leprosy, leptospirosis, malaria, melioidosis, mycetoma, strongyloidiasis, trenatodes, tropical sprue, typhus, and yaws.

Cambodians are at also at a distinct risk for oral cancer associated with betel leaf exposure that is commonly chewed and kept like loose tobacco as a quid at the gum.

Related Topics

- ▶ Alternative and complementary medicine
- ▶ Betel nut
- ▶ Explanatory model of illness
- ▶ Health beliefs
- ▶ Posttraumatic stress disorder
- ▶ Refugee
- ▶ Refugee camp
- ▶ Refugee health and screening
- ▶ Refugee resettlement
- ▶ Refugee youth
- ▶ Trafficking
- ▶ Trauma
- ▶ Trauma exposure

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Canada

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History

Canada's history spans thousands of years – from the Paleo-Indians to the present day. Aboriginal people inhabited Canada for millennia, evolving trade networks, distinct spiritual beliefs, and social hierarchies. Long since faded before the arrival of the first Europeans, some of these civilizations were discovered through archaeological investigations. Through the years, various treaties and laws have been enacted between European settlers and the Aboriginal populations.

In the late fifteenth century, French and British explorers settled along Canada's Atlantic coast. After the Seven Years' War, in 1763, France ceded to Britain nearly all of its North American colonies. Shortly thereafter, Canada was formed as a federal dominion of four provinces. This marks the beginning of a rapid accumulation of provinces and territories and of increasing autonomy from the British Empire. Complete autonomy came with the Statute of Westminster of 1931 and was finalized in the Canada Act of 1982 – which severed all remnants of legal dependence on Britain's parliament.

Over the centuries, aspects of Aboriginal, French, British, and more recent immigrant customs have melded to form a rich Canadian culture. Canada has been influenced greatly by the United States; the two countries are similar in terms of geography, linguistics, and economics. Post–World War II, Canada has been committed to a policy that espouses socioeconomic development domestically and multilateralism abroad, contending that broad goals – such as nuclear disarmament – are best addressed with the cooperative assistance of many nations.

Today, Canada is comprised of ten provinces and three territories and is governed as both a parliamentary democracy and a constitutional monarchy with Queen Elizabeth II as its head of state.

Geography

Canada's national motto is "from sea to sea," as it includes most of the northern portion of North America, occupying 41% of the continent. In terms of total area, Canada is second only to Russia. Its territory spans an immense distance, from the Pacific Ocean to the west, the Atlantic Ocean to the east, the Arctic Ocean to the north, and the contiguous United States to the south. The country covers 9,984,670 km^2, with a land mass of 9,093,507 km^2. The northernmost settlement in the world is found in Canada, at the Canadian Forces Station (CFS) Alert. It is positioned on the northern tip of Ellesmere Island, just north of Alert, Nunavut – a mere 834 km from the North Pole.

Culture

Historically, Canadian culture was influenced heavily by European traditions, in particular those of Great Britain and France. Over time, aspects of the cultures of Canada's Aboriginal peoples and immigrant populations have become part of the fabric of the broader Canadian culture. The Aboriginal peoples include members of the *First Nations*, a term of ethnicity that refers to those whose ancestry is characterized as belonging to the indigenous peoples of the Americas. Canada's Aboriginal peoples are neither *Inuit* (Arctic-situated) nor *Métis* (mixed European-First Nations ancestry). Today, there are more than 630 recognized First Nations governments or bands spread across Canada; approximately 50% of its nearly 700,000 peoples are located in Ontario and British Columbia.

The Canadian government has influenced the culture in specific ways, one of which is through the use of Crown Corporations, Canada's various government-sponsored programs, laws, and institutions that promote and affect the culture through media endeavors such as the Canadian Broadcasting Corporation and the National Film Board of Canada. The government promotes numerous events that support Canadian traditions. Also, the government has tried to shape the culture going forward by regulating various media by setting and enforcing legal minimums on Canadian content. They accomplish this through the efforts of oversight bodies such as the Canadian Radio-television and Telecommunications Commission (CRTC). The CRTC is responsible for the regulation of all Canadian broadcasting and telecommunications activities. The best-known of these regulations is known collectively as the Canadian content rules. Canadian content, or CanCon, refers to the requirements that radio and television broadcasters must broadcast a certain percentage of content that was contributed to by persons from Canada. The rules apply to specialty channels as well, and they extend to the nature of the content itself. The CanCon rules are controversial, with one side contending that they preserve the legacy of a rich heritage that is uniquely Canadian, and the other contending that the rules are undemocratic and allow for the trampling of individual consumers' rights.

As Canada's territory was developed later than other European colonies in the Americas, symbols of pioneers, trappers, and traders were important in the early development of Canadian culture. Francophone is used to describe a natively French-speaking person, whether referring to individuals, groups, or places. The term refers specifically to people whose cultural background is associated primarily with the French language, regardless of ethnic and geographical differences. The Francophone culture beyond Europe is the legacy of the French colonial empire and the Belgian colonial empire.

The British conquest of Canada in 1759 brought a large Francophone population under British rule, and the migration of Loyalists from the 13 Colonies brought in British and American influences, thus creating the demand for compromise and accommodation. Comparatively, Canada's initial interactions with First Nations and Inuit populations were relatively peaceful as compared to the United States' initial interactions with its native peoples. Combined with an economic structure that developed later than other European interests, this served to allow the native people of Canada to have a significant influence on the national culture while simultaneously preserving their own unique identity.

Multiculturalism thrives in Canada and is manifest in various regional, aboriginal, and ethnic subcultures – such as the French Canadian of Quebec and the Celtic influences in Nova Scotia and Newfoundland. The Quebec Act of 1774 was an act of the Parliament of Great Britain; it outlined procedures for governance in the Province of Quebec. Key among the Act's components was the restoration of the use of French civil law for private matters, while the English law was preserved for common law, including criminal prosecution. The Act is viewed as critical to French Canada's early history.

Canada's multicultural heritage is protected Section 27 of the Canadian Charter of Rights and Freedoms, a bill of rights entrenched in the Constitution of Canada. In this section is written that interpretation should be consistent with the preservation of the multicultural heritage of Canadians. In many of the major cities, Montreal, Vancouver, and Toronto, multiculturalism is robust and part of the cultural norm, with diversity uniting the community.

Political System

The Canadian government is unusual in that it borrows from both the British and American models of government; it is both a federal system of parliamentary government with strong democratic traditions and a parliamentary democracy. At the signing of the Constitution Act, 1867, governance was established as a constitutional monarchy, wherein the Canadian Crown acts as the core of Canada's Westminster-style parliamentary democracy. In a constitutional monarchy, a monarch (an individual who rules for life) acts as head of state (the official leader of a nation) within the guidelines of a constitution, which can be written, unwritten, or blended. A constitutional monarchy differs from an absolute monarchy in that an absolute monarch is not legally bound by a constitution of any form and serves as the only source of political power.

The Crown is likened to a corporation, with the monarch at the center and the power of the whole shared by multiple institutions of government that act under the sovereign's authority. In this way, the Crown is the foundation of Canada's executive, legislative, and judicial branches. Aspects of governance are detailed in the Constitution of Canada. Notably, included in the document are items that have been developed over hundreds of years such as written statutes, court rulings, and conventions.

The head of Canada's executive branch is the king or queen of the United Kingdom, entrusted with powers over the legislative and judicial branches. Historically, this position is honorary rather than enforced, though should they decide, the monarch could assert considerable power over Canada. As they are geographically quite far apart, the monarch appoints a Canadian governor-general to oversee the executive powers. Although the executive branch typically bows to the will of parliament and the constitution, it does so by tradition rather than law.

Economy

Canada, one of the world's wealthiest nations, has the ninth largest economy worldwide and is a member of the Organization for Economic Co-operation and Development and Group of Eight. Canada resembles the USA in its market-oriented economic system and production pattern. As of November 2010, Canada was still recovering from the recent global financial crises; its national unemployment rate was 7.6%, with a range of 5.0% in Saskatchewan to 13.8% in Newfoundland and Labrador. In 2008, Canada had 69 companies on Forbes's list of the 2,000 largest companies in the world. As of 2008, Canada's total government debt burden was the lowest in the G8.

Canada has considerable natural resources, for example, the fishing industry (British Columbia) and the oil and gas industry (Alberta, Saskatchewan, Newfoundland, and Labrador). Northern Ontario holds numerous mines, and historically the fishing industry has been of chief importance to the Atlantic Provinces. Mineral resources include coal, copper, iron ore, and gold. The Canadian economy relies heavily on the international trade of its natural resources. In 2009, agricultural, energy, forestry, and mining exports accounted for nearly 60% of its total exports, while machinery, equipment, automotive products, and other manufactures comprised 38% of exports. The United States is Canada's largest trading partner, accounting roughly for 73% of exports and 63% of imports.

Healthcare

Healthcare is delivered through a publicly funded system that is, for the most part free at the point of use, with most services provided by private entities. The system is guided by the Canada Health Act (CHA) of 1984. The CHA contains the stipulations with which the provincial and territorial health insurance programs must conform to receive federal payments. Criteria include universal coverage without co-payments for all "insured persons" for all "medically necessary" hospital and physician services.

The government establishes quality controls through federal standards; however, it is not involved in day-to-day care. Providers are responsible for handling insurance claims against the provincial insurer; the patient is not involved in the claims process. Private insurance is involved minimally in the overall health care system. Although costs are paid primarily through funding from income taxes, three provinces impose an additional monthly premium.

Pharmaceutical medications for the elderly or indigent are covered by public funds or through employment-based private insurance. To control costs, drug prices are negotiated between the federal government and suppliers. If a patient wishes to see a specialist or is counseled to see a specialist, a referral can be made by the family physician. Emphasis is placed on preventive care; annual checkups are encouraged.

Canada's Immigration Policy and Trends

Relative to its current population, Canada accepts more than twice as many legal immigrants than the United States. Boasting the world's second largest land mass, Canada has had a longstanding immigrant-friendly migration policy. In the 1960s, two key developments had far-reaching effects on the country's policy: the establishment of a point system that favors the highly skilled and the abolishment of provisions that allowed for the screening out of non-Whites. These events provided the possibility of admission to minorities who had been shut out previously. A large wave of immigrants quickly followed, with Chinese, Indians, and Filipinos arriving in the greatest numbers.

With the second largest land mass worldwide and a population only one-ninth that of the USA, Canada has tremendous growth potential. The point system has served to influence positively public perception of immigration. It promotes the theme that Canada is receiving immigrants that it needs, immigrants that are vital to its growth and economy. Other factors that support immigration include: children of immigrants typically do well academically and socially; Canada's economic downturn has been fairly mild in comparison to other developed countries; and the virtual absence of illegal immigration has removed a dominant source of the conflict that surrounds immigration in other countries such as the United States.

Multiculturalism is pervasive throughout Canada, permeating a political culture that is accommodating and attractive to immigrants. While intense debates over immigration are seen in many developed nations, from Australia to Sweden to the USA, Canada is nearly devoid of such anti-immigration sentiment. In fact, few nations accept more immigrants per capita. Recently, the Canadian province of Manitoba petitioned and won the right to bring greater numbers of foreigners in. As they select ethnic and occupational groups judged most likely to stay, currently approximately 600 immigrants each month arrive in and around the province.

Related Topics

► Health care
► Multiculturalism

Suggested Readings

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Suggested Resources

For information on the Canadian Broadcasting Corporation. http://www.cbc.ca/

For information on the governance of Canada. http://canada.gc.ca/home.html

Cancer

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Cancer Prevalence

In 2007, there were over 12 million new cancer cases worldwide, with 5.4 million diagnosed in developed countries and 6.7 million diagnosed in developing countries. Globally, there were approximately 20,000 cancer deaths per day. Of the 7.6 million deaths per year, 2.9 and 4.7 million occurred in developed and developing countries, respectively. In developed countries, the three most common cancers among men were prostate, lung, and colorectal, and among women are breast, colorectal, and lung. In developing countries, the three most common cancers among men were lung, stomach, and liver, and among women were breast, cervix, and stomach.

There are regional differences in cancer types depending on the availability and quality of prevention and treatment services, prevalence of risk factors, age of population, and reporting mechanisms. Rates of specific cancers in regions are crucial as the incidence of cancer for new immigrants closely mirrors their home country's rates. Cervical cancer is the most common cancer of Eastern and Southern Africa, Central America, and South Central Asia. Breast cancer is the most common cancer in Northern and Western Africa, South America, Western Asia, and Northern and Western Europe. Prostate cancer is the most common cancer in the Caribbean and North America. Lung cancer is the most common cancer in Southeast Asia, Eastern and Southern Europe, and Micronesia. The remaining regions of the world have the following most common cancers: Kaposi sarcoma (Middle Africa), stomach (Eastern Asia), colon and rectum (Australia/New Zealand), and oral cavity (Melanesia).

Cancer Incidence and the Healthy Migrant Effect

Data from the US National Institutes of Health's Surveillance Epidemiology and End Results (SEER), a dataset of regional cancer registries in the USA and other countries, found that cancer rates from new immigrants to the USA were the same as rates from their native country. Latino immigrants to the USA suffer from relatively rare cancers in their new country but have lower rates of common cancers. However, the immigrants' future generations experience similar cancers and cancer rates as the host country. In their move to Western countries, within a generation immigrants from Africa and Asia have the same cancer rates as that of their host country, even when rates in their country of origin are low. Also called the healthy migrant effect, new immigrants often are healthier and less likely to die from cancer. Assimilation to the new country's pollution levels, diet, smoking, and other behaviors over time changes one's susceptibility to cancer over the life span.

Disparities

Tobacco Use and Cancer

Tobacco use is one of the greatest risk factors for cancer. Differences in tobacco use between developed and developing countries are great: adults in developing countries use tobacco nearly 1.5 times greater than developed countries. However, there is a large variation among regions and countries and frequency of use. While Asian-Americans have the lowest smoking rates in the USA, Asian immigrant groups have the highest smoking rates of all US residents, ranging from 34% to 43% for Asian immigrants versus 10.4% for US-born Asians.

Smoking cessation programs are unevenly accessed by immigrant populations, despite their desire to quit. Latino smokers in the USA are half as likely to have ever used nicotine replacement therapy compared to Whites. Barriers to accessing these programs include lack of insurance, lack of awareness of the benefits of a cessation method, and receiving no information on how to quit from a physician.

Diet and Colorectal Cancer

Colon and rectal cancer (CRC) is the fourth and third most common cancer worldwide for men and women, respectively. However, CRC incidence is markedly higher among developed countries (third and second most common) than developing countries (fifth most common for men and women). Immigrants from countries with lower CRC rates continue to have lower rates after they migrated to a high CRC country. However, the immigrant's offspring experiences similar to or higher than the country's nonimmigrant populations.

Changes in CRC rates over the generations point to dietary changes. CRC risk factors include a diet high in animal fats and low in fiber, fruits, and vegetables. Other risk factors include alcohol use, obesity, physical inactivity, and smoking. Acculturation to a new country's diet, such as Asian and South Asian immigrants' children in the USA, increases their CRC risk.

Preventive Care

Unfamiliarity with prevention and early detection of cancer prevents many immigrants from being screened. Without symptoms, many foreign-born populations feel they do not need to visit a physician. When a doctor does not recommend regular examinations, cancer screening is often viewed as pointless. In studies on cervical cancer, foreign-born women said that women only go to the gynecologist when they had pain, unexplained bleeding, or were pregnant.

Viruses cause approximately 18% of cancers globally, with a larger percentage (26%) affecting developing nations than in developed countries (8%). Cancers such as cervical, liver, and stomach cancers and Burkitt's lymphoma are all caused by viruses. Vaccines for the human papillomavirus (HPV), the virus that causes cervical cancer, and hepatitis B and C, the viruses that cause liver cancer, are available but are often expensive and difficult to find in developing countries. Immigrants without these vaccines may migrate to a new country already infected with the virus or have no knowledge of a vaccine that can protect them.

Barriers to Care

Cultural Beliefs and Cervical and Breast Cancer

Cultural beliefs play a large role in cervical and breast cancer screening. Women from many cultures believe cervical cancer is caused by sexual activity and lack of hygiene and not the human papillomavirus (HPV). Latina immigrants are most likely to associate cervical cancer with lack of genital cleanliness after sex. Other thought causes of the cancer include sex during menstruation, sex at an early age, rape, and general poor hygiene. Mexican- and Salvadorian-born women report physical trauma to the breast, from accidental bumps to falling on something sharp to rough breastfeeding, can cause breast cancer.

Breast and cervical cancer is also associated with karma or fate. In these cases, foreign-born women feel that those with cervical cancer are being punished for improper behavior. Younger Asian and Pacific Islander immigrants associate cervical cancer with promiscuity. Women from Southeast Asia and Cambodia linked cervical cancer to karma and were less likely to be screened. Foreign-born Latinas are more likely than native-born Latinas to feel that God gives people breast cancer for leading bad lives. Many cultures feel that following behavioral standards and norms will keep the body healthy. Foreign-born physicians may also hold these views and not recommend Pap smears and breast exams for younger, unmarried patients.

Foreign-born women with fatalistic attitudes associated with breast and cervical cancer are less likely to be screened for breast and cervical cancer. Latina immigrants are more likely to believe that having cancer is a death sentence. Holding fatalistic views make immigrants less likely to seek preventive care. Screening is seen as pointless if cancer is unavoidable.

Acculturation

The length of time immigrants spend in their host country affects the probability they will be screened for cancer. For all cancer screening, naturalized citizens are more likely to be screened for cancer than noncitizens of the same nationality. Women residing in the USA less than 10 years were up to 20% less likely to receive cervical cancer screening than women residing longer. Latina women who spoke mostly Spanish are the least likely immigrant group in the USA to have had a Pap smear in the last 3 years. The more acculturated an individual is, the more likely they will be screened for cancer.

Language and Health Literacy

Speaking the host country's dominant language and being able to understand health information and services greatly affect access to care. Studies show that language barriers with a health care provider lower patient satisfaction and increase feelings that his or her questions and concerns were not addressed. Women who do not speak the host country's native language are less likely to receive breast and cervical cancer screening according to guidelines. While hiring interpreters decreases language barriers, the delays caused in scheduling and recruiting can lead to stress for both the patient and the provider.

Likewise, while patient education materials are often written in multiple languages, they are seldom written at or below a sixth-grade reading level. Knowledge of cancer screening guidelines is a strong predictor of being screened for cancer among all immigrant groups. Korean immigrants were three times more likely to have regular Pap regular screenings if they knew the recommended Pap smear guidelines. Both language and lack of health literacy are a major obstacle to education on cancer risks, prevention practices, and the benefits of screening.

Geography

Physical location can determine the likelihood of receiving cancer-related services. Immigrants living in urban locations, while commonly more equipped with cancer screening facilities, often face barriers with transportation and parking costs and availability and scheduling of services. Neighborhood safety of affordable services may be a factor in obtaining screening and treatment.

Immigrants living in rural areas face a different set of obstacles. In remote areas of many countries, health services may be few and far between, requiring the patient to travel hours for appropriate services. Lack of public health infrastructure in these areas puts the burden on the individual to find cancer-related information.

In large countries, like the USA, there may also be regional differences in cancer care. Mexican women were found to have different cancer screening rates across different states within the USA. With each state governing their own public health infrastructure and differing access to local resources, a country may have varying resources and barriers to care for immigrants.

Insurance Access

Access to health care insurance in countries like the USA is vital to accessing a continuous source of care. Compared to the native-born, immigrants are more likely to be uninsured and less likely to have been treated by a physician in the last year. While the uninsured rate for US-born citizens is 13.4%, naturalized citizens, foreign-born individuals, and noncitizens were uninsured at 17.9%, 33.6%, and 43.6%, respectively. The uninsured are less likely to have had routine examinations, including cancer screening tests. Uninsured patients, in general, are more likely to be diagnosed with late-stage cancer than those with insurance.

Private insurance is often expensive, the number one reason for being uninsured. Immigrants are less likely to have employer-based insurance and insurance coverage through a spouse. While legislation like the US Patient Protection and Affordable Care Act, enacted in 2010, provides assistance for citizens and legal immigrants to purchase health insurance through an employer or a health insurance exchange, it does not provide assistance to undocumented immigrants. Private health insurance also commonly requires a co-pay, which is often cost prohibitive to low-income immigrants.

In the USA, immigrants' access to federal programs is dependent on their immigrant status and income. Legal permanent residents (LPRs) – immigrants legally granted the privilege of residing permanently in the USA – with 40 work quarters (10 years of work) are eligible for Medicaid, a health program for low-income families. Noncitizen nationals (people born in American Samoa or Swain's Island), members (born outside the USA) of Indian tribes, and members of Hmong or Highland Laotian tribes that helped the US military during the Vietnam era who are legally living in the USA, their spouses or surviving spouses, and dependent children are eligible for Medicaid given they meet other income requirements. Asylees, refugees granted asylum, Cuban or Haitian entrants, Amerasian immigrants, and LPRs with a military connection are eligible for Medicaid benefits without a waiting period.

The State Children's Health Insurance Program (SCHIP), a health insurance program for low-income children, gives access to children of LPRs after the first 5 years of residency. Some states opt to use state money to cover children of LPRs during the waiting period. Refugee children are eligible for SCHIP during the first 7 years of their residency.

The majority of immigrants in the USA do not qualify for Medicaid; these populations have minimal options for cancer care. The Emergency Medicaid Treatment and Active Labor Act (EMTALA) requires hospitals and medical facilities to provide emergency care to individuals regardless of citizenship status, legal status, or their ability to pay. Emergency Medicaid does not cover patient's needs after treatment, including follow-up appointments, long-term medication, and follow-up tests. Community health centers are required to give care to everyone regardless of their ability to pay. While neither EMTALA nor community health centers are required to collect citizenship status, undocumented immigrants are less likely to seek care if they think they may be asked for documentation.

Continuity of Care

Uninsured patients are significantly less likely to have a continuous source of care. The uninsured are more likely to visit community health centers, urgent care centers, and emergency rooms – facilities that are not equipped to handle long-term diseases like cancer. Having a continuous source of care, no matter the type of doctor, increases a patient's access to preventive health care. Korean and Filipino women with a prior preventive health exam were three and five times more likely to have been screened for breast and cervical cancer than women without a checkup. Similarly, women seeing a doctor for their current pregnancy were nearly 250% more likely to have ever had a Pap smear and over 775% more likely to have had one within the last 3 years. Immigrants without a regular source of care are more likely to rely on emergency rooms when their condition becomes unbearable and commonly miss routine cancer screenings that could find cancer at a more treatable stage.

Low Socioeconomic Status

Immigrants' socioeconomic status – an intersection of income, education, and occupation – heavily affects their ability to access cancer screening and treatment. Co-pays associated with health insurance, designed to prevent overuse of services, can be a deterrent to care. Even when health care is free, there are other costs that may make screening prohibitive. Cambodian immigrants in the USA reported that lack of affordable transportation to services was one of the biggest reasons for not receiving cancer screening.

Immigrants tend to work in the lowest paying jobs without the option to take time off for doctor appointments. Rates of cervical cancer incidence increase with lower socioeconomic status across all ethnic groups. Being poor is one of the biggest predictors of a late-stage cancer diagnosis. Often, immigrants must choose between health care and other necessities, such as food or heat, or between getting care and losing their job. Regardless of country of origin or ethnicity, people with low socioeconomic backgrounds have worse cancer outcomes.

Related Topics

- ► Acculturation
- ► Cancer health disparities
- ► Cancer mortality
- ► Health barriers
- ► Health beliefs
- ► Health literacy
- ► Healthy immigrant
- ► Immigration status
- ► Language barriers
- ► Public health
- ► Public health insurance
- ► Smoking
- ► Tobacco
- ► Tobacco use
- ► Undocumented

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Cancer Health Disparities

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Immigrants to the USA may have health-related protective and/or detrimental health behaviors, cultural beliefs that contribute to their perception of health and health care, their view of the disease called cancer, or preexisting conditions. It should be noted, however, that the new resources available in the USA, the resident culture of Americans and assimilated migrants, and the immigrant experience itself may affect their health outcomes and health-seeking behavior over time. Thus, health outcomes found in donor countries do not necessarily correspond to outcomes for migrants to the USA.

Cancer is a group of diseases characterized by abnormal cell growth and spread or metastasis. There are over 100 different types of cancer. Cancer is the second leading cause of death in the USA and accounts for significant morbidity and mortality globally. The National Cancer Institute (NCI) defines "cancer health disparities" as "differences in the incidence, prevalence, mortality, and burden of cancer and related adverse health conditions that exist among specific population groups in the United States." Cancer survivorship disparities are included in this definition.

Health disparities are defined as "differences in the incidence, prevalence, mortality, and burden of diseases and other adverse health conditions that exist among specific population groups in the United States."A health disparity population is one in which there are significant differences in the overall rate of disease incidence, prevalence, morbidity, mortality, or survival rates in the population as compared to the health status of the general population.

Complex and interrelated factors contribute to the observed disparities in cancer incidence and death among racial, ethnic, and underserved groups including immigrants. Health behaviors, cultural factors and language barriers, health care access, satisfaction with health care, and risk/exposures from the "parent country" all have significant influences on cancer disparities. When describing, monitoring, and addressing cancer disparities for immigrants, it is critical to consider worldwide cancer rates in the parent country as well as US rates. Contributing factors include:

- Major risk/exposures including tobacco use, occupational exposures, SES, alcohol intake, viral (EBV, HBV, BCV, HPV)
- Health care seeking and access to health care
- Advanced stage at diagnosis
- Culture, language, and beliefs
- Participation in clinical trials
- Discrimination in the health care delivery system
- Biology

Immigrant Factors

Identification and understanding of factors unique to immigrant communities are essential to address cancer health disparities in such richly diverse communities.

- *Migration factors* and related differential risk/exposures and generational issues: documented for many immigrants including Japanese immigrants, Latinos, and some African immigrants.

- *Acculturation*: Documented for Latino/Hispanic communities especially for dietary patterns and nutritional consumption.
- *Language and cultural influences*: Related to access to health care, health literacy, treatment regimen, and medication compliance. It is also related to gender factors for Latino and Asian females who often prefer a female health care professional.
- *Discrimination, satisfaction with health care, and racial/ethnic concordance between patient and provider*: Documented for Latino/Hispanic, Asian, and African immigrants.

Cancer incidence patterns among first-generation immigrants are often nearly identical to those of their native country. Through subsequent generations, these patterns evolve to resemble those found in the USA especially for hormone-related cancers, such as breast, prostate, and ovarian cancer and neoplasms of the uterine corpus and cancers attributable to westernized diets, such as colorectal malignancies. Longer residence in the USA appears to lead to lower rates of cancers attributed to Asian diets, such as stomach cancer associated with the highly salted and nitrite-containing foods common in Asia. Studies have documented the following:

- Known viral-related cancers include primary liver cancer caused by hepatitis B and C.
- *Helicobacter pylori* related to stomach cancer incidence.
- Cervical cancer caused by human papillomavirus (HPV) has been documented as a worldwide cause of elevated cervical cancer rates in Latin America, Mexico, Africa, and parts of Asia.
- Environmental factors and cancer in immigrants: nasopharyngeal cancer associated with exposure to smoke from stoves used for cooking in the home and salivary cancer associated with cold, dark environments that produce vitamin A deficiencies.

Cancer disparities and immigrant studies have been reported, with an emphasis on environmental factors and cancer risk. This includes:

- First- and second-generation Japanese immigrants living in Hawaii
- Asian-American women
- Africans including primary liver cancer
- Vietnamese-Americans
- Hmong refugees from Vietnam, Laos, and Thailand settled in California
- Korean-Americans
- Pacific Islanders and Alaska Natives
- African and Asian men: cancer of the penis
- Asians and esophageal cancer and stomach cancer
- Migrant farm workers in California, many of whom were recent Mexican immigrants:
  - Lack of access to care, including screening programs and treatment was identified as a contributor to cancer disparities for migrant farm workers.
  - Higher incidences of brain cancer and leukemia were attributed to occupational exposures, particularly to pesticides.

Cancer mortality is related to the interaction of complex factors such as stage at diagnosis, cell type and tumor biology, access to quality oncology care, and follow-up. Cultural and language influences of new and existing immigrants to the USA are related to cancer outcomes.

Disparities in Racial/Ethnic Groups

Overall, African-American males develop cancer 15% more frequently than White males. African-American woman have a lower breast cancer rate, but higher death rate than White women. For all cancers combined, Blacks have the greatest burden, with incidence and death rates higher than any other racial/ethnic group, specifically a death rate 25% higher than Whites. Although Whites have the highest breast cancer rate, for all ages combined, of any racial/ethnic group, Blacks are more likely to die from this disease. This may be caused by lack of medical coverage and late detection, as well as unequal access to improvements in medicine. There is also some research that shows that Blacks and Latinas are more likely to have a more aggressive form of breast cancer than other races. Latinas and Black women also have the highest rates of cervical cancer, with Black women having a higher death rate. This high rate is due to the lack of screening and persistent infection with certain strains of HPV. African-American men have the highest incidence and death rate for prostate cancer, with a death rate twice that of Whites. Blacks have higher incidence and death rates of both colorectal and lung/bronchus cancers.

Latinas and Black women have the highest rates of cervical cancer, and though Black women have a higher death rate, Latinas have a higher incidence rate. This high rate is likely due to the lack of screening and persistent infection with certain strains of HPV. Latinos have the lowest rates of colorectal and lung cancer of any US racial/ethnic group.

Overall cancer incidence rates are lower for Asians and Pacific Islanders living in the USA than non-Hispanic Whites, with the exception of Native Hawaiian women, who have statistically higher all cancer combined rates than White women. The Asian and Pacific Islander (API) population have the highest rates of liver and stomach cancers. They suffer more often from cancers that are related to certain infections, though more study is needed.

Asian and Pacific Islanders should not be viewed as one, homogenous group, however, especially regarding cancer disparities. For example, Barry Miller and colleagues examined varying patterns in cancer incidence and mortality among the API population. A majority of the sample for this study was born outside the USA, with the exception of Native Hawaiians and Japanese-Americans. They found that liver cancer is highest among Laotian men, though liver cancer incidence and death rates were higher than non-Hispanic Whites for both men and women. The presumed cause was hepatitis B and C infection, which are endemic in Asian, Middle Eastern, and African countries. Laotian men also had the highest rates of liver, prostate, and stomach cancers, while Japanese men and women had the highest colorectal cancer rates. Stomach cancer rates were also high for many of the API groups, with the exception of Asian Indians/Pakistanis and Filipinos. Samoan and Native Hawaiian men were found to have the highest overall cancer rates, because of high rates of prostate and lung cancers, but they are not higher than those of White men. Lung cancer was among the four cancers most frequently experienced by all the API women groups, as was colorectal cancer (for those for whom they had enough data). Native Hawaiian, Samoan, and Tongan women have the highest overall cancer rates, higher even that White women. Breast cancer was highest among Native Hawaiian women. Vietnamese women were found to have higher rates of cervical cancer than White women, along with Kampuchean, Korean, and Laotian women. In another study, Chinese and several Southeast Asian immigrants have also been found to be at increased risk for nasopharyngeal cancer, with suggested causes including high consumption of preserved foods from an early age.

Alaska Natives have higher rates of colon and rectal cancer than the national average. American Indians have the lowest cancer survival rates of any US ethnic group. Native American data are not representative, but they have been shown to have higher rates of kidney and renal pelvis cancers than other racial/ethnic groups.

Eleven million cases of cancer occur annually worldwide, six million of them in low- and middle-income countries. In recent years, four million deaths from cancer have occurred each year in low- and middle-income countries. High smoking rates in these countries have made lung cancer the most common form. Of the approximately 1.1 billion smokers in the world, 80% of them live in low/middle-income countries. In developing countries, 26% of all cancers are attributable to infectious agents, compared to about 8% in high-income countries.

Nearly 300,000 women die every year from cervical cancer every year, 85% of them from low/middle-income countries; the likely cause is infection with one of several strains of human papilloma virus (HPV). Disparities in cancer outcomes worldwide pertain to children as well as adults.

One hundred and sixty thousand children worldwide are diagnosed with cancer; currently, 80% of US children under 15 are cured, while 80% of children in low/middle-income countries die because of late diagnosis and lack of treatment. In developing countries, most cancers may already be incurable when first noted, because cancer stage at time of detection is typically much further advanced than in wealthier countries. Patients in low/middle-income countries also tend to have additional health problems that may make their recovery from cancer more difficult.

Approaches to Address Cancer Disparities in Immigrants

The unique cultural and cancer patterns of immigrants require careful strategies and program development to successfully address cancer disparities in such diverse communities. Going beyond translation services is mandated. Assuring culturally competent and relevant prevention, screening and early detection and quality treatment necessitates bidirectional community engagement between communities and the health care delivery system. Models such as WINCART, AANCART, Redes En Accion, and the New York Center for Immigrant Health's Cancer Disparities Program are examples of community engaged and tailored programs, including for immigrants, which address cancer health disparities for diverse communities.

Related Topics

- ► Barriers to care
- ► Breast cancer screening
- ► Cancer mortality
- ► Cultural competence
- ► Environmental exposure
- ► Ethnicity

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Cancer Incidence

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According to the current population survey, 28.4 million immigrants now reside in the United States, a 43% increase since 1990. Many immigrants that settle in the United States bring with them age-old traditions and practices that may be different from Western customs. Cultural factors may affect their risks for certain diseases such as cancer as well as impact their use of the American health care system. Therefore, the study of disease patterns in immigrant populations has become an important area of research in the field of public health. There are differences in the incidence, prevalence, mortality, and burden of cancer among specific population groups in the United States. This has created opportunities for research and much debate about the causes of health disparities between ethnic and racial groups.

Addressing cancer health disparities has become a priority for the United States government's principal agency on cancer research, the National Cancer Institute (NCI) and other major cancer organizations like the American Cancer Society (ACS), in addition to medical centers and community-based organizations. Cancer trends may give researchers some insight into how different aspects of culture like diet, exercise, and religious beliefs and practices may affect risks for cancer in addition to health care access issues. Studies have shown that cancer incidence patterns of immigrants tend to mirror those of their native countries. Through subsequent generations, however, cancer incidence patterns change to resemble those in the United States, particularly in cancers related to hormones, such as breast, prostate, and ovarian cancer and cancers related to Westernized diets, like colorectal cancers. Later generations tend to abandon some of their cultural practices and adopt an American lifestyle that typically includes a diet high in fat and processed foods. An example of this phenomenon is that Asians living in the Far East have lower incidence of breast and prostate cancers than their American counterparts. However, when Asians migrate to the United States, in time their risk of breast and prostate cancer becomes similar to those of people in this country. These changes typically start to take effect with the second generation and become more prominent by the third generation.

There are methodological issues that may impede research on cancer incidence among immigrant populations as well as cultural factors. The population-based Surveillance, Epidemiology, and End Results (SEER) program of the NCI is an important resource for the study of cancer incidence and prevalence among immigrant and minority populations. SEER collects and publishes cancer incidence and survival data including patient demographics, primary tumor site, tumor morphology and stage at diagnosis, first course of treatment, and follow-up for vital status from population-based cancer registries covering approximately 26% of the US population. Collecting information on place of birth is an important variable for studies of immigrants. Although these data are collected by SEER registries, the information is often missing for a significant number of patients. SEER registries rely on hospitals for this information, many of which do not have uniform data collection systems and birthplace information if often not included. Additionally, many immigrants do not know certain aspects of their medical history including their family history because of distance between family members and customs that may prohibit discussions about cancer diagnoses. They may not know if any of their relatives had cancers that could potentially put them at a higher risk of one day developing the disease. Knowing a patient's family history is important for research purposes and to also help practitioners to determine a patient's risk for familial cancers and an appropriate screening schedule.

Health disparities research will likely continue to be a priority in areas with large immigrant populations. Understanding incidence rates among different populations is important to help health practitioners and health educators to develop tailored culturally appropriate education and early detection campaigns in addition to effective treatments. Information gleaned from this research could also have far-reaching effects by improving cancer outreach and treatments efforts worldwide through international collaborations.

Related Topics

- ► Cancer health disparities
- ► Cancer mortality
- ► Cancer prevention
- ► Health barriers
- ► Health beliefs
- ► Health disparities

Suggested Resources

American Cancer Society. http://Cancer.org

Current population survey. http://www.census.gov/cps/

National Cancer Institute Center to Reduce Cancer Health Disparities. http://crchd.cancer.gov/disparities/defined.html

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Cancer Mortality

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Cancer mortality is determined by the risk of developing cancer (cancer incidence) and factors that influence the survival after cancer diagnosis. Some cancers, such as colorectal or breast cancer, are better detectable and treatable than others as opposed to, for example, liver, stomach, and pancreatic cancer, which are less curable. Survival from the former can be influenced by adequate prevention, screening, and therapy. Disparities in cancer mortality and survival may therefore be ascribed to differences in (i) disease susceptibilities, (ii) exposures to carcinogens, (iii) access to cancer prevention and (iv) quality of treatment.

Cancer burden, particularly cancer mortality, shows substantial variation within and across populations. Individual and area-based differences in socioeconomic position – comprising education, occupation, income, housing situation and social environments – are associated with poor access to prevention measures, suboptimal treatment, and follow-up as well as a higher mortality within certain population groups. Disparities in cancer mortality across populations, for example, between allochthonous (immigrant) and indigenous (native) people of a country may reflect the importance of another prognostic factor: ethnicity. Several studies suggest negative correlations and a close connection between the two, since immigrants are often likely to be socially disadvantaged in their country of residence. In this context, immigrants are defined as persons or groups that leave their country of origin in order to settle permanently in another, whereas ethnicity corresponds to a social construct that is based on shared beliefs, views, lifestyles, and cultural habits – mostly also common origin. Thus, immigrants usually belong to (or consider themselves members of) a certain ethnic minority group and are therefore of "foreign ethnicity."

In less well-developed regions of the world, infectious diseases still dominate as primary causes of disease and death. However, due to the epidemiologic health transition, low-income countries undergo a shift of global burden of disease, entailing ageing populations and an increasing occurrence of chronic conditions like cancer. Still, cancer incidence is rather low in these countries, but cancer mortality plays a big role in comparison to more developed regions. Immigrants from non-Western/low income countries retain some features of their countries of origin and carry their cancer risk profile (characterized by low incidences but high mortality) to their new country of residence, where they face new exposures and environments. Several studies confirm that migrants show substantial risk diversity in comparison to the indigenous population and indicate elevated risks for cancers that are associated with infections, like cervical, liver, or stomach cancer. Those risks strongly relate to exposures experienced in early life/childhood and thus underscore the importance of the life-course perspective in carcinogenesis. Lower risks are observed for lifestyle-related cancers such as breast, colorectal, or prostate cancer.

Several studies show that African Americans are disproportionally more likely to develop and to die from cancer than any other ethnicity. This applies to all cancer sites combined as well as in particular to cancer of the esophagus, oral cavity, stomach, liver, and prostate where large discrepancies exist and risks are often more than twice as high compared to Whites. Moreover, even mortality from cancers associated to lifestyle factors is elevated in this population group (i.e. breast, lung, and colorectal cancer); however, this pattern is more pronounced among men. Migrants from Asia often exhibit high mortality rates for cancers of the oral cavity, nasopharynx, stomach, and liver. Similar observations have been made for immigrant populations residing in European countries. South American migrants were found to be more likely to die from cancer of the nasopharynx, stomach, liver, gallbladder, and cervix as well as Hodgkin's disease; migrants from Turkey show high mortality rates for cancer of the nasopharynx, stomach, liver, thyroid gland, and Hodgkin's disease in comparison to autochthonous populations of their western host countries, respectively.

Key factors that may explain disparities in cancer mortality across ethnicities are differences in stage of disease at diagnosis as well as treatment, compliance, and survivorship.

Cancer Stage at Diagnosis

Cancer burden could be decreased significantly if patients with cancer would be detected and treated early and thus more effectively. Early detection implies recognizing symptoms in due time and immediate seeking of medical care. Regular attendance in screening programs helps identifying early or pre-cancerous stages for some cancer sites, before any obvious symptoms occur.

Several studies report that immigrants are more likely to be non-attendees in screening programs and tend to present at later and less curable stages of cancer than indigenous populations of their host countries.

There are various reasons for non-attendance, the most important barriers being personal (literacy, language skills, health knowledge), cultural (religious beliefs, differences in health seeking behaviors, perception of symptoms), and financial (health insurance status) factors. Personal beliefs about illness, especially culturally determined disease perception, have been found to have a major impact on the time of first diagnosis, survival, and mortality.

Treatment, Compliance, and Survival

Adequate treatment and care are essential to reduce cancer mortality. This especially applies for cancers that have high cure rates when detected at an early stage and treated according to best practice (such as breast and colorectal cancer). Cancer patients require continuous medical care and psychosocial support on how to maintain physical, emotional, social, and spiritual health and how to cope with long-term effects of therapy. Response to illness and coping mechanisms vary across ethnicities and can influence the success of treatment and may distinguish outcomes. Sociocultural factors are very important in decision-making processes: they may determine adherence to treatment and willingness to develop health-maintaining behaviors as well as personal allowance for appropriate follow-up, surveillance, and post-treatment monitoring.

Studies show that immigrants are all too often less likely to receive appropriate cancer care. In this regard, survival is especially poor for cancers that require complex and costly therapies (e.g., stomach cancer and leukemia). It has also been observed that cancer patients with migration backgrounds are more likely to be affected by treatment complications and are less likely to adhere to medication regimens. For example, Chinese American women decline therapy more often compared to White women and women of other ethnicities. Especially among women, often other obligations, such as care giving, family, or employment, dominate over the need for the own medical care, amplified by logistic factors like extra costs, difficult transportation, and additional time expenditure. Furthermore, evidence suggests a high prevalence of comorbidities in immigrant groups, possibly entailing poorer health outcomes and poorer cancer survival.

Ineffective and insufficient treatment often results from inadequate communication between health care providers and patients. Consequently, patients with limited literacy and language skills do not always receive proper information about treatment options, possibly leading to suboptimal treatment choices. Moreover, the provision of culturally sensitive support and treatment for minority cancer patients is often hampered by the lack of relevant information available to clinicians and oncologists. Treatment plans have to incorporate culturally relevant differences in care seeking and disease coping.

In conclusion, ethnicity and immigration status represent important prognostic factors for cancer survival, and disparities can partly be explained by diverse cancer risk patterns, a later stage at diagnosis and differentials in treatment and care. Thorough research has been dedicated to the role of socioeconomic determinants on cancer mortality, but the independent effect of ethnicity stays unclear and still needs to be evaluated. Differences in cancer mortality between populations may underscore existing inequalities in early detection as well as treatment and require culturally sensitive prevention programs, targeting high risk groups. Ethnic inequalities in cancer mortality are not yet adequately documented and require careful surveillance and action.

Related Topics

- ► Breast cancer
- ► Cancer
- ► Cancer incidence
- ► Cancer prevention
- ► Colorectal cancer
- ► Health determinants

Suggested Readings

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Cancer Prevention

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Cancer is one of the most important causes of death worldwide. Cancer burden, however, varies widely across geographical regions as well as across ethnic groups. According to the World Health Organization (WHO), many cancers are associated with risk factors such as smoking, excessive alcohol consumption, certain dietary patterns, and lack of physical activity. Others are caused by infectious agents. Many cancers are therefore partly preventable. In general, cancer prevention is achieved on different levels and comprises (1) the complete prevention of the disease using methods that avert the exposure to risk factors (primary prevention), (2) early detection of disease and the limitation of its effects after diagnosis (secondary prevention), and (3) the avoidance of further disabilities in persons diagnosed with cancer (tertiary prevention).

Assuring equality with regard to healthcare services and access to preventive medicine is sought by many industrialized countries and is gaining political importance. Quality of and access to healthcare are important preconditions for health and should be free from bounds to socioeconomic position and ethnic origin. Nevertheless, disparities attributable to social determinants such as education, occupation, social status, housing, and the degree of integration in social environments exist and result in social gradients of health within countries. Concomitance of low socioeconomic status (SES) and (a foreign) ethnicity, corresponding to cultural differences and cross-country variations, are known to amplify health gaps in populations.

The coherent roles of social and cultural determinants need to be disentangled in order to appreciate the detached impact of culture on health. Ethnicity is a social construct, referring to one's sense of identity in a cultural group or society. Unlike race, ethnicity is not restricted to phenotypes and is motivated by sharing certain views, lifestyles, and cultural habits. Immigrants of non-Western origin often represent ethnic minority groups in their countries of residence and share cultural identities as well as common ideals and goals. Their individual health care needs require careful analysis and need to be addressed by sensitive targeting of prevention programs.

There may be differences in cancer risk across ethnicities, meaning immigrant groups, and causal factors which determine those differences. Additionally, there are barriers in access to cancer prevention that immigrants might face. We propose how ethnic minorities should ideally be targeted with respect to cancer risk reduction.

Cancer and Culture: Disease Susceptibility, Perception, and Healthcare Utilization

Immigrants are equipped with unique constellations of disease risk patterns and exposures experienced before, during, and after migration. Many cancers are still relatively rare in non-Western parts of the world as compared with industrialized countries where cancer ranges among the most common causes of death. Immigrants are exposed to sudden changes of environmental risk factors between their home and their host country while their genetic disposition and cultural habits persist. Favorable risks of immigrants mostly result from persistence in healthy behaviors, for instance dietary or reproductive patterns. Elevated cancer risks among immigrants are known for cancers related to infectious diseases, experienced in early life and childhood, such as stomach, nasopharyngeal, or liver cancer. In addition, cancer mortality shows different patterns and often suggests poorer survival among persons from ethnic minority groups. Lower survival may be due to a lower participation in prevention programs, hindering early detection in this group, possibly leading to disparities in access to care and treatment.

Immigrants are not a homogeneous group. Ethnicity implies diverse concepts of and attitudes toward health that have an impact on the individual utilization of health care services. Cultural roots determine disease perception and coping patterns; both need to be considered when planning preventive measures and deciding on treatment options. Prevention measures should initially focus on barriers that inhibit the uptake of adequate health care, and on ways to overcome those difficulties. Language barriers, low health literacy, insecure or unstable insurance situations, unfamiliarity/distrust with new health care structures and systems, as well as the pursuit of religious beliefs and other cultural aspects may hamper access to healthcare. These aspects need to be addressed by developing special prevention strategies.

Disparities in Cancer Care and Cancer Prevention

Low participation in primary prevention and screening programs is associated with a late-stage cancer diagnosis and poorer survival. This has particularly been observed in migrant and ethnic minority groups.

Barriers that are relevant in many ethnic minority groups are *personal and cultural beliefs* and related behavioral patterns. A very important factor is poor knowledge of the local language. Factors that also play major roles are a general fear of a cancer diagnosis and fear of pain. Lack of awareness of the need for testing due to the absence of symptoms or an inherent dislike of the idea of being screened also contribute to lower uptake of prevention measures in these groups. Many women claim other priorities in life such as strong family obligations and often fear loss of privacy or embarrassment during examination. In addition, ethnic minorities often follow alternative medicine approaches and have fatalistic views toward cancer, perceiving it as a result of personal fate.

Social networks can have a considerable impact on personal decisions in the clinical context. Families or cultural communities may determine attitudes and adherence toward interventions.

Economic barriers are ubiquitous in immigrant populations and may hamper access to cancer prevention services. Unstable insurance coverage as well as additional costs for screening and vaccinations influence screening uptake, in particular among immigrants who are often affected by social deprivation and a higher risk of poverty.

Access to care is additionally affected by the *sex and ethnicity of the health care provider*. Especially, immigrant women with strong religious beliefs often only accept physical examinations by female practitioners. Furthermore, practitioners with foreign backgrounds themselves may not recommend cancer screenings to women because they do not want to intrude on their modesty. Many immigrant groups show a general mistrust toward Western medical systems, as well as a greater degree of dissatisfaction with their physicians.

Primary Cancer Prevention

Primary cancer prevention aims at the complete prevention of disease, applying measures that reduce the exposure to risk factors. It addresses lifestyle as well as environmental risk factors (e.g., diet, physical activity, and occupation) and should particularly stress exposures to infectious agents that are more prevalent in ethnic minority groups and may cause cancer.

Awareness and acceptance of different prevention measures differ between ethnic groups and are strongly linked to health policies. Targeting ethnic minority groups according to their needs is one of the major goals of public health and health service research. This demands knowledge of risk factors that are relevant in immigrant populations and tailoring prevention programs in order to limit ethnic inequalities in cancer risk.

Infections

Infections, predominantly experienced during early life, may play a causal role in carcinogenesis in later life. Immigrants originating from countries where particular infections are highly prevalent may become infected in childhood and develop disease after migration to the host country. This risk mainly affects first generation migrants whereas it appears to fade in their offspring and following generations.

Epstein-Barr Virus (EBV)

EBV is an ubiquitous herpes virus in humans and is involved in the causation of cancers of the lymphatic system (Burkitt's lymphoma, non-Hodgkin lymphoma, Hodgkin lymphoma), as well as nasopharyngeal and other oral cancers. EBV is most prevalent in equatorial Africa and other developing countries primarily tropical regions, and often infects HIV-infected individuals. EBV is transmitted by oropharyngeal secretions. Vaccines against the virus are currently being developed.

Hepatitis

Hepatitis is the most common chronic infectious disease in the world. Chronic forms can cause cirrhosis, failure, and cancer of the liver, often leading to death. It is highly endemic in parts of East Asia, sub-Saharan Africa, and Latin America. Immigrants from high risk countries are disproportionally affected by hepatitis B (HBV) and C (HCV) infections. The prevalence of HBV infection among Asian Americans is up to 10%, while only 0.1% of White Americans are affected. Liver cancer is thus the most significant health disparity affecting Asian Americans in the US.

HBV infection is preventable and vaccination against the infection can lower the risk of liver cancer. There is still no vaccine against HCV. HBV transmission occurs through blood and infected bodily fluids. Mother-to-child transmission in the uterus during birth represents the most common mode of infection in many Asian populations. HCV is less contagious than HBV and mostly transmitted by injection drug use.

Immigrants are often less likely than the majority of the population to receive vaccinations and blood screenings against hepatitis. There is a link between the knowledge of prevention, the level of educational attainment, and the decision to receive vaccination against HBV. Many Asian immigrants in the US are not fluent in English, which affects their ability to communicate with their primary care providers, often leading to the avoidance or delay of visits. Financial aspects certainly also contribute to lower participation in high risk immigrant groups.

There is a clear need for prevention programs targeting high risk groups such as Southeast Asian migrants and increasing the awareness of the connection between hepatitis and cancer. For example, the *San Francisco Hep B free campaign* promotes routine blood tests, improves referral and access to care for people with chronic hepatitis, and supports the expansion of hospital services offering low cost or free screenings and vaccinations for HBV as well as adequate monitoring. Prevention measures for immigrants should focus on both families' and individuals' susceptibility to the virus and enhance awareness and motivation for screening and vaccination.

Helicobacter pylori (*H. pylori*)

H. pylori infection is a risk factor for developing peptic ulcer disease and stomach cancer. Its distribution varies geographically. Incidence is highest in developing countries whereas it is low in high-income countries. *H. pylori* infection is relatively common in non-Western immigrant groups who are accordingly at increased risk to develop stomach cancer. The mode of *H. pylori* transmission is still unknown, but the infection is typically acquired in early childhood. Crowded, unhygienic living conditions, and social deprivation are known to foster *H. pylori* transmission.

Early detection and eradication of the virus would, if possible, be a sensible prevention strategy against stomach cancer. *H. pylori* can be diagnosed by checking for dyspeptic symptoms (stomach-related problems) using noninvasive such as blood antibody and stool antigen tests or invasive tests such as biopsies and tissue (histologic) examination.

Human Papilloma Virus (HPV)

The human papilloma virus (HPV) is typically transmitted through sexual contact. Persistent infection with one genetic type can, in rare cases, cause cancer in most cases of the cervix. The incidence of HPV infections is high among young, sexually active adults (aged 15–24) but varies greatly across populations, being highest in South Asia, sub-Saharan Africa, and Latin America.

Newly developed HPV vaccines prevent infection from HPV types 16 and 18, accounting for up to 70% of cervical cancers. Vaccination is usually offered to girls starting at age 12, although implementation and administration vary greatly across countries. The introduction of HPV vaccines has caused controversy among clinicians and researchers. The protective effectiveness as well as the ideal age for administration, the number of necessary vaccinations, and the risk of side effects are still under debate.

A survey from the UK revealed a much lower awareness of HPV and a significantly lower acceptability of HPV vaccinations among immigrant women, compared to the majority population. Very low levels of awareness and acceptance were found in mothers of South Asian and African origin. Differences in cultural views toward a vaccination against a sexually transmitted disease might partly explain this pattern. It has been observed that parents with strong religious beliefs and cultural views were less likely to accept HPV vaccinations. Their concerns were most often based on social or religious reasons such as a belief that sex-related topics are taboo, monogamy, refraining from sex before marriage, a fear of promiscuity, and a fear of side effects.

Environmental Carcinogens and Important Lifestyle-Related Factors

In general, immigrants experience low risks of cancers that are associated with a Western lifestyle. This especially applies to breast, colorectal, and prostate cancer. Cultural views and behavioral patterns also impact on health-related habits such as physical activity, dietary, and smoking patterns.

Tobacco smoking prevalence differs substantially by ethnic group, gender, age, socioeconomic position, as well as geography. Several cancers, most importantly lung and bladder cancer, are strongly attributed to tobacco smoking. A high smoking prevalence in male and low-income immigrants has been observed in several studies. Tobacco use is widespread and significantly elevated in Asian Americans and migrants from Eastern European countries, compared to the indigenous population of their host country. In many ethnic minority groups, smoking is often an important part of social functions and events. Currently, there are few smoking cessation programs that specifically target immigrants. Some studies indicate a high probability for relapse among migrants that take part in smoking cessation programs.

High alcohol consumption is associated with many cancers. Many immigrants from Muslim countries, however, are likely to be total abstainers and thus at low risk for these cancers.

Dietary patterns (e.g., salt, meat, fat, and fruit/vegetable intake) and obesity are important risk factors for the development of cancers of the digestive system such as cancer of the stomach, esophagus, colon and rectum, gallbladder, and pancreas. Immigrants often show healthy dietary patterns, such as greater fruit and vegetable intake, and a strong familial persistence in different nutritional habits retained from their country of origin. In contrast, obesity has been noted to be high and increasing in many immigrant groups. This may be caused by a lack of traditional foods at affordable price and a gradual adaptation of Western dietary patterns. Dietary prevention programs require sensitive communication as well as motivation and should put emphasis on the nutritional value of cultural dishes and healthy nutrition. Often, immigrants exhibit lower degrees of physical activity compared to the native population of their host and their home country. Physical inactivity contributes to higher rates of obesity and may be involved in the development of colorectal, gallbladder, and kidney cancer.

Reproductive factors play an important role in the occurrence of breast, cervical, ovary, and testicular cancer. Immigrant women are more likely to have more children and to breastfeed and are less likely to use oral contraception or hormone replacement therapies after menopause, compared to the majority population. These protective factors are associated with a decreased risk of breast and other cancers of genital organs.

Most environmental and lifestyle-related factors and habits are hard to change, not only in ethnic minority groups. Cultural and religious beliefs affect behavioral patterns and determine lifestyle, diet, and sexuality. Some studies suggest a lack of adherence to medical advice regarding lifestyle and nutrition in immigrant groups. Prevention programs need to target high risk groups such as immigrant smokers, increase awareness of the link between lifestyle and cancer, and should operate on the community/family level.

Secondary Cancer Prevention

Immigrants are more likely to receive a late-stage cancer diagnosis in comparison with the majority population. This could be due to a low uptake of secondary cancer prevention measures, such as screening, aiming for early disease detection, and the limitation of disease effects after diagnosis. Secondary cancer prevention programs are particularly important in ethnic minority groups, because they often underutilize preventive care or fail to make return medical visits, and often lack cancer awareness. However, a higher participation in screenings has been observed in immigrants who spent a higher proportion of their lifetime in the host country and an increasing uptake the longer their duration of residence. This probably is a result of an acculturation process that is related to increasing trust and familiarity with health care structures in the host country.

Early detection during routine screenings for breast, cervical, colorectal, and prostate cancer represents a key factor for better survival in high risk groups. Cultural barriers to screening programs and suggested remedies are summarized in Table 1.

Breast Cancer Screening

Breast cancer is the most common malignancy among women worldwide. However, its frequency varies widely by country and population. Whereas the incidence in more developed regions of the world is 67.8 per 100,000 women, it is less than half in less developed regions (23.8 per 100,000). Breast cancer mortality is 18.1 and 10.3 per 100,000, respectively. There is evidence that reproductive factors partly determine the breast cancer risk. This comprises the age at first birth, the number of children, the age at menarche/menopause, and the use oral contraceptives and/or hormones during menopause. Other established risk factors for breast cancer are familial susceptibility and excessive alcohol use.

Breast cancer prevention focuses on screening. The most common methods of screening are mammography and breast self-examination. Since the introduction of breast cancer screening, the incidence of breast cancer increased whereas mortality decreased due to detection at earlier stages, implying a better chance for survival. Recent studies, however, have cast some doubt on the effectiveness of breast cancer screening.

Breast cancer screening is usually recommended to start between age 40 and 50. Some studies on breast

Cancer Prevention. Table 1 Cultural barriers to established cancer screening programs and suggested remedies

Type of screening	Barriers	Suggested remedies
Breast cancer	Perception of absence of symptoms, claiming health	Policies that alleviate women's anxiety
	Misconceptions, cancer fatalism, fear of possible diagnosis	Identification and elucidation of misperceptions, fear, and fatalism
	Patriarchal values, modesty	Encouragement of presence of family members during screening
	Strong religious beliefs	Employment of female practitioners who understand the role of cultural beliefs, especially the expression of modesty
	Fear of loss of privacy, embarrassment	Faith-based settings as venue for cancer education programs
	Distrust in system and clinician	
Cervical cancer	Fear of loss of privacy, embarrassment	Increasing awareness, clarification of misconceptions
	Aversion to invasiveness of Pap smear	Education of medical providers to recognize cross-cultural differences in health care to enhance their competence in engaging with minority women during medical encounters
	Modesty, strong cultural views	Involvement of family members in decisions and allow for their presence during screening
	Poor communication with providers	
	Prohibitions against examination by male health care providers	
	Competing life priorities (e.g., familial responsibilities)	
Colon cancer	Embarrassment of receiving digital rectal examinations/colonoscopy	Increasing awareness, cancer education
	Strong cultural beliefs	Offering alternative tests

cancer screening uptake in ethnic minority groups reveal large ethnic disparities and a rather passive attitude of migrant women toward screenings. Foreign born women are less likely to attend screenings and show lower referral and detection rates compared to native-born women. Furthermore, a clear association between age and health screening attendance (the higher the age, the lower the attendance) was found in immigrant women. Reasons for nonattendance with screening were particularly ascribed to patriarchal values (men as decision-makers), embarrassment, and modesty.

Cervical Cancer Screening

Cervical cancer is the second most common cancer in women from less developed regions (incidence 19.1 per 100,000) and fourth in females from developed regions (incidence 10.3 per 100,000). Mortality from cervical cancer is 11.2 per 100,000 in less developed regions and 4.0 per 100,000 in developed regions. The main known risk factor for cervical cancer is HPV infection. In many countries, the cervical Pap (Papanicolaou) smear test is used in women aged 30–60 in order to identify abnormal cells that can turn into cancer. The implementation of Pap smears is believed to have significantly reduced incidence and mortality of cervical cancer in many Western countries, but randomized controlled trials have not yet confirmed this assumption.

In many countries, screening uptake in immigrant women is far below target and significantly lower than in the majority population. Reasons for nonparticipation in cervical cancer screening are mostly related to language problems, dissatisfaction with practitioner, and the absence of symptoms. Religion also may play an important role. Among all US ethnic groups, Asian American women have the lowest participation rates, apparently determined by strong cultural views.

Colorectal Cancer Screening

Colorectal cancer is much more common in developed regions, being the second most common malignancy in females and the third in males. Incidence is 40.0/26.6 per 100,000 in more and 10.2/7.7 per 100,000 in less developed regions (females/males). Mortality is 17.7/12.3 and 6.2/4.7 per 100,000, respectively. Colorectal cancer is associated with dietary and environmental risk factors, such as a high intake of meat and unsaturated fat as well as physical inactivity. Screening is recommended starting around age 50 using fecal (stool) occult blood tests (FOBT) or endoscopic exams (colonoscopy or sigmoidoscopy). These measures require resources that are not available to everyone.

Colorectal cancer screening uptake varies significantly across ethnic groups and tends to be lower in immigrants than in the native population of their country of residence. For example, uptake was found to be very low among Asian Americans. However, screening patterns converged toward that of the majority population with increasing time of residence in the US.

Prostate Cancer Screening

Prostate cancer is far more common in more developed regions compared to less developed regions (incidence 56.2 vs. 9.4 per 100,000; mortality 13.5 vs. 5.2 per 100,000). Causes of prostate cancer are still poorly understood; however, a family history of prostate cancer seems to play a role. Certain ethnic groups such as African-Americans are disproportionally affected.

Prostate cancer screening is routinely done by digital rectal exams (DRE) and increasingly by prostate-specific antigen tests (PSA) which measures the level of PSA in the blood. However, there is no continuing evidence of decreases in mortality from prostate cancer due to screening.

In conclusion, immigrants are significantly less likely to attend cancer screening services than natives of their host country. This has various reasons, mainly differences in cultural views, disease perception, and health care utilization patterns. Identifying and addressing cultural barriers helps to reduce existing disparities in survival and to keep mortality low.

Tertiary Cancer Prevention

Screening alone does not ensure the improvement of cancer survival. What follows the initial diagnosis and how patients with a positive test result are treated is very important. Appropriate care, therapy, and diagnostic follow-up as well as rehabilitation are crucial for optimal health outcomes.

Some studies report a lower likelihood of receiving stage-appropriate treatment and a less frequent adherence to recommendations for follow-up care in immigrant populations. This may subsequently lead to poor clinical outcomes and lower survival.

The Challenge of Providing Culturally Sensitive Cancer Prevention

The goal of cancer prevention in immigrant populations should be to perpetuate – and if possible expand – advantageous lifestyle factors and to provide culturally adequate access to care. Culturally sensitive cancer prevention incorporates diversity of cultural beliefs, experiences, perceptions, norms, values, and behavioral patterns. Implementation demands a general awareness of cancer risk diversity and cultural aspects of cancer in every expert involved in cancer care, education, and research. Providing culturally sensitive cancer prevention is the key to diminish inequalities and increase access as well as awareness.

Before planning for new prevention measures, it is important to collaborate with ethnic minority groups in order to assess their understanding and opinions on existing cancer prevention programs. Best practice definitions and guidelines could be useful in order to ensure greater consistency of use and implementation of culturally sensitive cancer programs.

Cancer prevention needs to be encouraged by increasing awareness, by promoting the necessity for screenings, and by providing adequate cancer information and education. Educational materials should be developed together with members of ethnic minority groups in order to incorporate cultural beliefs in multilingual health messages that are accessible to those with limited literacy skills. High risk groups should be targeted and the stigmatizing nature of disease perceived by some ethnic groups needs to be addressed. Equal access to preventive medicine should be enhanced by providing comprehensive, well-coordinated, affordable, and culturally appropriate cancer care. Treatment plans should be developed together with the patient and other family members. Research on cancer disparities should be promoted and the inclusion of ethnic minority populations in clinical trials should be supported in order to learn more about the efficacy of treatment options for immigrants.

Related Topics

► Cancer
► Cancer mortality
► Cancer screening
► Disease prevention
► Health barriers
► Health care utilization
► Health literacy
► *Heliobacter pylori*
► Language barriers

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Suggested Resources

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San Francisco Hep B free campaign. http://www.sfhepbfree.org/

Cancer Screening

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Cancer screening refers to a set of medical procedures intended to identify the presence of cancer before any symptoms appear, and can include physical exams, laboratory tests, and medical imaging. Regular screening offers the potential to reduce both cancer mortality and morbidity since treatment options and survival are related to stage at diagnosis for almost all forms of cancer. Estimates of the premature deaths that could have been avoided through cancer screening vary from 3% to 35%.

Screening guidelines for the detection of the most commonly occurring cancers are well established, and while national health agencies such as the US National Cancer Institute (NCI) periodically review these guidelines in order to ensure that the guidelines reflect the latest research, there is little debate about the overall importance of regular cancer screening. Most developed countries actively maintain screening registries for two types of cancer affecting women – breast and cervical cancer – in order to alert women to the importance of regular screening and to remind them to get screened.

Adherence to screening guidelines has been found to vary significantly by demographic factors such as race as well as by socioeconomic status, with screening less likely to occur among individuals in lower socioeconomic groups. Given the continued high levels and changing ethnic composition of immigrant inflows to the United States, Canada, the UK, and other countries that have significantly altered the demographic profile of these countries, the use of regular cancer screening by immigrants has become an issue of significant interest and importance to policymakers and health care professionals.

Theoretical Determinants of Cancer Screening

A variety of theoretical frameworks has been advanced to help explain possible differences in cancer screening among different subpopulations. One commonly used model is an adaptation of the Andersen framework of health service use that identifies three types of factors likely to be important determinants of an individual's demand for health services: predisposing factors such as age and sex; needs factors such as health status and awareness of cancer and screening, and enabling factors such as income and education, health insurance, and community resources. For immigrants, the use of cancer screening can also be reduced by barriers arising from difficulties with host country language and unfamiliarity with the host country health system. Immigrants' social and ethnic backgrounds can give rise to differences in attitudes about cancer and cancer screening. For example, traditions of modesty among some Asian and Hispanic populations might lead immigrants from those regions to avoid certain physical examinations. This discussion implies that patterns in cancer screening may vary significantly across immigrant subgroups even after accounting for differences in age, education level, income, and other factors. In addition, immigrants' participation in cancer screening could also increase over time following migration, as language barriers are overcome, experience with the health system is gained, and as attitudes and behaviors increasingly reflect host country norms.

Data on the Incidence of Cancer Screening

Most empirical evidence is based on two main types of data. The first type includes population-based self-reported surveys such as the National Health

Interview Survey in the USA and the Canadian Community Health Survey in Canada. The second type includes smaller scale interview-based surveys of particular ethnic groups. In some jurisdictions, researchers may also have access to administrative data on cancer screening that are drawn from cancer screening registries.

Screening for Cervical Cancer

Cervical cancer is one of the most preventable forms of cancer, and deaths from cervical cancer have declined by approximately 70% since the mid-twentieth century, due in large part to the introduction of the Papanicolaou (Pap) test. The Pap test is an easily implemented and widely accessible form of cancer screening, and systematic population-wide screening has been organized by government and nongovernment agencies at all levels. Current guidelines from both the US National Cancer Institute and Health Canada suggest that adult women aged 21–65 have a Pap smear test every 1–3 years, depending on prior history and risk factors.

Regardless of data type, the evidence points unequivocally to the fact that immigrant women have significantly lower participation in regular cervical cancer screening than nonimmigrant women. This result has been established for most ethnic groups of immigrants and in a number of immigrant-receiving countries. Importantly, while demographic and socioeconomic characteristics are well-established determinants of cervical cancer screening rates, lower rates of regular screening among immigrants are not explained by differences in these factors between immigrant and nonimmigrant women.

Analyses based on population survey data indicate rates of Pap smear testing that are lowest for immigrants recently arrived from developing countries, with rates of testing in the last 3 years in the order of 30–50% less than for comparable nonimmigrant women. In contrast, immigrants from other English-speaking developed countries have been found to have screening rates generally comparable to nonimmigrant levels. There is also evidence that rates of testing increase with additional years in the immigrant's new country, a result consistent with a process of acculturation to host country attitudes, as well as improved familiarity with and access to the health system. However, immigrants from Asian ethnic backgrounds do not necessarily reach nonimmigrant rates of cervical cancer screening even after many years in their host country.

More narrowly focused analyses of specific subpopulations of immigrant women suggest factors that help to explain differences in cervical cancer screening between immigrant and nonimmigrant women. For immigrant women from China, Korea, and other Asian countries, lack of knowledge of cervical cancer risk factors and of cervical cancer screening guidelines are important determinants of lower screening rates. The nature of the doctor–patient relationship is important for Asian, Hispanic, and Haitian women, including the physician's degree of cultural awareness, the presence of a female doctor, and the communication of guidelines by the doctor to the patient. More generally, characteristics of the health system are important among various immigrant subpopulations in the USA, with both a single source of primary care and having health insurance being associated with higher screening rates.

Screening for Breast Cancer

Breast cancer is a common disease and leading source of cancer mortality among women. It is estimated that one of every nine women will develop breast cancer during her lifetime, while one of every 25 will die prematurely from malignancy. It is well established that early detection is essential to the effective treatment of the disease. Detection modalities include clinical and self breast examinations and mammography, though it is mammography use that has been the main focus of research in the literature. Evidence indicates that regular mammography screening among older women could reduce breast cancer mortality by one third, and current screening guidelines published by Health Canada recommend biennial mammography for asymptomatic women aged 50–69 years. Although the benefits of mammography screening are less clear for women aged 40–49, some Canadian provinces (NS, Alberta, BC) include these women in their provincial recall and screening programs.

As with cervical cancer screening, rates of mammography screening are lower among immigrant women to the USA, Canada, and other developed countries than for nonimmigrant women, and the gaps are not accounted for by differences in demographic and socioeconomic factors. Low screening rates are of special concern for particular immigrant subgroups such as Filipina women, who experience higher mortality rates from breast cancer than from any other disease. In contrast to what is found for cervical cancer screening, evidence is mixed about whether gaps in regular mammography screening narrow with years in the host country, although some studies find such patterns for immigrant women in the USA and Australia.

Research on various immigrant subgroups identifies a number of characteristics associated with lower mammography screening rates that are more prevalent among immigrant than nonimmigrants. These include having no regular source of health care services, low education level, poor English language skills, a lack of knowledge about breast screening modalities, and a lack of health insurance. Other research has also established that certain cultural views such as traditions of modesty are associated with lower incidence of mammography screening.

There is less evidence available on other modalities of breast cancer screening including clinical breast exams and self-exams, although some research suggests that greater acculturation of immigrant women and more time in the host country are both associated with a higher incidence of breast self-exams and clinical breast exams. Interestingly, one study of Chinese women in San Francisco found that while knowledge of breast cancer and the importance of self-examinations was high (81% of women), adherence with recommended guidelines was markedly lower (54% of women).

Screening for Colorectal Cancer

In Canada, colorectal cancer is the third most common cancer, accounting for more than 12% of cases of cancer in both sexes, while in the USA, colorectal cancer is the fourth most common cancer. Given the occurrence of this form of cancer, research over the past decade has examined the merits and effectiveness of periodic screening in the asymptomatic population. A variety of means are available to screen for colorectal cancer, including fecal occult blood testing, sigmoidoscopy, and colonoscopy. For people at normal risk of colorectal cancer, annual or biennial testing using fecal occult blood testing (FOBT) and sigmoidoscopy are recommended for men and women aged 50–75 years. There is insufficient evidence to include colonoscopy as an initial screening test of people in this age group.

While the research on the incidence of colorectal cancer screening among immigrants is limited, US evidence suggests that most subgroups of immigrants by region of origin have lower incidence of screening than nonimmigrant individuals. Similar results are found for South Asian immigrants in the UK. As with other forms of cancer screening, demographic and socioeconomic factors have been established as important correlates of colorectal cancer screening but lower incidence of screening among immigrants is not explained by differences in these factors between immigrants and nonimmigrants. Furthermore, additional years in the host country appear to increase rates of cancer screening, which approach those of the nonimmigrant population. Having a regular health care provider is also positively associated with the incidence of colorectal cancer screening.

Screening for Prostate Cancer

Two types of screening for prostate cancer in men include digital rectal examination (DRE) and prostate specific antigen (PSA) measurements. Both types of screening have been shown to increase the early detection of clinically significant prostate cancer. However, available research is ambiguous about whether early detection and treatment leads to any change in the natural history and outcome of prostate cancer. Thus, different health agencies in the USA and Canada vary in terms of recommendations for their use among asymptomatic men over 50 years of age, and there is no general consensus on appropriate guidelines for regular screening. Some health agencies such as the United States Preventative Services Task Force recommend against screening for prostate cancer in men aged 75 years or older.

Researchers studying the incidence of screening for prostate cancer among immigrant men have noted significant variation in the regular use of both DRE and PSA screening across immigrant subgroups even after controlling for demographic characteristics and access barriers. Immigrant men in the USA who originated from Trinidad, Haiti, and Eastern Europe were all less likely than US-born White men to obtain regular screening for prostate cancer. Education and access to medical care were also important determinants of the incidence of prostate cancer screening.

Conclusions

A robust result of the extensive research on immigrant cancer screening is that rates of screening for the most commonly occurring types of cancer are significantly lower for most immigrant subgroups than for nonimmigrants, and these gaps are not explained by differences in demographic, socioeconomic, or geographic factors. Policies to encourage greater participation in cancer screening by immigrants may need to be tailored to the characteristics of specific immigrant subpopulations, particularly recent immigrants.

Related Topics

- ► Cancer incidence
- ► Cancer prevention
- ► Colorectal cancer
- ► Mammography
- ► Pap test
- ► Physician–patient communication

Suggested Readings

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Suggested Resources

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Cardiovascular Disease

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Globally, cardiovascular disease is the number one cause of death, and in 2005, cardiovascular disease caused 30% of all deaths worldwide. Cardiovascular disease is a category that encompasses a myriad of disorders of the heart and blood vessels, including coronary artery disease, cerebrovascular disease, peripheral vascular disease, infectious diseases of the heart, and congenital heart disease. Coronary artery disease is an impairment in the coronary blood vessels that are responsible for supplying blood to the heart, and disruption in this circulation can in turn lead to heart attacks. Similarly, cerebrovascular disease causes an impairment of blood flow to the brain, resulting in strokes, and peripheral vascular disease causes disruption of blood to body organs and extremities, resulting in organ dysfunction and pain.

There is a large body of evidence that supports the causal role of a number of risk factors in increasing the risk of cardiovascular disease related events, such as heart attacks and strokes. These cardiovascular disease risk factors are hypertension, diabetes, hyperlipidemia, tobacco use, and obesity. The global rise of cardiovascular disease can be largely attributed to the increase in prevalence of modifiable risk factors due to shifts in lifestyle such as immigration from smaller rural communities and villages to larger urban settings. With these shifts comes an increased risk of tobacco use, diets high in sodium, saturated fats and carbohydrates, and sedentary lifestyles, in turn leading to an increase in rates of hypertension, diabetes, hyperlipidemia, tobacco use, and obesity. With this increased prevalence of risk factors comes an increase in heart attacks and strokes. Because of the large environmental component to cardiovascular disease, immigration plays a vital role in the global rise of cardiovascular disease.

Immigration also plays a central role in the rates of congenital, metabolic, and infectious diseases of the heart. Maternal health and perinatal care are important determinants of cardiovascular morbidity and mortality in newborns. Maternal health and perinatal care are largely dependent on the social and economic conditions of different societies, and cultural norms and values and immigration status play an important role in the amount and type of pre- and postnatal care mothers receive. This in turn impacts the prevention and management of congenital heart disorders.

Endocrine and metabolic disorders such as thyroid disease and vitamin deficiencies may also cause heart dysfunction. There are a number of infectious diseases that lead to heart dysfunction, including a parasitic disease such as Chagas disease and bacterial diseases of the heart valves such as endocarditis. The prevalence of infectious causes of heart disease differs widely based on geographical location, and immigration status plays a vital role in the development of these disorders.

The Global Rise of Cardiovascular Disease

Cardiovascular diseases are responsible for more deaths worldwide than any other cause. An estimated 17.1 million individuals died from cardiovascular illnesses in 2004. This accounted for 29% of all global deaths. By 2030, approximately 23.6 million people will die from cardiovascular diseases each year, maintaining cardiovascular disease as the number one cause of death in the world. It is estimated that the largest percentage increases in death will occur in the Eastern Mediterranean region, and the largest number increases in death will occur in Southeast Asia. Income levels play a large role in both the prevalence of cardiovascular disease and the mortality rate of cardiovascular illnesses. Eighty-two percent of cardiovascular disease deaths occur in low- and middle-income countries.

In the United States, 31% of the population has cardiovascular disease, and 34.3% of annual deaths are due to cardiovascular causes. In Canada, in the year 2000, 34% of male deaths and 36% of female deaths were due to cardiovascular diseases, and cardiovascular diseases cost the Canadian economy approximately $18.4 billion annually. In the United Kingdom in 2003, there were 233,000 deaths due to cardiovascular disease and 38% of all deaths were from cardiovascular diseases. Death rates from cardiovascular disease are generally decreasing in developed nations – in the United States, from 1996 to 2006, death rates from cardiovascular disease declined by 29.2%. Over 80% of global deaths from cardiovascular disease occur in low- and middle-income countries.

The number of years of productive life lost to cardiovascular disease will increase by 20% in 2030 as compared to 2000. The rate of increase in cardiovascular illness is much higher in developing nations as compared to more economically developed nations. In Portugal, this 30-year rate of increase is 30% – in South Africa it is 28% and in Brazil it is 64%. The 30-year increase in risk of cardiovascular-related mortality in China is 57% and in India, it is 95%. In India, currently 10–12% of the population has cardiovascular disease. It is estimated that India bears 60% of the world's coronary heart disease burden. The rate of heart attacks in South Asians in the United States is double that of the American average. There are more individuals with cardiovascular diseases in India and China than in all economically developed nations of the world combined.

In Europe, each year cardiovascular disease causes over 4.3 million deaths, which is 48% of the total number of deaths in Europe. Cardiovascular disease is the main cause of death in women in all European countries, and is the main cause of death in men in all countries except France, the Netherlands, and Spain. Each year, cardiovascular disease costs the European Union approximately €192 billion.

There are likely multiple reasons why cardiovascular disease prevalence and death rates are higher in low- and middle-income countries as compared to higher income countries. Individuals in low- and middle-income nations have more exposure to cardiovascular disease risk factors and have less access to preventive methods as compared to higher income populations.

Preventive measures to detect risk factors and provide early interventions that in turn prevent morbidity and mortality related to cardiovascular disease are much scarcer in economically disadvantaged regions.

In general, people in lower income nations die younger from cardiovascular diseases when compared to people in higher income nations. These deaths of individuals in their most productive years in turn lead to increased poverty. Cardiovascular diseases are predicted to reduce GDP between 1% and 5% in low- and middle-income countries experiencing rapid economic growth. For instance, China is predicted to lose $558 billion due to loss of income in people with cardiovascular diseases.

The sex distribution of cardiovascular disease is roughly equal at this time, but in many countries, women experience a disproportionately higher risk of dying from cardiovascular disease compared to men. The rates of cardiovascular disease death are increasing at higher rates in women as compared to men in many economically emerging countries, such as China and Brazil.

Cardiovascular Disease in Immigrant Populations

Numerous studies have been conducted to determine whether there is a relationship between immigration status and incidence of cardiovascular disease. These studies have consistently shown that first-generation immigrants have cardiovascular disease rates that reflect their countries of origin. After two to three generations, however, several studies have shown that cardiovascular disease rates in immigrant populations tend to match those of the adopted country.

One study in 2008 in Sweden showed that Iranian immigrants had higher rates of cardiovascular disease than their native Iranian counterparts. Similarly, a study in 2006 showed that Chinese immigrants in New York City have a higher rate of cardiovascular disease than native Chinese from the same community. These results are consistent even after adjustments were made for income level and age. Similar studies in Indian, Pakistani, and West African populations have showed that both emigration from rural areas to more developed urban settings as well as emigration from developing to developed nations result in increased rates of cardiovascular disease rates. This likely is the result of increased rates of risk factors such as obesity, tobacco use, Westernized diets, and sedentary lifestyles in urban populations.

In the United States, individuals of South Asian descent have a fourfold higher rate of coronary artery disease as compared to the general American population. This is independent of the individual's immigration status – first-, second-, and third-generation South Asian immigrants all have a consistently increased rate of cardiovascular disease prevalence and mortality. In South Asians, more than 30% of deaths from heart attacks occur in those younger than 65, a rate double that of the United States national average. This increased risk of cardiovascular disease has also been noted in South Asian immigrants in the United Kingdom. According to the British Heart Foundation, the death rate from coronary artery disease is 46% higher in South Asian men and 51% higher in South Asian women than in the UK population as a whole – this, again, is the case among both first- and second-generation South Asian immigrants. However, data from California have shown that South Asian women are the only ethnic group in California that has experienced an increase in mortality due to cardiovascular disease.

Immigrants from Latin America to the United States have increased rates of cardiovascular disease when compared to native Latin populations. This could be at least partially due to health policies in Latin American countries. For example, Brazil has been cited as a model for effective cardiovascular disease prevention in Latin America. Brazil has been a world leader in promoting programs that reduce obesity, including national food and nutrition policies to promote healthy eating habits and lifestyles that lead to cardiovascular health.

In the United States, there is a marked difference in cardiovascular disease rates across different ethnic groups and immigrant communities. Among Caucasians, 12.1% have heart disease, 6.5% have coronary heart disease, 23% have hypertension, and 2.7% have had a stroke. African American populations have lower rates of heart disease and coronary heart disease than their Caucasian counterparts but higher rates of hypertension and stroke. Ten percent of African Americans have heart disease, 5.6% have coronary heart disease, 31.8% have hypertension, and 3.6% have had a stroke in the past. In contrast, Latinos in the United States have lower rates of cardiovascular disease, and 8.1% of Latinos have heart disease, 5.7% have coronary heart disease, 21% have hypertension, and 2.6% have had a stroke. Native Americans and Alaska Natives have higher rates of cardiovascular disease, and 12.1% have heart disease, 6.6% have coronary heart disease, 25.3% have hypertension, and 3.9% have had a stroke in the past. South Asians in the United States have the largest rates of cardiovascular disease of any subgroup, with rates of developing coronary heart disease ranging from 18% to 25%.

Cardiovascular Risk Factors in Immigrant Populations

Hypertension

Globally, high blood pressure, or "hypertension," causes approximately 7.1 million deaths each year. Hypertension, if left untreated, is a risk factor for strokes and heart attacks. It is estimated that about 62% of strokes and 49% of heart attacks are caused by hypertension. It has been predicted that the prevalence of hypertension will increase to 1.56 billion people by the year 2025. Currently, about 15–37% of the global adult population has hypertension, and in the United States about 140 million people suffer from hypertension. Throughout the world, it is believed that a significant percentage of hypertension is undiagnosed. Of the diagnosed cases of hypertension, it is thought that more than half of all hypertensive patients do not receive adequate treatment.

In India and China, there has been a rapid rise in the prevalence of hypertension over the past 20 years, and a concomitant increase in rates of stroke. These increases correlate with a shift from rural to urban lifestyles and mirror the increases in rates of hypertension in Chinese and Indian immigrants in the United States and the United Kingdom. In contrast, studies have shown that rates of hypertension are higher in native Mexicans than in first-generation Mexican immigrants to the United States. Despite the lack of consistent health care coverage in Mexican immigrants, rates of diagnosis and treatment of hypertension appear to be better in Mexicans living in the United States as compared to native Mexicans.

In Africa, the prevalence of hypertension is estimated at approximately 20 million people. The hypertension-related stroke rate is higher in Africa than in other regions of the world, and victims of hypertension-related stroke in Africa are relatively young. There is a lower rate of hypertension in Africans and first-generation African immigrants to the United States when compared to African Americans who have lived in the United States for several generations. This difference exists even when there are corrections for body mass index and age.

There is a well-established relationship between increased salt intake and hypertension. Numerous studies have also shown that tobacco use, alcohol use, and sedentary lifestyle can lead to increases in blood pressure. It is likely that development of hypertension is multifactorial and that inherent ethnic differences, varied patterns of exercise, diverse dietary habits, and differences in alcohol and tobacco use all contribute to increased rates of hypertension. Because immigrants often bring with them dietary and social habits from their native cultures, there is a complex interplay between genetic and lifestyle factors that determine rates of hypertension in immigrant populations.

Hyperlipidemia

High blood cholesterol or "hyperlipidemia" is another important risk factor for cardiovascular disease. Three components of cholesterol are measured to determine overall cardiovascular risk – LDL or low-density lipoprotein, increased levels of which lead to an increase in heart disease; HDL, or high-density lipoprotein, a component that can actually protect individuals from cardiovascular disease if high enough; and triglycerides, a component that is also linked to cardiovascular disease. Hyperlipidemia is estimated to cause about 4.4 million deaths every year, and is directly responsible for 18% of strokes and 56% of coronary heart disease globally. Diverse studies of immigrants have shown that there is a strong environmental component to hyperlipidemia, and rates of hyperlipidemia rapidly change as patients emigrate to another country and dietary patterns change. A study in Israel published in 1960 showed that immigrants from areas where typical diets are high in fruits and vegetables and low in animal fat have much lower rates of hyperlipidemia. This study also showed how, as immigrants' diets change to match local patterns and include increases in consumption of foods high in saturated fat, cholesterol levels also increase. Another study in 1985 showed that Japanese immigrants to Brazil had lower levels of HDL, the component of cholesterol that is protective against cardiovascular disease, when compared to native Japanese. Another study in Costa Rica in 2002 showed that as Chinese immigrants increased their consumption of animal protein, rates of hyperlipidemia increased. As with hypertension, there appears to be both inherent ethnic differences in rates of hyperlipidemia and a strong contributing lifestyle component.

Obesity

Obesity, defined as an unhealthy weight that adversely affects an individual's health and well-being, has a strong and well-established relationship with cardiovascular disease. There is a direct correlation between increases in body mass index, a common measure of weight, and cardiovascular illnesses. As BMI levels and abdominal circumferences increase, the prevalence of hypertension, high blood glucose levels, hyperlipidemia, and low HDL cholesterol levels increase. The rates of overweight and obesity are rising dramatically throughout the world. This is thought to be due to increasingly sedentary lifestyles as well as dietary factors.

In immigrant communities in the United States, studies have shown a direct correlation between the number of years of residence in the United States and increases in rates of overweight and obesity. A study in 2004 showed that after adjusting for age, socioeconomic and lifestyle factors, living in the United States for 10 years or more is associated with significant increases in the levels of overweight and obesity. Immigrants in the United States were also noted to be less likely than US-born individuals to discuss diet and exercise with clinicians. The study showed that only 8% of immigrants who had lived in the United States for less than a year were obese, but that 19% of individuals who had lived in the United States for at least 15 years were obese.

Another study in September 2009 looked at immigrants in the United States, and noted that the sons of immigrants had higher rates of overweight and obesity than their American-born counterparts. It was found that 34% of kindergarten-age immigrant boys were obese or overweight compared with 25% of the sons of native-born Americans. By age 13, 49% of sons of immigrants are overweight or obese as opposed to 33% of natives. This difference was independent of socioeconomic status and was more pronounced in children whose parents did not speak English. It is thought that a combination of easily available and inexpensive high-calorie, low-nutrient foods and beverages and the fact that often new immigrants are not aware of the risks of unhealthy lifestyle choices likely contributed to this effect.

One of the most important causes of overweight and obesity in immigrants is lack of education about the adverse effects of obesity and the contribution of diet and exercise to moderating weight. Another small study in 2009 showed a direct correlation between education and rates of obesity in immigrants – immigrants with advanced degrees were less likely to become obese, while immigrants without advanced degrees were more likely to become obese after 5 years in the United States. The other factors influencing rates of obesity in immigrants are perceived health status and body image. In many resource-poor cultures, overweight and obesity are associated with economic success, and physical activity is associated with blue-collar jobs and poverty. Other cultures associate overweight and obesity with good health and in some cultures individuals who are overweight or obese are considered more "marriageable." One study of Latina immigrant women in 2006 showed that the majority of women in the study associated overweight and obesity with attractiveness and were reluctant to lose weight because of perceived unattractiveness to men.

Diabetes Mellitus

Currently, it is estimated that there are approximately 150 million people worldwide with type II diabetes, and this figure is expected to double by 2025. About 58% of global diabetes mellitus is attributable to overweight or obesity. Rates of death from diabetes mellitus are also increasing.

In general, immigrants from the developing world to more economically developed regions have higher rates of diabetes than native populations. One study in 2006 in Sweden showed that immigrants from non-European countries had higher rates of diabetes than native Swedish populations or immigrants from European countries. Another Dutch study showed that immigrants from Suriname, India, Turkey, and

Morocco to the Netherlands had higher rates of diabetes than their native counterparts. This tendency is independent of rates of overweight and obesity. A study of Ethiopian immigrants in Israel in 2005 showed a growing prevalence of type II diabetes. In Canada, individuals of aboriginal, Latino, Asian, South Asian, or African descent have been noted to be more vulnerable to diabetes.

It is very well documented that South Asian immigrants have a much higher rate of diabetes mellitus than the general nonimmigrant population in developed nations. In the United Kingdom, studies have shown that the Bangladeshi and Pakistani communities have a disproportionately high level of diabetes when compared to Caucasians. In the United States, South Asian immigrants are seven times more likely to have type II diabetes than the general population, and in New York City, Indian immigrants are at a greater risk of hospitalization from diabetes than other immigrant groups. Studies in New York City have also shown that South Asian immigrants have a rate of diabetes that is almost three times higher than the rate for other Asian American immigrants in New York City. Another study in 2009 showed that 28% of Bangladeshis living in New York City have diabetes. South Asian immigrant women in New York City have the highest prevalence and highest increase in prevalence of gestational diabetes mellitus.

There is also evidence that immigrants with diabetes have poorer glycemic control than their native counterparts. A study in 2008 in Ireland showed that non-White immigrants to Ireland had poorer glucose control than native Irish individuals with diabetes mellitus. Factors that are thought to play a role in higher rates of hyperglycemia in immigrant diabetic patients include lack of education about the consequences of untreated diabetes and the importance of medication compliance, and lack of information about appropriate food and diet choices. Studies have shown that a strong family support system and targeted culture-specific education can have a significant impact on rates of cardiovascular disease.

Finally, immigrants who arrive in the United States at younger ages are more likely to become overweight with increasing time in the United States as compared to immigrants who come to the United States at older ages.

Tobacco Use and Immigrants

Currently, there are about 1.3 billion smokers in the world, and this number is projected to rise to 1.7 billion by 2025. Smokers in general have death rates two to three times higher than nonsmokers. A joint study by the Centers for Disease Control and Prevention (CDC) and the World Health Organization (WHO) showed that smoking causes a 100% increase in the risk of stroke and coronary heart disease, a 300% increase in the risk of death from undiagnosed coronary heart disease, greater than a 300% increase in the risk of peripheral arterial disease, and a 400% increase in the risk of aortic aneurysm.

In the United States, the rates of tobacco use in 2000 were 13.7% among Asian and Pacific Islanders, 19.1% among Latinos, 25% among non-Hispanic Whites, 24.7% among African Americans, and 40% among Native Americans and Alaskan natives. Various studies have looked at tobacco use rates among different immigrant populations in the United States. One study of Chinese Americans in Texas showed that while smoking rates were significantly lower in Chinese Americans as compared to the general Texas population, the smoking rate among recent immigrant men was higher. Twenty-eight percent of immigrant Chinese men smoked, as compared to 20.6% of the local population. In contrast, US born Chinese American smoking rates are comparable to those of the local American population. In Latino populations, studies have shown that adolescents are particularly vulnerable to tobacco use, and that there is a strong connection between poverty, unemployment, high school dropout rates and tobacco use. One study in California in 1993 showed that disadvantaged Latino youths were three times more likely to use tobacco than non-Latino youths. South Asian individuals in the United States have lower rates of smoking than other Asian groups.

The tobacco epidemic is affecting an increasing number of children and adolescents. Tobacco use in children and adolescents is highest in the Americas and Europe, where it is approximately 20%. Cigarette smoking is higher among young people in the Americas and Europe, while use of other tobacco products is higher in South East Asia and the Eastern Mediterranean. Everywhere, tobacco use is significantly higher in boys than in girls.

Infectious Diseases of the Heart in Immigrant Populations

Infectious diseases that affect the heart are an important cause of morbidity and mortality in immigrants. In particular, two infectious conditions – Chagas disease and rheumatic fever – are commonly responsible for cardiovascular disease in immigrant populations. Chagas disease is transmitted by the protozoan parasite *Trypanasoma cruzi.* Infected insects take blood meals from humans and their domestic animals and deposit parasite-laden feces. The parasites are then transmitted to humans through breaks in the skin, mucosal surfaces, or conjunctiva. Transmission also occurs congenitally or through blood transfusion or organ transplantation. Once an individual is infected with *T. cruzi*, there is no way to eradicate the infection. Longstanding *T. cruzi* infection can lead to the serious cardiac disease of Chagas disease. Ten to 30% of individuals with chronic Chagas disease develop clinical manifestations of the disease. The most serious cardiac complication is an inflammatory cardiomyopathy that results from the presence of parasites in the heart. This cardiomyopathy results in congestive heart failure, causing symptoms of severe shortness of breath, decreased exercise tolerance, and swelling in the lower extremities. Cardiac rhythm disturbances can also occur.

While the rates of cardiac disease due to Chagas disease are low in the native population of the United States, there has been a notable increase in the number of people with complications of Chagas disease in the last few decades due to immigration of people from endemic countries. It is estimated that now approximately 13 million people from endemic countries live in the United States and 80,000–120,000 of these people have chronic *T. cruzi* infection. Approximately two thirds of these individuals are from Mexico.

Acute rheumatic fever is another infectious cardiac disease that is common in immigrant populations. Streptococcal throat infections are sometimes followed by rheumatic fever, typically beginning about 2–3 weeks after the initial streptococcal infection. In about half of patients with acute rheumatic fever, inflammation of the heart called carditis can follow, and carditis leads to heart failure in some patients. Rheumatic fever can also damage heart valves. In the United States, rheumatic fever is most common in recent immigrants from developing countries in which there is poor access to antibiotics.

Conclusions

Immigration status plays a large role in the development of cardiovascular disease. Shifts from rural to urban lifestyles and changing patterns of diet and exercise are largely responsible for the development of cardiovascular risk factors that in turn lead to coronary heart disease. Perinatal, metabolic, and endocrine causes of heart disease also are affected profoundly affected by immigration status. Immigrants without appropriate access to regular medical care are more likely to experience the sequelae of various cardiovascular illnesses. Cardiovascular disease rates are determined by a complex set of cultural, biological, and social factors, and immigration status is intimately tied to these factors. In order to adequately identify and treat cardiovascular illness in diverse populations, it is vital that this cultural milieu is recognized and considered. This will become even more imperative as increased immigration and globalization lead to increasingly heterogeneous populations throughout the world.

Related Topics

- ► Body mass index
- ► Cardiovascular risk factors
- ► Chronic disease
- ► Diabetes mellitus
- ► Hypertension
- ► Obesity
- ► Stroke
- ► Tobacco use

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Cardiovascular Risk Factors

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Cardiovascular (CV) disease remains the single greatest cause of mortality in developed nations and is fast rising as a major cause of mortality elsewhere. While many developed nations have begun to address CV disease and the associated population risk factors, few resources are dedicated to identification and modification of CV disease risk factors elsewhere. Immigrants face multiple challenges addressing CV disease risk factors; many developing nations may fail to identify CV risks within immigrant populations and when these risks are identified, access to care, beliefs systems inconsistent with the Western medical model, and competing (non-health related) priorities may interact to make CV risk factor identification and modification difficult. Additionally, the CV risk profile that immigrants arrive with will change over time, often to include a more sedentary and stressful lifestyle and less healthy diet.

Two important questions regarding immigrants and CV risk are whether one's status as an immigrant confers inherent CV risk and whether ethnic or geographic variation changes the relative importance of various CV risk factors. These questions touch on the basic conundrum of medical providers, public health workers, and policy makers. How are immigrants different than other patients and how specialized do health care services need to be in order to address their unique health issues without recreating services that already exist elsewhere and for which specialization is not beneficial?

Immigration clearly imparts stressors that may contribute to CV risk. The psychological stress associated with migration has been linked to increased CV risk and for immigrants leaving their country of origin after traumatic events, either natural or man-made, this stress translates to heightened CV risk. In addition to the psychological stress associated with immigration, the transition to a new country almost certainly interrupts normal diet and activity level.

Some ethnic and regional groups of immigrants have been reported to possess inherently increased CV risk profiles. For example, multiple reports have identified increased rates of insulin resistance, diabetes, and other CV risks among Asian and Pacific Islander immigrants to the United States, Brazil, and other nations. Other groups of immigrants that have been identified as having particularly high CV risk profiles include

It is likely that the most significant cardiovascular risk factors among immigrants stem from variables that are unrelated to immigrant status. One of the single largest studies to examine cardiovascular disease predictors among multiple national and ethnic groups was the INTERHEART study. This case-control study was conducted in 52 countries and identified 9 easily measured risk factors that account for over 90% of the risk of acute myocardial infarction (AMI) among patients presenting with their first AMI at 262 participating centers. These risk factors (smoking, lipids, diabetes, hypertension, obesity, diet, physical activity, alcohol consumption, and psychosocial factors) were analyzed for approximately 12,000 cases and 9,000 controls. Conventional wisdom has held that these traditional risk factors might account for only 50% of AMI risk and that these risk factors might vary widely in their predictive power across geographic regions. Surprisingly, these nine risk factors proved remarkably consistent in their predictive powers of AMI in both men and women as well as across the 52 nations of Africa, Asia, Australia, Europe, the Middle East, and North and

South America where subjects participated. One geographic dichotomy that INTERNEART reported was the much earlier presentations of AMI among men (8–10 years versus women) and in the regions of Africa, the Middle East, and South Asia (10 years versus all other regions).

While most studies compare the CV risks of immigrant to a native-born cohort, a key consideration is whether the immigrants' CV risks are truly acquired or not. For example, smoking among immigrant populations appears to mirror rates from the country/region of origin. Immigrants moving from low to higher smoking prevalence nations (such as Africans living in Europe) appear to conserve their low prevalence status while immigrants making the opposite transition appear to similarly continue their high rates of smoking. Given projections that global smoking rates will continue to rise and soon account for 10% of all deaths, these observations may not hold and immigrants from less developed nations may arrive with additional CV risks.

Unlike smoking, rates of diet and physical activity appear to change relatively quickly with immigration. Multiple studies have examined the role of new dietary habits among immigrants as well as the changes in physical activity and mental health. Immigrants from Africa to Europe may have lower rates of smoking but higher rates of physical inactivity and higher BMI than their native-born cohort. These changes in risk profile likely result in physiological consequences such as increased atherosclerosis changes over time. Additional information may be gained from knowledge of migration within nations that replicates external migration. For example, an analysis of CV risk factors among Tanzanian men and women who migrated from rural to urban setting revealed increased weight and decreased physical activity but mixed changes in cholesterol and diet (more red meat but also more fresh fruit and vegetables). In some cases, such as that of emigration from the former Soviet Union to the United States, the dietary and activity changes may actually improve CV risk from baseline.

For policy makers, public health professionals, and medical providers, a central challenge is how to communicate CV health knowledge to immigrant patients and work to promote healthy living. Multiple studies have documented that immigrants acquire CV risk factors associated with the diet and level of activity, but to date, the evidence concerning targeted interventions is mixed. Since most of these interventions are small community-based programs, rigorously evaluating their effectiveness is often a challenge.

One challenge to these interventions is difficulty in targeting the intervention to a particular immigrant community. Some immigrant groups are well-acquainted with the Western medical model and long-term health risks and disease progression may be widely accepted concepts. Such groups may include immigrants moving between developed nations or those migrating from nations with established primary care systems. For many immigrants, however, the notion of CV risks and decade-long developments of CV disease is quite foreign. Many immigrants from developing nations are familiar with medical care, providers, and medication as interventions for urgent or emergent problems such as trauma, seizure, and complicated childbirth. For these immigrants, traditional beliefs and practices are often very intact when they arrive in a new home country. These traditional concepts of disease, and the traditional healers that offer services in the new country, must be integrated into any efforts to educate or otherwise engage immigrants about CV risk. Such an undertaking may be too great a challenge for primary care providers and concerted community and public health campaigns are often needed. Traditionally, public health interventions with immigrants in developed countries have focused on infectious disease, such as screening for tuberculosis, HIV, and parasitic infection. While these diseases remain important, similar efforts must be made to communicate abut CV risks and disease in immigrant communities.

Another challenge that may impair CV risk reduction strategies among immigrants is the presence of more pressing needs. In developed nations, newly arrived immigrants face a dizzying array of social services and regulations that they must navigate in order to secure basic food, shelter, and employment. For immigrants arriving or staying in a new country without proper immigration status, the need to avoid detection (and detention/deportation) by immigration officials may supersede almost all other needs. For immigrants who do seek to engage with medical care, it is most often on behalf of their children, who may require certain medical documentation for school registration, and for whom medical care may be more accessible. Communities that have successfully engaged with immigrants concerning CV risks have done so by providing care in a convenient manner (i.e., in a mosque or taxi garage or school) and without any threat of immigration or police presence.

CV risks among immigrants are essentially like those of nonimmigrants, an aggregation of dietary, lifestyle, and genetic components as reported in the INTERHEART and other studies. The unique concerns for promoting CV health among immigrants are how to identify changing CV risk profiles and engage immigrant communities on these risks and their modification. Several levels of intervention are required for meeting this goal. First, leaders in immigrant communities must be enlisted as advocates for promotion of CV health. Next, public health institutions must target their CV risk reduction campaigns toward the immigrant groups in their communities with programs that are rooted in familiar language and concepts. Simple, protective interventions such as smoking cessation, increased daily intake of fruits and vegetables, and moderate physical activity can be incorporated into most belief systems and concepts of health. Finally, primary medical care must be available to immigrants so that their physicians can perform adequate CV risk assessment and discuss CV risk modification.

Related Topics

- ► Blood pressure
- ► Body mass index
- ► Diabetes mellitus
- ► Dietary patterns
- ► Disease prevention
- ► Obesity
- ► Percent body fat
- ► Stroke

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Caregiving and Caregiver Burden

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Caregivers or, as they are known in some countries, careers, are people who are responsible for looking after, tending to, or aiding others who suffer from illness or disability. While there are numerous formal sources of care, such as nursing homes, assisted living communities, rehabilitation hospitals, and home health care, most caregiving occurs informally and at home. Likewise, although there are professional caregivers who get paid for their services, caregivers are more often unpaid family members or friends of the individual requiring care. Parents, spouses, siblings, and adult children are often informal caregivers. The care recipients can be of any age and are often ill, injured, physically disabled, mentally ill, mentally disabled, or elderly. Family members and friends commonly step into the role of caregiver out of love, respect, commitment, and/or a sense of duty or responsibility for the care recipient.

With advances in medical science, the populations of many countries have seen an increase in longevity for the elderly, ill, and disabled. This has created an increased need for caregiving. In 2004, it was estimated there were 44.4 million caregivers in the USA The UK reported six million caregivers in 2001. In the same year, there were 481,579 caregivers in Scotland. As caregiving is very personalized, the amount of care provided, as well as the type of care provided, varies with each care recipient. The care recipient may need full-time care, requiring the caregiver to be present for forty or more hours a week. Other care recipients may need as little as a few hours a week. Depending upon the care recipient's needs, the caregiver may have a full or part time job in addition to aiding the care recipient. In recent years, employers have begun to work with caregivers by offering more flexible hours, job sharing, the ability to work from remote locations, and leaves of absence.

Most caregivers are women. A study performed by the National Alliance of Care Giving and American Association for Retired Persons (AARP), released in 2004, showed 61% of caregivers in the study were women. Male caregivers are more likely to provide care to other men. Female caregivers also tend to provide a greater number of hours of care and a higher level of care.

Caregiving is extremely individualized. It can be relatively undemanding, highly demanding, or anywhere in-between these extremes. The care may be as minimal as grocery shopping, paying bills, driving to an appointment, and/or housekeeping. However, the care could be comprehensive and require assistance with cooking, feeding, dressing, bathing, wound care, transferring/lifting, and management of medical equipment like catheters, wheelchairs, respirators, or oxygen tanks.

As well as assisting in activities of daily living, caregivers often play other roles. Caregivers are usually advocates for the medical management of the care recipient. The provision of care requires that caregivers understand the care recipient's illness, disability, or medical condition and participate in the treatment or management of it. Caregivers often dispense medication and provide both reassurance and emotional support to the care recipient. They may also be in charge of, or assist with, the care recipient's finances and upkeep of the household.

Informal caregiving may be coupled with formal caregiving, depending on the needs and resources of the care recipient. For example, the recipient may attend adult day care or have a home health nurse who only performs specific tasks related to the care recipient's medical needs. The care recipient may have a housekeeper, driver, or the ability to utilize community transportation services to attend appointments. When this occurs, informal caregivers are required to coordinate the sources of care to ensure all the care recipient's needs are met.

An individual's need for care can occur quickly, such as when there is an accident, or may develop over time. A care recipient's need may also change as a disease progresses. Individuals who suffer from Alzheimer's or dementia may be able to function relatively well in the beginning, requiring little to no care, and progress slowly toward a need for around the clock care. Caregivers must adjust to meet the needs of the care recipient and, when necessary, consider whether more formal care is required. When the needs of the care recipient become greater than the abilities and/or resources of the caregiver or caregivers, a decision must be made regarding whether to turn to institutionalization of the care recipient.

Caregiving can be a rewarding experience. Although caregiving can be complicated and demanding of time and resources, many caregivers find a sense of purpose stems from the act. In fact, a 2007 nationwide survey by *Caring Today* magazine revealed, in the USA, nearly 80% of family caregivers found the experience to be emotionally rewarding. Caregivers also often find their bond with the care recipient strengthened through the caregiving experience. The caregiver may also develop increased self-esteem through the provision of care. These positive findings can be characterized as caregiver gain.

While some find caregiving to be a positive experience, others find the opposite. Caregiving, especially if the care recipient's needs are highly demanding, can be extremely stressful. The stress (physically, emotionally, and financially) experienced by those who provide care to the ill, disabled, and elderly can be characterized as caregiver burden. Caregiver burden is also known as caregiver syndrome, caregiver stress, caregiver distress, and caregiver strain.

Caregiver burden is the result of more than the need to provide care. The way the caregiver approaches the task can affect how he or she feels about the role. Many times the role as caregiver is unexpected, unfamiliar, and unwanted. If the caregiver feels he or she had no choice in assuming the role, it is more likely there will be anxiety and a negative attitude on the part of the caregiver. There may be feelings of resentment toward both the role as caregiver and the care recipient. Additionally, the nature of the relationship between the caregiver and care recipient before the need for care arises can affect how the caregiver feels about his or her role. When the caregiver and care recipient have a good relationship before the need for care arises, the caregiver may feel more positive about his or her role. Conversely, when the participants have a bad or shaky relationship before the need for care arises, the caregiver may experience a greater amount of anxiety, bitterness, or resentment.

The effect of caregiving on the caregiver's relationships with others can add to caregiver burden. The majority of caregivers have a spouse and children. Caregiving can cause strain on marriage and relationships with children, friends, and coworkers. When the care recipient is also a member of the caregiver's family, caregivers may find their relationships with other family members are also strained. The caregiver may feel other family members are not providing the additional aid they should. Disagreements may arise between family members, especially siblings, concerning the type of care being provided, the manner in which the care is provided, use of the recipient's resources, or whether the recipient should be institutionalized.

In addition to the strain on relationships, it is not uncommon for the caregiver's social activities to diminish. Social isolation leads to feelings of loneliness, guilt, and resentment. The caregiver may feel anger over losing time with others, the ability to engage in hobbies or favorite past times, and free time. Such isolation, and the resulting feelings, can lead to depression and/or anxiety. Studies have shown caregivers suffer from a higher incidence of depression than control groups. If the caregiver has few coping skills, the burden felt can be magnified.

Caregivers often neglect their own mental and physical health while caring for another. Caregivers are twice as likely to report a physical or mental health condition. Caregivers have been found to have a reduced immune function and slower healing of wounds. Viral illnesses tend to last longer in caregivers than non-caregivers. Studies have also found higher mortality and morbidity levels in caregivers who perceive greater stress in the provision of care. One study found elderly spouse caregivers who experienced caregiver burden had a 63% higher mortality risk than the control subjects.

The amount of caregiver burden that is experienced by caregivers can be affected by the culture from which they belong. In some cultures, the caregiver does not differentiate this role from their other daily activities. Instead, it is perceived as a part of life. The Chinese culture, for example, views caregiving as just another part of family life. Caring for family is considered part of filial piety, or respect and love for one's parents and ancestors. The Hispanic or Latino culture is very similar. The concept of *familia* dictates family members are morally responsible to help each other. Thus, members of this culture are raised to expect the need to aid family members when problems arise with their health, finances, or other life issues. The African-American culture has been found to have comparable values.

Caregiver burden can have an effect on both the caregiver and the care recipient. As the caregiver declines, the quality of care to the recipient may also decrease. The care recipient may be exposed to the caregiver's negative attitude and resentment. This can lead to guilt and resentment on the care recipient's behalf. Moreover, the possibility of abuse, verbally or physically, increases when the caregiver is under, or perceives, a larger amount of stress and anxiety.

When considering caregiver burden, consideration must be given to what is occurring financially, socially, physically, and psychologically for both the caregiver and the care recipient. Once all of this is considered, steps can be taken to reduce the burden on the caregiver. Respite can provide the caregiver with a break from the provision of care. The caregiver can use the time to relax, take care of his or her own needs, spend time with friends or family, and engage in hobbies or favorite past times. Aid from other family members, support groups, and the utilization of community support programs can also help reduce the caregiver's burden.

The stress experienced by caregivers can be reduced further by having legal documents that outline the care recipient's wishes. Discussion of the care recipient's wishes coupled with legal documents like advanced directives, wills, powers of attorney, and Do Not Resuscitate (DNR) orders helps alleviate the stress that accompanies a caregiver having to make financial, health care, and end-of-life decisions for the care recipient. It can also prevent conflict among family members who have different ideas concerning the care recipient's finances, treatment, and end-of-life decisions. Open and frank communication between the caregiver, the care recipient, and other members of the family about the conditions under which the recipient would be institutionalized can also serve to reduce the burden experienced by the caregiver.

Unlike in the past, individuals today have an increased longevity. Technology and medical advancements permit many people who once would have been institutionalized to live at home. These factors, along with the rising cost of health care, have increased the need for family and friends to provide care for the ill, elderly, and disabled. Along with the increased need for caregivers is an increase in the burden they may experience. While caregiving can be stressful and demanding, it can also be a rewarding and fulfilling experience. However, caregivers should know their limits, develop additional coping skills, and be aware of the resources available to them financially, emotionally, and in the community. Caregivers must also learn to balance their roles as a skilled caregiver, friend, spouse, parent, employee, and family member. Caregivers that are successful in doing this are more likely to view caregiving experience in a positive light and provide a higher quality of care.

Related Topics

▸ Depression
▸ Disability

Suggested Readings

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CAT

▸ Convention Against Torture

Celiac Disease

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Celiac disease (also known as celiac sprue, nontropical sprue, and gluten sensitivity enteropathy) is an autoimmune disorder that damages the villi (small, fingerlike projections) in the small intestines and interferes with the absorption of nutrients from food. In individuals with celiac disease (CD), a negative reaction of the immune system is triggered by gluten, a protein primarily found in wheat, barley, and rye. When individuals with CD ingest gluten, their immune system responds by attacking and damaging the lining of the small intestine. This damage impairs the body's ability to absorb important vitamins, minerals, and other nutrients properly, leading to malnutrition and other conditions. Developing CD requires a genetic predisposition, exposure to gluten through digestion, and a trigger to start this abnormal reaction from the immune system. Common triggers include stress, trauma, or possibly infection. CD is permanent and damage to the small intestine will occur every time gluten is consumed, regardless if symptoms are present or not. Left untreated, individuals with CD may develop further complications such as diabetes, infertility, neurological disorders, osteoporosis, thyroid disease, and cancer. Strict adherence to a gluten-free lifestyle is the only known treatment for CD. CD was once believed to only affect populations of European descent. Due to this belief, the majority of research for CD was focused on individuals of European origin until the late 1970s. Today, researchers consider CD to be a worldwide health problem with evidence of it affecting all ethnic populations, without exception. CD is common in developing countries where the major diet staple is wheat, posing a challenging health problem for individuals requiring a gluten-free diet.

In addition to the misconception of CD only affecting Europeans, it was also thought of as a childhood disease presenting exclusively with GI (gastrointestinal) symptoms. It is now recognized that the disease is a multi-symptom, multisystem (organ) disease that can be triggered at any age. There are over 300 symptoms that may be associated with CD. The classic symptoms for CD include: chronic diarrhea/constipation, abdominal pain, bloating, and weight loss. More common but seemingly unrelated symptoms include joint pain, infertility, anemia, tingling/numbness, dermatitis, depression, irritability, and headaches. The symptoms of CD vary considerably from person to person, as does the severity of symptoms. To further frustrate patients and physicians, CD may present different symptoms at differing times within an individual's lifetime. For example, at age 20, GI symptoms may be present, while years later, at age 35, the same individual may experience joint pain, fatigue, or anemia, without GI issues. Others with CD may not experience any symptoms at all. With such a wide variety of symptoms associated with CD, coupled with many symptoms mimicking numerous other health issues, an accurate diagnosis can be time consuming, frustrating, and difficult. On average, it takes 10 years from the onset of symptoms for an individual with CD to be appropriately diagnosed.

Initial screening for CD is done through blood tests. The major tests that are available for CD screening include blood tests such as the IgA tissue transglutaminase antibody (also known as the TTG), the IgA anti-endomysial antibody, and the IgA antibody to deamidated gliadin. If these tests suggest CD, a small intestinal biopsy should be done, which is absolutely required to establish a definite diagnosis of CD. Individuals should not start a gluten-free diet prior to confirming the diagnosis of celiac disease by small intestinal biopsy. This is because the damage to the small intestine that is caused by gluten can heal when gluten is removed from the diet, therefore potentially causing a false-negative test result.

CD is the most common genetic autoimmune disorder in the United States today. It is also the most underdiagnosed autoimmune disorder and considered a hidden epidemic by many celiac specialists. CD affects approximately 1% of average, healthy Americans. This means that more than three million people in the United States are living with CD and 97% of them are undiagnosed.

Celiac disease predominately affects people of European descent (30% of Europeans currently carry the gene for celiac disease), but recent studies show increased prevalence of CD worldwide. It is a global health concern that affects both developed and underdeveloped countries. No continent nor ethnicity has been spared of this disease. Information, awareness, and support are all necessary factors for every individuals managing CD. In Finland, England, and Australia, celiac disease awareness is more advanced than in the United States and other countries. For example, health policy makers in Finland set out to achieve high detection rate by training health personnel, and advocating blood tests for people known to be at risk for developing celiac disease. However, individuals with CD living in the United States have more food options than ever. Once only available through mail order or in health food stores, gluten-free foods are now mainstream, providing celiac suffers with more food options than ever before. Many restaurants offer gluten-free menus, making dining out a possible option for individuals with CD, an option that was not long ago unheard of for individuals with such dietary constraints. Sales of gluten-free foods increased 74% from 2004 to 2009 in the United States and the gluten-free market is expected to reach $2.6 million in sales by 2012.

Many individuals experience several different emotions after being diagnosed with CD. Following a strict gluten-free diet for life can feel overwhelming. Individuals with CD must not only give up common foods such as bread, pasta, and pizza, but also have to be aware of items that may contain hidden gluten, such as lip balm, vitamins, and medicines. It is, however, a very a promising time for individuals with CD. New research results and information are becoming more accessible. Adhering to a gluten-free diet is challenging, although it is becoming easier as more and more gluten-free products come to market. The prognosis for CD is excellent in individuals that remain gluten-free. The small intestine will steadily heal and start absorbing the needed nutrients, and most individuals report an improvement with symptoms immediately after gluten has been removed from their diet.

Related Topics

- ► Food
- ► Nutrition

Suggested Readings

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Suggested Resources

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The Celiac Disease Foundation. www.celiac.org
Celiac Sprue Research Foundation. www.celiacsprue.org
National Foundation for Celiac Awareness. www.celiaccentral.org

Central America

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Location

Central America is a region of the continent of South America. It is situated between the southern border of Mexico and the northwest border of Colombia. Most often Central America is understood to include the nations between Mexico and Colombia, including Belize, Costa Rica, El Salvador, Guatemala, Honduras, Nicaragua, and Panama. There is some disagreement, however, as some geographers classify Central America as a large isthmus, in which case the boundaries include the portion of Mexico that lies east of the Isthmus of Tehuantepec, including: the Mexican states of Chiapas, Tabasco, Campeche, Yucatán, and Quintana Roo.

Geography

The region covers 524,000 km^2. Its population was estimated at 41,739,000 as of 2009, with a population density of 77 people/km^2. The land mass is recognized as the isthmus of southern North America, with boundaries that can be traced from southern Mexico's Isthmus of Tehuantepec, running southeastward to the Isthmus of Panama, where it connects to the northwestern portion of South America at the Colombian Pacific Lowlands. The furthest reaches of Central America can be seen to the north at the Trans-Mexican Volcanic Belt and the Gulf of Mexico, to the southwest at the Pacific Ocean, and to the northeast at the Caribbean Sea.

Central America is active geologically, with periodic volcanic eruptions and earthquakes. For example, in 1976, 23,000 persons were killed when Guatemala was devastated by an earthquake. Nicaragua's capital city, Managua, was the site of two catastrophic earthquakes in 1931 and 1972. Approximately 5,000 perished in the latter quake. Volcanic eruptions are common. As a consequence, fertile soils from weathered volcanic lavas have made it possible to sustain dense populations in the agriculturally productive highland areas.

Central America has many mountain ranges; the longest are the Sierra Madre de Chiapas, the Cordillera Isabelia, and the Cordillera de Talamanca. Fertile valleys lie between the mountain ranges and offer an attractive climate in which much of the population is concentrated. In fact, most of the population of Honduras, Costa Rica, and Guatemala live in valleys. Valleys are suitable also for the production of coffee, beans, and other crops. As part of the Mesoamerican Biodiversity hotspot, Central America holds greater than 7% of the world's biodiversity, featuring many species from the Nearctic and the Neotropic ecozones. The most biodiversity is found in the southern countries of Costa Rica and Panama, followed by the northern countries of Guatemala and Belize.

Recently, deforestation has been a concern for the region of Central America. The UN reports that despite efforts to arrest the decline, Central America had the highest rate of forest loss in Latin America for the decade 2000–2010. Over that same decade, the average annual rate of forest cover loss was 1.19% in Central America, compared to 0.13% globally, while Central America's forested area shrank from 54 million acres in 2000 to 48 million acres in 2010. The chief cause of deforestation in the region is conversion of forest land due to urbanization and agriculture; reportedly 90% of the wood removed in the region is used for fuel. It is reported, however, that a variety of practices are being developed to avoid deforestation, such as emission reduction projects, forest fire control efforts, and improved stoves.

History

Due to the Spanish conquest in the sixteenth century, most of Central America had a similar history – the exception was British Honduras. To the English, the land was called *British Honduras*; to the Spaniards and Guatemalans, the land was called *Belice*. In 1973, independence from Great Britain was earned, and the name "Belize" was adopted. From the sixteenth century through 1821, Central America formed the Captaincy General of Guatemala, or the Kingdom of Guatemala – formed by the states of Chiapas (now part of Mexico), Guatemala (including present day Belize), El Salvador, Honduras, Nicaragua, and Costa Rica. Officially, the Captaincy was part of the Viceroyalty of New Spain; however, it was administered not by the viceroy or his deputies, but by an independently appointed Captain General headquartered first in Antigua, Guatemala, and later in Guatemala City.

In 1821 a congress of Central American *criollos*, persons of Spanish heritage born in Latin America, declared their independence from Spain. Independence was short-lived; however, as on January 5, 1822, the leaders in Guatemala welcomed annexation by the First Mexican Empire of Agustín de Iturbide. When Mexico became a republic in 1823, it acknowledged Central America's right to determine its own destiny. On July 1, 1823, the congress of Central America declared absolute independence from Spain, Mexico, and any other foreign nation, and a republican system of government was established and the nation of Central America was formed.

The Constitution for the Federal Republic of Central America was signed in 1824; the nation was comprised of Guatemala, El Salvador, Honduras, Nicaragua, and Costa Rica, with an additional state – Los Altos – being added in the 1830s. Although Central American liberals hoped the new country would evolve into a modern, democratic nation, the Union dissolved in civil war, beginning when Honduras separated from the federation on November 5, 1838. The federation faced significant obstacles such as strong opposition by conservative factions allied with the Roman Catholic clergy, deficient transportation and communication routes between states, a broad lack of commitment toward the federation, and poverty and extreme political instability.

Although various attempts have been made to reunite Central America, none has succeeded for any length of time. While reunification lacks popularity with the leaders of the individual countries, the concept arises occasionally. Today, all five nations fly flags that have incorporated the old federal ornamentation of two outer blue bands bounding an inner white stripe.

Demographics and Ethnicity

The Central American population has grown rapidly over the last 60 years, with an estimated population in 2007 at over 40 million, up from 10 million in the early 1950s. On average, the population density is 77.3 inhabitants/km^2, though the population is distributed very unevenly across the region.

Spanish, the dominant language of the region, is the official language in six of the nations, while English is the official language of Belize and along much of the Caribbean Coast. Many of the native tribes speak only their native tongue, though some speak Spanish and others speak more than one native language. In some areas of Central America, many indigenous languages still exist; for example, there are 23 different Mayan dialects spoken in Guatemala. In other Central American countries, indigenous languages are now less prevalent.

Central America is comprised of a large percentage, nearly 70%, of persons who are of mixed ancestry. It is estimated that approximately 60% of those with mixed ancestry are of mixed European and American Indian descent; they are called *ladinos* in Guatemala and *mestizos* elsewhere; with an additional 5% descended from European and African ancestors, referred to as *mulattoes*; and 1% descending from a mix of native and Black ancestors. The original indigenous population, *Amerindian*, comprise 20% of the population. Those of strictly European ancestry make up approximately 12%, with the remainder claiming descendency from Chinese and East Indian indentured servants. The population is distributed unevenly across the region, with one-third in Guatemala, one-sixth in El Salvador, one-sixth in Honduras, one-eighth in Nicaragua, one-tenth in Costa Rica, and one-twelfth in Panama. A very small percentage, less than 1%, resides in Belize.

The native populations were converted to Catholicism during the Colonial Period. Catholicism has remained the majority religion of the region, ranging across Central America from 80% to 90%. The Catholic faith was blended into the religious practices of the native peoples, and their original beliefs and rituals have become a part of the Catholic faith of the region.

Culture

Central America has a rich cultural heritage that includes influences from the Maya, Olmec, Teotihuacán, Toltec, Aztec, and other Mexican civilizations. From approximately 2000 BC, the Maya occupied the Yucatán and adjacent parts of Central America. Their greatest achievements included their elaborate calendar, writing, palaces and temple pyramids with vaulted rooms made of limestone, polychrome pottery, stone stelae, and stylized wall paintings and bas-reliefs. Maya architectural styles are found in three regions: the Petén district (Uaxactún and Tikal); the cities of the river valleys, such as Piedras Negras and Palenque; and the cities of central and North Yucatán (Uxmal).

To the west, in the area of Veracruz and Tabasco, Mexico, the Olmec civilization developed in the Preclassic period. The finest Olmec art was produced between 800 and 400 BC. The Olmec are noted for the excellence of their stone carving; frequently, they used a motif combining human and jaguar features.

Much to the west of the Olmec and Maya civilizations, dating from the first century AD to 700 AD, the Teotihuacán civilization formed – with the peak of its artistic expression occurring approximately between 300 and 700 AD. The Teotihuacán produced extraordinary architectural achievements including monumental pyramids, temples, and processional roads. The site of Teotihuacán was destroyed by invaders around 700 AD.

The two centuries following the fall of Teotihuacán are characterized by the absence of a single dominant force, with a multitude of warring factions vying for power. Eventually one group, the Toltec, made their capital northwest of Teotihuacán at Tula and reigned approximately from 900 to 1,200. The Toltec dominated much of Mexico until they were defeated in the mid-1100s. During their reign they invaded Maya country, in particular Chichén Itzá. The Toltec's cultural influences are revealed in the pyramids at Tula and Chichén Itzá, with their deep colonnades, their decorative bas-relief, and their many sculptured structural elements.

Following a period of anarchy after the destruction of the Toltec's, the Aztecs rose to power. By 1344, at the site of present-day Mexico City, they had founded Tenochtitlan, their grand capital, which became one of the architectural wonders of ancient America. Aztec art developed a unique character, drawing on the traditions of conquered areas, but under the influence of the harsh Aztec religion as well. The importance of human sacrifice in the cult of the war god, Huitzilopochtli, permeated life and art, and representations of skulls, hearts, hands, and sacrificial scenes were common.

The Aztecs sculpted magnificent works made of stone; pieces were large and elaborate. One such example is the statue of the earth goddess Coatlicue, which features intertwined serpents and a necklace of human hearts and hands. Less ominous subjects, such as the plumed serpent, Quetzalcoatl, and various animals, were carved in a smooth, compact style. Feather work, jade carving, gold work, extraordinary ceremonial vases, and superb textiles were produced by the artisans of subjugated groups. Aztec power over Central Mexico extended until the arrival of Cortés in 1519.

Modern Central America is undergoing considerable change – culturally, politically, and economically. With efforts toward cooperation, if not unification, communication between states has increased over recent decades. Four countries, Guatemala, El Salvador, Honduras, and Nicaragua, are undergoing a process of integration and have formed The Central America Four or *CA-4*, which has introduced common internal borders. The policy of common internal borders enables the citizens of the four signatory states to freely move across borders, without restrictions or checks. Foreign nationals who enter one of the signatory countries can travel to other signatory states also without having to obtain additional permits or to undergo checks at border checkpoints. The CA-4 Agreement is similar to the Schengen Agreement in Europe in that it establishes a harmonized visa regime for foreign nationals traveling to the area. Belize, Costa Rica, Panama, and Dominican Republic join the *CA-4* only in matters of economic integration and regional friendship.

Economy

There is significant economic diversity within the Central American countries. Nicaragua is the least developed as reflected in rates of infant mortality, adult literacy, and GDP, common indicators of development. Panama and Costa Rica are more developed. Although Panama has the highest GDP per capita, Costa Rica is considered to be the most developed of the Central American countries due to its relatively high GDP per capita and has the best indicators of the Central American countries for life expectancy at birth, infant mortality rate, and adult literacy rate.

Historically, Central American trade has been highly dependent on two exports – coffee and bananas. In fact, during much of the twentieth century, coffee was the single largest Central American export. The export of bananas has been critical to the economies of Honduras, Panama, and Costa Rica. The United States and Central America have strong trade agreements. The United States was the main importer of Central American products during the twentieth century. In recent decades, Central America has had success in diversifying its exports and is now less dependent on bananas and coffee. Furthermore, the region has sought to diversify its trading partners as well.

At times the countries that comprise Central America have sought to promote mutual economic development. In 1960, with the chief goal of economic growth, Guatemala, Honduras, El Salvador, and Nicaragua created the Central American Common Market (CACM). However, CACM suffered from political disagreements, culminating in 1969 in a war between El Salvador and Honduras. The conflict resulted in slowed economic cooperation in all of Central America. In recent years, efforts have been made to increase economic integration among the Central American nations.

Health

As with many developing regions of the world, there are significant disparities in health equity across Central America. Public health campaigns were widely implemented first by the Pan American Sanitary Bureau and the ministers of health of Costa Rica, El Salvador, Guatemala, Honduras, Nicaragua, and Panama. They were instrumental in the creation of the Institute of Nutrition in 1946, which was inaugurated formally in September 1949. The Institute orchestrated pioneering clinical and epidemiological studies and interventions. A primary goal was identifying and correcting dietary deficiencies in the region, and the Institute developed some of the first studies on the chemical composition of foods used by the population. Today, the Institute is known as the Instituto de

Nutritión de Centro América y Panamá (INCAP) and serves as a Pan American Health Organization (PAHO)/World Health Organization (WHO) Regional Center.

Migration

Central America has experienced high rates of migration for generations, including rural-to-urban and regional migration as well as emigration abroad, predominantly to the United States. Before the 1980s, a decade wrought with armed conflicts in the region, Central America drew little global or hemispheric attention in terms of migration. In this period, however, the region became a geographic bridge to North America as migrants from South America sought to enter the United States. Furthermore, Mexico has become the main transit country for Central Americans headed north.

Emigration abroad has produced a range of profound changes within Central America, including economic dependency on remittances, an exponential increase in the volume of international phone calls, and – from fashion to governance – the importation of outside tastes. While Central America is a junction of numerous migratory flows, migration does not affect the region uniformly. The more conflictive zones and countries in the region, such as the civil strife in El Salvador, Nicaragua, and Guatemala for example, have experienced significantly higher rates of emigration than rates in the more stable countries of Panama and Costa Rica.

Colonized by the Spaniards in the 1500s, Central America was chiefly a subsistence agricultural zone; that is, any agricultural economy in which the crops and/or animals are used nearly exclusively for local or family consumption. As such, the *Kingdom of Guatemala* provided far fewer riches than other Spanish colonies. Though independent as of 1821, the region's livelihood did not change substantially until the late nineteenth century when coffee and other export crops were introduced. The reforms at that time privatized communal lands and displaced thousands of peasants. Equally important, however, is that the policies catalyzed a pattern that endures today – oligarchic control of the land and the armed forces, while much of the population fights to overcome perpetual poverty. This combination of agricultural labor needs with people displaced from the land produced seasonal, rural-to-rural migration – a pattern that endured into the second half of the twentieth century.

In the 1960s, several Central American countries attempted industrialization. However, the divided class structure persisted and became the impulsion for revolutionary and civil warfare in the region during the 1970s through the early 1990s. Warfare not only killed thousands and displaced millions, but also institutionalized a migration pattern to the north – a pattern that until this time had been very minor. Massive refugee flows moved through the isthmus into the United States and, to a lesser extent, Mexico, Costa Rica, Canada, and Belize. Until then, Central American emigration had consisted of small numbers of professionals, skilled laborers, and domestics. Internal labor migrations became increasingly dangerous as a result of the region's conflicts. Thus, regional economies suffered, inciting combatants and noncombatants alike to flee. Figures derived largely from the 1990 US census suggest that more than a million Central Americans fled their homelands and sought asylum in the United States during the turbulent decade of the 1980s.

Regional Migration

In 1970, approximately half of all Central American emigrants relocated to other Central American countries, while half moved out of the region. By 1980, however, the proportions had altered dramatically, with 80% leaving the region. In fact, by 1990, 93% of all Central American migrants left the region. Information on extraregional migration flows is much more readily available, although there is some notable research on Nicaraguan migrants emigrating to Costa Rica and, to a lesser degree, migrations of Guatemalans and Salvadorans to Belize. Intraregional migration is an area that calls for further study. For example, there is growing evidence of migrations of Nicaraguans and Hondurans into El Salvador spurred by the late 1990s postwar economic recovery in that country – a rebound financed in large part by remittance dollars from Salvadorans living in the United States. Additionally, the Panamanian economy attracts a modest number of Central American migrants; the number of Central American foreign born rose 11% between 1990 and 2000.

Related Topics

- ► Asylum
- ► Emigration
- ► Health care
- ► Health outcomes
- ► Immigration status
- ► Mexico
- ► Refugee

Suggested Readings

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OECD. For information on Central America from the Organization for Economic Development and Cooperation. http://www.oecd.org

Cervical Cancer

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Cervical cancer is the seventh most common cancer worldwide and the third most common among women. In 2008, there were 529,000 new cases of cervical cancer and 275,000 deaths worldwide. Cervical cancer arises in the epithelium after persistent infection with one or more oncogenic types of human papilloma viruses (HPV). The resulting precancerous lesions can progress to invasive cervical cancer over a period of 10–20 years if not identified and removed in a timely manner. The main risk factors are therefore HPV infection and a lack of screening with early treatment. The established identified cofactors that increase the risk of cervical cancer are long-term use of hormonal contraceptives, high parity, tobacco smoking, and coinfection with HIV. Common factors that contribute to most of these risks are low education and poverty.

Epidemiology

It is estimated that among women worldwide with normal cytology about 10.4% are positive for cervical HPV DNA. HPV and cervical cancer are unequally distributed globally with a high concentration in the Global South. The prevalence of HPV is higher in less developed countries (15.5%) than in more developed countries (10.0%). Women in Africa have the highest HPV prevalence (22.1%), followed by women in Central America (20.4%). In contrast, women in South America and North America have a lower prevalence (12.3% and 11.3%, respectively).

While the geographic pattern of cervical cancer generally follows the HPV pattern, cervical cancer screening and treatment inequities modify the pattern somewhat. Approximately, 85% of the cervical cancer cases occur in low-income countries where cervical cancer accounts for 13% of all female cancers. In Africa, the age-standardized incidence rate (ASR) is 29.3 per 100,000 with an ASR of 42.7 in Eastern Africa. Central and South America have ASRs around 30 while the rate in Asia is 15.4 (26.6 in South Asia). In contrast, the cervical cancer ASRs in North America, Japan, Australia, Western Europe, and Northern Europe are all below 10.

The slow conversion of an HPV infection to cervical cancer provides a long window for action. Early detection methods and curative treatments were introduced in the 1950s in developed countries, leading to falling cervical cancer rates in most parts of the world. The high incidence and mortality rates in low-income countries are mainly due to the lack of or ineffective screening programs, in addition to elevated disease burdens, a lack of basic health care services for women, and to general barriers to access and utilization of health care.

Cervical Cancer in the Context of Migration

The low international migration rates of residents of the poorest nations result in most migrant women coming from countries with middle incomes and an intermediate risk profile for HPV and cervical cancer. When they settle in high-income countries, those migrant women are often the focus of special efforts to screen, diagnose, and treat HPV and cervical cancer because their rates are noticeably higher than the average of their new homelands.

Screening

Data from high-income countries with large immigrant populations consistently show that screening rates are lower for immigrants than for the native born, and that Asian immigrants have particularly low rates.

The majority of the 40 million immigrants in the USA come from Latin America (54.6%) and East and South Asia (17.6%). One study found that 18.6% of recent immigrant women (those who have lived less than 25% of their lives in the USA) and 9.9% of more established immigrants had *never* received a Pap test in their lifetimes, compared to 5.8% of US-born women. The highest rates of never being screened were for women born in India who had lived less than 25% of their lives in the USA (recent immigrants, 43.7% unscreened) and those who had lived more than 25% of their lives in the USA (established immigrants, 25.0% unscreened). The study similarly found high non-screening rates among immigrant women from Mexico, with 32% of recent immigrants and 16.6% of established immigrants reporting that they had *never* been screened for cervical cancer. There was a consistent trend among immigrant women of increasing "ever screened" rates as they lived a longer portion of their lives in the USA. When the rates were adjusted by socioeconomic factors, the adjusted prevalence of never receiving a Pap test was highest among women from Asia, Southeast Asia, and India (19.6%); followed by women from South America (12.7%), Mexico (11.2%), the Caribbean (11.0%), Europe (9.9%), and Central America (9.2%).

Immigrants constitute 20.8% of Canada's total population. While the largest number of foreign-born persons is from the United Kingdom (UK), the largest migrant groups since the 1990s have been from China, India, and other Asian nations. A study of immigrants in Canada found that White English-speaking foreign-born women have the best Pap smear screening rates (only 3.8% never screened and 16.1% screened more than three years previously or not at all). These percentages were similar to the rates for White native women. In contrast, other groups of immigrant women reported high rates of never having been screened: 34.3% of South Asians, 30.1% of Arab/West Asians, 25.5% of Southeast Asians, and 17.5% of Hispanics. The authors concluded that Pap testing for Hispanic immigrant women and White women from continental Europe eventually reaches, and in some cases surpasses, that of Canadian born White women. Immigrant women from Asia, however, never reach the cancer screening rates of native-born women even after living many years in Canada.

Immigrants in Australia constitute 26% of the total population and mostly come from the UK, New Zealand, China, and India. Several studies have shown that migrant women in Australia had significantly lower levels of screening compared with the native-born population, with only 39% of Thai women reporting regular Pap tests and Vietnamese women being at 10–12% points lower than the general population in cervical cancer screening rates. Similarly, the odds ratio of reporting ever having a Pap smear were significantly lower for migrants from Southern Europe, Southern Asia, the Middle East, and Southeast Asia compared to Australian-born women.

While culturally based notions of modesty, embarrassment, and fatalism have been extensively studied as possible contributors to lower screening rates, it is important to note that most of these studies have not controlled for cohort and history effects. The Pap smear was introduced in 1949 and gradually became part of the routine care for women in developed countries. On the other hand, in low-income countries cervical cancer prevention programs compete with many health priorities in the midst of major financial constraints and have been plagued by ineffectiveness or limited to coverage in urban areas. Therefore, some cohorts of immigrant women lack familiarity with Pap testing, resulting in a lack of knowledge about the test and its purpose. However, increased education, the utilization of community health workers and interpreters, accessible transportation and child care, and most importantly, access to healthcare, have been shown to increase rates of Pap screening among immigrant women.

Incidence

Immigrants in high-income countries tend to exhibit cervical cancer rates that are between that of the country of origin and the receiving country.

In the United States in 2007, the age-adjusted cervical cancer incidence was 7.9 for non-Latina White women, 10.7 for Latinas, and 7.0 for Asian American women. Just over half of Latina adults were immigrants and almost 80% of adult Asian American women were immigrants. The higher rate of cervical cancer for Latinas than Whites is the opposite of the pattern for most other cancer sites. In addition, Latinas living in heavily low-income Latino neighborhoods, which are also primarily immigrant communities, have higher odds that both cervical and breast cancer will be detected at a later stage compared to those living in neighborhoods with a lower proportion of Latinos. This suggests that barriers to screening, noted above, have a consequence on the severity of cervical cancer when it is identified.

Immigrants to the USA from other low and middle-income countries also have high incidence rates. For example, in Miami, Florida the cervical cancer rate is highest among recent Haitian immigrants with an estimated incidence of 38 per 100,000. According to the Pan American Health Organization (PAHO), Haiti has the highest cervical cancer rate in Latin America and the Caribbean at 93.8 per 100,000 women. Laotian women have the highest rates among Asian American women with a cervical cancer incidence rate of 24.8; reliable data from Laos is not available.

Cervical cancer rates in Canada among refugee women 45–64 years of age exceed rates among their Canadian counterparts. Refugee immigrants had an elevated incidence of cervical cancer with a standardized incidence ratio of 1.58 to native Canadians. Among non-refugee immigrant women of the same age, the rate was no higher than among native Canadian women. The majority of refugee immigrants originated from Southeast Asia and South and Central America, while non-refugees are from Northeast Asia, Middle East, North Africa, and Western Europe.

In Sweden, there is an increased risk of cervical cancer among women who immigrated to Sweden at age 50 or higher and who were born in Asia, South America, Poland, Bosnia, Eastern, and Southern Europe; there was a decreased risk among women born in Turkey. The observed risk for women over 50 corresponds to the incidence rate of country of birth of the immigrants. These results also suggest that these women are not fully benefiting from screening programs due to differences in socioeconomic position.

Survival and Mortality

A comprehensive study of cervical cancer survivors in California found that a lack of English proficiency and Latin American origin were associated with lower levels of physical, social, and sexual well-being. Among cervical cancer survivors, the disease and its treatment appear to place additional demands on monolingual Spanish-speaking survivors and their families, including difficulty in accessing appropriate follow-up medical and psychosocial care that results in a poorer overall health-related quality of life. These outcomes underscore the greater disease-related burden of cervical cancer among immigrants and low-income survivors.

Mortality rates in the USA for the period of 1985–1996 showed that there was a marked difference in cervical cancer mortality rates between immigrant and native-born women, primarily among Latina and Asian and Pacific Islander women (AA/PI). The ratio of mortality rates between foreign born and US born was 4.11 for Latina women and 1.40 for AA/PI women. More recent data show that Latina women continue to have increased cancer mortality rates compared with non-Latina women. From 1998 to 2003, Latinas had increased cervical cancer mortality rates compared to non-Latina White women. A more concerning finding was that among Asian–Pacific Islanders and Latinas over the age of 50, the rates of invasive localized cervical cancer declined and regional and distal invasive cervical cancers increased, signifying a late presentation at diagnosis. There is a lack of studies on cervical cancer mortality among immigrants from other countries.

Conclusion

Most published studies have been conducted in developed nations where there are large numbers of immigrant populations. They reveal that immigrant women tend to lag behind in screening and have higher cervical cancer incidence rates than native-born populations.

For most immigrant populations, high socioeconomic position, having health insurance (or access to healthcare), younger age, higher education, speaking the main language in the host country, having a usual source of health care, and spending more time in the host country are associated with increased cancer screening likelihood.

Studies in California, where 27% of the total population is foreign born, show that near parity in cervical cancer screening has been reached among most groups of women. According to the 2007 California Health Interview Survey, 91% of US-born women between the ages of 21–64 received a Pap test in the past 3 years, compared with 92.3% of women born in Mexico and 80.3% of women born in Asia and the Pacific Islands. These results are to a large extent attributed to the successful implementation of a government sponsored cancer control program in the state that provides free screening and treatment to low-income women regardless of their immigration status. This success provides additional support to the many studies that conclude that the sociodemographic variable most strongly associated with screening and screening maintenance is healthcare coverage and access to care.

Survival and mortality have been studied less often for immigrants, although some studies report higher mortality; there is less conclusive evidence about differentials in survival length and outcomes. When multivariate analyses were conducted that adjusted for socioeconomic differences and access to care, differences between immigrant and nonimmigrant populations in screening, incidence, and mortality usually disappeared, indicating that socioeconomic differences and differences in access to care are the most influential causes of variation in the cervical cancer care continuum for all women regardless of migration status.

New technologies developed for cervical cancer prevention and control pose great opportunities and challenges in order to expand access to the new vaccines and detection technologies to the women who are most at risk. Newly developed vaccines for the most prevalent strains of the HPV virus may make prevention easier, especially in countries with less developed health care systems. But cost of a complete series of vaccinations ($375) remains a barrier since it is more than the entire per person national health care expenditures of the poorest countries of the world and will compete with other priorities in middle-income countries.

Cervical cancer prevention requires age appropriate interventions in order to be effective; women who are already affected by HPV need to be monitored while young women may be targeted for vaccination. Data show that many populations are receptive to vaccination of young girls. According to the 2007 California Health Interview Survey, 60% of US-born parents expressed interest in having their daughters vaccinated against HPV or had already had them vaccinated. Asian-born parents had the same level of interest (59%) and Mexican-born parents in the state had among the highest level of interest (70%).

US immigration policy briefly (2008–2009) required that women aged 11–26 have the HPV vaccine to obtain permission to immigrate. The controversy over this requirement highlights the concerns over costs, coercion, and the portrayal of immigrants as vectors of disease in relationship to cervical cancer. Finally, although low-income immigrants tend to fare poorer in terms of cervical cancer screening, as well as higher incidence and higher mortality compared to their native-born counterparts in some countries, access to care, access to new vaccines, and novel testing methods have the potential to bring health equity to all women.

Related Topics

- ► Access to care
- ► Asian Americans
- ► Australia
- ► Barriers to care
- ► Canada
- ► Cancer health disparities
- ► Cancer incidence
- ► Cancer mortality
- ► Cancer prevention
- ► Cancer screening
- ► Ethnic minority group
- ► Global health
- ► Health barriers
- ► Health care utilization

- ▶ Health disparities
- ▶ Health services utilization
- ▶ Healthy immigrant
- ▶ Hispanics
- ▶ Immunization
- ▶ Latinos
- ▶ Pap test
- ▶ Reproductive health
- ▶ Screening
- ▶ United States

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Chain Migration

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Chain migration is a social process that is more complex than a simple mechanical process of people migrating. Sociological factors such as social networks are the key during the chain migration process. It is common for some scholars to refer to *chain migration* in the context of *social network* which usually operates within a social network that includes family, friends, community, etc. However, the term *chain migration* usually refers to the migration chain that operates within family members only. Most research on chain migration has focused on the operating mechanism of chain migration and its demographic and socioeconomic impact on the destination countries on a macro level. Some research has examined chain migration at local levels.

During a typical chain migration process, the initial immigrants migrate to a destination country on their own, although they have no family ties there. These initial immigrants will migrate either driven by the *socioeconomic factors* (such as wages, employment potentials, etc., as validated by all of the economic and sociological immigration theories), or by *non-socioeconomic factors* (wars, natural disasters, refugee and asylum policies, etc., as validated by all of the non-socioeconomic theories). They are either *voluntary* or *involuntary* (or *forced)* migrants, depending on their situations. The key is that these initial immigrants make the move on their own; there is no family tie in the destination countries. Therefore, migration for them usually has a high price, both *economically* (in terms of financial cost) and *noneconomically* (in terms of the disruption of their family lives and the cultural shock associated with migration). Once they arrive at their destination countries, they will settle down and start bringing their family members over by sponsoring them. The potential *cost* of the future migration of their family members and relatives is substantially lower. With these initial immigrants anchoring at the destination countries, it is relatively easier for them to arrange for the migration of their family members and relatives. The growth and expansion of *migration chains* will reduce both the *costs* and the *risks* for future migrants, potentially making it virtually risk free and almost cost free, as they can diversify their household labor and earnings after their family members and relatives have joined them in their new countries.

At the same time, the migration chains are also regulated by the emigration policies of the countries of origin and the immigration policies of the countries of destination – that is the non-socioeconomic aspect of the immigration process. For example, some European countries do not have family-unification-specific immigration laws similar to those in the USA. The differences among the immigration laws contribute to the differences in immigration patterns between US and European countries.

Generalized Chain Migration Process

The generalized chain migration process consists of three phases: the initiation phase, the family unification phase, and the family reproduction phase.

The *initiation phase* of the chain migration process is the migration of the initial immigrants or *principal immigrants,* who are sponsored by nonfamily entities. The nonfamily entities include employers who sponsor immigrants as professional immigrants (or through investment as investment immigrants); the government that sponsors immigrants as refugees, asylum-seekers, or diversity immigrants; and US-born citizens who sponsor immigrants as foreign-born spouses. Theoretically, undocumented immigrants could also be considered initial immigrants because they might obtain legal immigration status and someday sponsor family members.

The *family unification phase* of the chain migration process is the *cumulative* migration of family members. During this phase, all prospective migrants immigrate under the sponsorship of previously migrated family members. Migration chains are usually established through the sponsorship of family members who were sponsored by other family members, and so on. It is important to understand that the original principal immigrants usually sponsor their immediate family members only, and they usually do not and cannot sponsor other relatives, such as nieces and nephews, of their family members. These relatives can, however, be sponsored by the other family members who were sponsored by the principal immigrants. These relatives, once they arrive at the destination country, can also later sponsor their own immediate family members. Therefore, the chain migration process can progress to bringing more *derived* family members into a country. However, the principal immigrants are in fact truly *responsible for* all of the derived family members. This is the phase where the Immigration Unification Multiplier (IUM) is defined. *IUM* measures the multiplier effect of the chain migration during this immigration unification process.

The *family reproduction phase* of the chain migration process is the settlement stage of the immigrant family, during which the immigrant second-generation will be born in the destination country. In this phase, immigrant fertility plays a significant role in affecting the size of the second-generation immigrant population. As immigrants arrive from different countries, their respective fertility patterns will have various chain migration multiplier effects that Immigration Reproduction Multiplier (IRM) can measure.

Major Factors Affecting the Chain Migration Process

During the chain migration process, the strength and length of the migration chains will be determined by several key factors, such as the total number of principal immigrants, the size and structure of immigrant families, and the immigrants' fertility patterns.

The total number of principal immigrants is the most important factor during the chain migration process because the number is actually the total number of migration chains to be initiated. Since each migration chain will have its own family network to sponsor future family immigrants during the complete chain migration process, larger numbers of migration chains will mean a larger number of family members could be potentially sponsored. Therefore, the greater the number of principal immigrants, the greater the number of migration chains that will be generated during the process and the greater the potential number of future family immigrants will be.

Since each future family immigrant could be sponsored either directly by a principal immigrant or indirectly by other family immigrants (who were sponsored by the original principal immigrant), the size and structure of the immigrant family will determine the potential size of the eventual migration chain. Every such sponsorship is a chain migration event that will result in bringing an additional family member into the destination country. Since each newly sponsored family immigrant could later also initiate his or her own migration sub-chain (for a spouse, children, parents, siblings, and in-laws), these migration sub-chains, combined with the all other migration sub-chains originated from the same principal immigrant, are the basic elements of the large family migration network or the complete migration chain. The potential total number of family members to be sponsored is directly linked to the family sizes of these immigrants, which is determined by the culture of their countries of origin. The larger the immigrant family is (determined by the culture in their own countries), the larger the total number of family immigrants and the stronger and longer the migration chain will be.

Immigrant fertility is another very important factor that will have major impact on the chain migration process after immigrants (both principal and family immigrants) settle down in the destination country. Immigrants with higher fertility rates will produce more children, while immigrants with lower fertility rates will produce fewer children. Since various cultures in the countries where the immigrants are from all play significant roles in shaping the immigrant fertility, immigrants from different regions/countries usually have quite different immigrant fertility patterns in producing immigrant children. Therefore, various immigrant fertility patterns decide the total number of second-generation immigrants in the destination country. The higher the immigrant fertility rate, the greater the immigrant second-generation population will be, if the immigrant population size is the same.

At the same time, other socioeconomic and non-socioeconomic factors also have major impacts on the process of chain migration, and the actual realization of the chain effects could differ greatly among various immigrant groups. Other possible determinants include:

- The *attractiveness* of the destination country

  The more attractive the destination country is relative to the country of origin, the more family members will want to be part of the chain. According to existing research on international migration, developed countries are highly attractive to immigrants from underdeveloped or developing countries.
- The *openness* of the immigration policy of the destination country

  The more open the immigration policy of the destination country is, the greater the potential for more chain effect during the chain immigration process. While most European countries are among the least open in terms of immigration policies, the USA is one of a few top countries with very open immigration policies.
- The *culture* factor of the immigrant home country

  Assimilation is one of the most discussed topics in international migration research. During the assimilation process, the greatest challenge for immigrants is usually the process of cultural adaptation and adjustment. The degree of successful cultural adaptation and adjustment of earlier immigrants will have major impact on the migration decisions of potential future immigrants within the chain migration process.

Measuring the Migration Chain

Measuring the impact of chain migration is very complicated. The current available indicators are the Immigration Unification Multiplier (*IUM*) and the Immigration Reproduction Multiplier (*IRM*). Both are the components of the Immigration Multiplier (*IM*).

The *Immigration Unification Multiplier* (*IUM*) is the total number of first-generation immigrants each principal immigrant generates. The IUM reflects the total number of future immigrants who come to the host country through the family unification process as a result of the admission of one principal immigrant (who was not him or herself sponsored for a family reunification visa by any previous family immigrant). The IUM value is, therefore, the multiplier factor that measures the family reunification process in migration chains. Since principal immigrants are part of the first-generation immigrants, the value of the Immigration Unification Multiplier (*IUM*) will have to be 1 or greater. The extreme case of the *IUM* being 1 would mean that the principal immigrants migrate to the destination country all by themselves without sponsorship of any of his/her family members. In reality, however, immigrants will most likely sponsor some of their family members. Therefore, with the assumption that the additional family members will join the principal immigrants, we should always see a value greater than 1 for the *IUM*. Since the family reunification process is heavily influenced by the immigrants' cultural backgrounds (such as family size, family values, etc.), it is easy to suggest that the larger the immigrant family is and the stronger its family values are, the higher the *IUM* value it will have, and the stronger the chain effect of the migration chain will be in the form of Immigration Unification Multiplier.

The *Immigration Reproduction Multiplier (IRM)* is the combined total of the first- and the second-generation immigrants that each first-generation immigrant generates. The value of IRM is the multiplier for measuring the family reproduction component of the chain migration process. Since all first-generation immigrants are responsible for all of their immigrant children (i.e., the second-generation immigrants), the Immigration Reproduction Multiplier (*IRM*) will also have to be 1 or greater. If, in an extreme case, the *IRM* is equal to 1, it means that the principal immigrants (and their sponsored family members, if *IUM* is greater than 1) will not produce any children in the destination country after their migration. In reality, immigrants do usually have children in the destination country. Therefore, we can use this new indicator to measure the fertility component of the chain immigration process, because producing children in the destination country is the final phase of the migration chain. Usually, the higher the immigrant fertility rate, the higher the *IRM* value, and the stronger the chain effect of the migration chain in the form of the Immigration Reproduction Multiplier will be. As some research suggests, when children are born in the destination country, immigrants tend to stay there permanently. This fertility component in chain migration process is very important.

The IM, therefore, indicates the total number of all future immigrants who are directly or indirectly sponsored by one principal immigrant, and the total number of all second-generation immigrants who are born to all of these immigrants. For example, higher IUM indicates higher sponsorship rate, and thus stronger family unification multiplier effect of the chain migration; higher IRM indicates higher fertility rate, and thus stronger family reproduction multiplier effect of the chain migration. With clear multiplier effects from unification and from reproduction, we will have the overall IM and can assess the overall multiplier effect and its impact of the chain migration process.

Related Topics

- ► Assimilation
- ► Citizenship
- ► Family reunification
- ► First generation immigrants
- ► Illegal immigration
- ► Labor migration
- ► Social networking

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Chaldean Americans

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In the Detroit metropolitan area, an estimated 490,000 individuals refer to themselves as Chaldeans. While most people in the Detroit area are accustomed to the term, due to small populations elsewhere, few individuals outside the area have heard the term. Even fewer individuals know the full definition of what it means to be Chaldean or the history behind Chaldean Americans.

Chaldeans are commonly thought of as Christian Middle Easterners, but this definition lacks precision. More specifically, Chaldeans are Roman Catholic individuals who have immigrated from the northern Tigris-Euphrates Valley, the area historically known as Mesopotamia, and presently known as Iraq. It should be acknowledged that while Chaldeans compose only about 10% of Iraq's population, the vast majority of Iraqis living in America are Chaldean.

As a result of the early promise of Detroit's auto industry, the vast majority of Chaldeans living in America reside in Detroit, with small communities also appearing in Chicago, Illinois; El Cajon, San Jose, and Turlock, California; and Oaxaca, Mexico. Of the Chaldeans living in Detroit, nearly 95% of people can track their ancestry back to the Tigris-Euphrates town of Telkaif.

At the same time that auto incentives drove the first Chaldeans to Detroit in the late 1800s, many Chaldeans left Telkaif for Mosul, Baghdad, Basra, and Beirut. But, by the time Chaldean Americans settled and found success in Detroit, many encouraged their families and friends to join them. This second coming started the process of chain migration, which continued with wavering intensity through the 1960s.

While newly arriving Chaldeans viewed Detroit as a hospitable economic environment, the Detroit's large Catholic population also drew Chaldeans in. Though the majority of Iraqis are practicing Muslims, Chaldeans are Roman Catholics, thought to have been converted by the missionary St. Thomas the Apostle in the early part of the first century. Until the arrival of St. Thomas in the Tigris-Euphrates Valley, the Chaldean people followed Nestorius, a patriarch of Constantinople who led the Church of the East and taught that Jesus was not simultaneously God. Aside from this division, Chaldean people followed the teachings of the Roman Catholic Church. In 1445, the Church under the leadership of Pope Eugenius IV and the Nestorians reconciled their differences: the Church agreed to permit a new Catholic rite, the rite to hold mass in Aramaic, and the Nestorians agreed to accept Jesus as God. Those Nestorians who refused to accept the Church's terms continue to belong to the Church of the East.

Unlike the majority of Iraqis who speak Arabic, the ancestral language of Chaldeans is Aramaic, commonly known as the language Jesus was thought to have spoken. Despite being better educated and from wealthier families than their Chaldean counterparts who immigrated in the early and mid-part of the twentieth century, most recent Chaldean immigrants do not speak Aramaic. The loss of the Aramaic language among modern Chaldean immigrants is considered a grave loss and can primarily be attributed to the fact that the Iraqi school system requires school to be taught in Arabic.

Following the Gulf War in the 1990s, the USA has seen fewer Iraqis and Chaldeans immigrate. Because many Chaldean families had sons and nephews on both sides of the Gulf War, fighting for the USA on one hand, and Iraq on the other, many families suffered devastating psychological effects. The result of this so-called brother versus brother combat left many Chaldean families who identified first and foremost as Americans without a sense of home or belonging. The result of this impact can arguably be seen today where Chaldean and Arab Americans continue to be cautious of anti-Arab attitudes by limiting the extent to which they are willing to acculturate. Instead, many Chaldeans and Arabs elect to live in close proximity to one another.

Due to continued stigma associated with mental disorders in Middle Eastern culture, less acculturated Chaldeans face major obstacles in admitting problems and seeking mental health services. In Chaldean culture, it is still believed that mental disorders cast shame upon the family. Unfortunately, these negative attitudes toward mental health greatly undermine the work many Middle Eastern refugees need. Many Middle Eastern refugees come to America after having witnessed serious atrocities, political unrest, and in some cases, even torture. More acculturated individuals similarly face problems due to the creation of a public identity to minimize ethnicity when desirable and a private identity to be used around family and friends. These negative attitudes pose further risks when considering that Chaldean Americans who seek out proper services do so in the context of there being little empirical research on the culturally relevant services needed.

Related Topics

- ► Arab Americans
- ► Chain migration
- ► Iraq
- ► Labor migration

Suggested Readings

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Chemical Exposure

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There are over 80,000 chemicals in use in the USA and it is safe to say even more if one were to do a global inventory. In addition, there are many more chemicals that people are exposed to that are generated by combustion and other reactions in the environment. Combustion products, smoke of various sorts, can by themselves be composed of thousands of chemicals. In contrast, only a small number of these chemicals have been thoroughly tested for their toxicity and an even smaller number are regulated in terms of human exposure or environmental release. Thus, it is almost impossible to comprehensively review chemical exposure in general, let alone for immigrants. However, some broad strokes of understanding are possible.

Chemicals come in three basic forms: gases, liquids, and solids. The form that a chemical takes will influence how it might or might not get into the body. Gasses or very tiny suspended particles of liquid or solid can be breathed in. Inhalation is a critical entry path because the lungs provide an easy surface onto which chemicals can be deposited or be absorbed into the blood. Liquids and solids may be ingested. The gastrointestinal tract is more protective than the lungs in terms of penetration into the blood, but depending on the nature of the chemical, it may be absorbed to a greater or lesser extent.

The skin is another route of entry and is most easily penetrated by fat-soluble substances such as organic solvents. Many potentially hazardous substances will not easily pass through the skin, although some, such as acids, can cause direct damage to the skin on contact. In addition, some chemical substances will cause harm if they penetrate the skin physically, such as depleted uranium shrapnel fragments that may remain lodged internally in combat veterans leaching uranium into the body.

The chemical structure of a substance is highly deterministic of its toxicity and ability to enter the body. As suggested above, a fat-soluble compound, such as benzene, which is found in the gasoline that we put into our cars, has numerous properties that contribute to its toxicity. It is a liquid, but evaporates easily to form vapors that can be breathed in. It is fat soluble and can pass through the skin on contact and enter the blood and travel through the body. Benzene is an acute toxin and can cause drowsiness, dizziness, rapid heart rate, headaches, tremors, confusion, unconsciousness, and even death in a short time at high doses. But it is also a well-established carcinogen and can cause a specific type of leukemia (acute myeloid leukemia) following years of low-grade exposure.

The settings in which people are exposed to chemicals are also quite varied. Some people are exposed at work, others at home or during recreation. There may be exposures at school that are not present at home or vice versa. There may be chemicals in the food that we eat, pesticides for example, and in the water we drink, arsenic being one. Particularly in industry, mining, construction, and other manual jobs there can be toxic chemicals that are part of the job, such as silica dust or various solvents. In other settings, restaurants for example, there will be chemicals from the combustion associated with cooking and tobacco smoke (if it is not banned), even though we think of these as "safe" occupations. Some chemicals in the home are a legacy of the past, an example being interior lead paint, while others are introduced to address a problem, such as pesticides used to kill cockroach infestations.

Because there are so many chemicals and they each have their own properties and toxicities it is impossible to remember all of them. Even an expert will need to seek documentation of what is known about a chemical that they have not already investigated. The first problem is to find out what the chemical is. This may not be easy; but many consumer products and substances used in the workplace have labels on the container that give the chemical names. Also, in the USA and many other countries workplaces are required to retain and provide to workers Material Safety Data Sheets that have information about chemicals. Other sources (listed at the end of this entry) include the Agency for Toxic Substances and Disease Registry's Toxicological Profiles and the National Institute of Occupational Safety and Health's Pocket Guide to Chemical Hazards.

A couple of examples will provide a sense of how chemical exposure might be higher for some immigrant populations.

Nail salon workers in the USA are staffed heavily by Vietnamese immigrants, perhaps making up a majority of these workers. While nail salons are not industrial and may not be considered hazardous occupations by many people, they use products that contain many toxic chemicals, including solvents, resins, acids, and plasticizers. While there is little question that Vietnamese immigrants in the USA will have higher exposures to these compounds, it is unclear to what extent this is affecting their health because of the paucity of studies on this occupation. The few studies to date have depended largely on surveys and observation and do not directly monitor exposures or measure biomarkers or long-term health outcomes.

Southeast Asian immigrants to the USA often come from rural villages. Due to their experience and comfort with fishing and hunting, their low-income status, and the general acceptability of fishing in the USA, many will fish for food. However, in industrialized areas, fish may be contaminated with chemicals that bioaccumulate, such as methyl mercury or polychlorinated biphenyls (PCBs). Bioaccumulation is a process by which certain chemicals, often fat soluble, increase in concentration as they move up the food chain to higher order predators. If humans are at the top of the food chain, then they may be consuming and thus bring into their bodies these substances. Indeed a study by Schantz et al. found elevated levels of some of these pollutants in Southeast Asian immigrants who fish.

A classic example of chemical exposure in immigrants is farm worker exposure to pesticides. Many farm workers are immigrants, documented or not, and many are migrant in that they move to follow the available work. Farm operations commonly use pesticides to control insects and other pests and herbicides to control weeds. While there are a large number of chemicals that are used for these purposes, the toxicity of some of them are well understood, raising concerns about occupational exposure.

Numerous studies have confirmed what is clear simply from observation, that many farm workers are exposed to pesticides on a regular basis and that they receive little or no training or protective equipment.

Farqhar et al. studied Oregon indigenous farm workers who mostly did not speak English or Spanish and found that 48% worked with pesticides (probably an underestimation) and that only 57% received any training. Arcury et al. reported findings in 2009 from a study that measured urinary concentrations of six metabolites of organophosphate pesticides. Frequency of detection of the pesticide metabolites ranged from about 8% at the low end to over 78% at the high end and reported that these metabolites increased during the farm work season.

Studies have also associated pesticide exposure in farm workers with biological harms, including genetic damage. Our understanding of the mechanism of action of the organophosphate and *N*-methyl-carbamate types of pesticides is highly developed. We know that these substances inhibit a specific enzyme in the body, cholinesterase, and that their immediate, acute/short-term, effects are primarily on the nervous system. Long-term associations include increased risk of developing cancer. Indeed, the leading edge of research on the biological effects of these pesticides is now investigating and showing that some genetic/biological traits interact with pesticide exposure to modify their impact on enzyme activity.

In the USA, regulation of occupational exposure of farm workers to pesticides is through the Environmental Protection Agency rather than the Occupational Health and Safety Administration. This, combined with the exclusion of agricultural workers from many labor laws and the often undocumented status of these workers, places severe barriers on the ability of immigrant farm workers to be afforded basic protections from chemical exposures that are hazardous to their health.

At the more local level of workplace practices aimed at reducing chemical exposure, a 2009 report by Pechter, Azaroff, Lopez, and Goldstein-Gelb addresses the use of hazardous cleaning products for Janitors in Massachusetts, USA. This project, engaged the workers, their union, and a local nonprofit called the Massachusetts Coalition for Occupational Safety and Health. Using a survey and having workers show and describe the substances they were using at work, it was possible to identify products that were the most hazardous, misused, or not needed. Supervisors responded to this effort with a number of changes aimed at reducing exposures and addressing health complaints.

While the examples given above only scratch the surface of chemical exposures to immigrants, many more of which are probably not even identified let alone studied, they illustrate that there are distinct aspects of chemical exposure for at least some groups of immigrants. There is a need for more research as well as increased education of immigrant populations about chemical exposures and health.

Related Topics

- ► Air pollution
- ► Environmental exposure
- ► Environmental health
- ► Environmental tobacco smoke
- ► Migrant farmworkers
- ► Occupational and environmental health
- ► Occupational health
- ► Pesticides

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Suggested Resources

ATSDR Toxicological Profiles: http://www.atsdr.cdc.gov/toxprofiles/tp3.html

NIOSH Pocket Guide to Chemical Hazards: http://www.cdc.gov/niosh/npg/

Chernobyl Sequelae

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Twenty-four years have passed since the time when the world was shaken by the damage at Chernobyl nuclear power station, the fatal consequences of which many thousands of people now feel. A tragic fate overtook 1,800 citizens of the Republic of Tajikistan who participated in the response to the disaster. The effect on the environment of the Chernobyl atomic catastrophe has been investigated many times, and from different points of view, since the accident. But investigations of the effects of different radiation doses on the human immune system have not been studied.

In our Institute in Dushanbe, we examined approximately 750 people who had taken part in the liquidation of Chernobyl between 1994 and 2006. The psychological, digestive system, and immune responses of these people, who directly took part in the liquidation, were assessed. The investigation began eight or more years after the catastrophe. All of the patients were investigated and treated in our hospital, opened after the Chernobyl disaster.

This work characterized the immune status of 350 individuals who participated in the 1986–1990 cleanup work of the Chernobyl nuclear power plant explosion. The level of immunoglobulin (IgA, IgG, and IgM), the numbers of peripheral blood leukocytes, lymphocytes, T-lymphocyte and their subpopulations (CD3+,CD4+, CD8+),B− lymphocytes (CD19+), and natural killer cell (CD16) were determined in the peripheral blood.

Most of our patients were sent by general physicians to us for psychiatric consultation about psychological and psychiatric problems. The doses received by our patients depended on the time at which they began their work in the contaminated area and its duration. The first signs of disorders appeared at the end of 1986 among 45% of our patients. It took 1.5–2 years or more for these disorders to appear. The average age of our patients was 30–45 years at the time. Most of them had similar multiple complaints: headache, dizziness, fatigue or chronic tiredness, poor concentration and lack of attention, memory loss, irritability, sometimes anger, mood swings, anxiety, exhaustion after physical and mental activities, high blood pressure, respiratory deregulation, feelings of hopelessness and worthlessness, and lack of libido. They also had a high sensitivity to loud noises, bright light, and high temperatures. The overall symptoms of these patients were so similar, that we call this syndrome: "Cerebrasthenic post Chernobyl Syndrome." In some cases, the cerebrastenic syndrome developed into an encephalopathic syndrome. The pathological change in these cases included autoimmune, neuro-immune reactions and biochemical changes. At the same time, most of our patients suffered from various somatic diseases.

The results of psychological examination of those patients indicated poor attention, lack of concentration and attention, memory loss, mental exhaustion, and reduction of mental ability. Eighty percent of the patients had a very high level of anxiety. Some patients could not even remember their phone numbers or what they just had read in the newspaper. Sometimes they did not remember where they were going. More than 85% had changes in their character, and 96% had low levels of self-esteem and self-evaluation.

At our Institute, we saw many patients, and we realized that it was very difficult, and sometimes impossible, to sort out all these symptoms. Psycho-organic syndromes can evolve in three stages:

- The first is mild, with asthenia or cerebrasthenia, reduced emotional ability, decreased physical working ability, changes in mood, poor attention, lack of concentration, and memory impairment.
- The second stage is moderate, which includes all of the first stage, plus personality changes, irritability,

Chernobyl Sequelae. Table. 1 Parameters of immunity and biochemical parameters in blood of the liquidators

	Control group	Liquidators	*P*
T-lymphocytes suppressors	2.0 + 0.08	1.37 + 0.07	$P < 0.01$
Immune complex	1.88 + 0.12	3.35 + 0.25	$P < 0.05$
IgA	2.65 + 0.2	1.86 + 0.2	$P < 0.05$
IgM	1.24 + 0.15	0.78 + 0.1	$P < 0.01$
IgG	15.8 + 1.1	10.3 + 1.1	$P < 0.01$
Protein	74.0 + 0.59	66.1 + 0.4	$P < 0.01$
Bilirubin	20.5 + 0.3	25.5 + 0.6	$P < 0.01$
Cholesterol	4.11 + 0.4	3.86 + 0.5	P > 0.1
AsAT	125 + 11.9	156 + 11.8	P < 001
ALAT	280 + 12.3	380 + 13.1	P < 0.001

dysphasia, periods of anger and psychotic-like states.

– The third stage is severe, with important aggravation of the symptoms of the first and second stage, plus instability.

Clinical and psychological examinations allowed us to describe a specific "cerebrasthenic Syndrome" as the first stage of organic mental disorders. The diagnosis, the prevention, and the treatment of neuropsychiatric syndromes, especially those related to radiation and to acute radiation sickness, are of great interest and they need to be analyzed and studied further.

In 350 liquidators from Chernobyl, we found a significantly decreased number of CD16+ cell (natural killer), of CD4+ and CD8+ T-lymphocytes. In Chernobyl cleanup workers there was variation in the number of T-lymphocytes. Levels of IgG and IgM were significantly decreased in persons who worked in Chernobyl in 1986 during the first month after the accident. For the T-lymphocytes suppressors, there is a similar situation: a decrease of the T-helpers which increases the defense mechanism against various infections, and an important increase of T-lymphocytes suppressors, which reduces these deference mechanisms. Our results clearly reflect an impaired immune system in the Chernobyl cleanup workers even 10–14 years after the nuclear accident (Table 1).

The liquidators from Chernobyl had a reduced IgG (gamma-globulins), pointing to a reduced reaction of their immune system. They also have low doses of Cs 137 in their bodies. We also found an increase in the number of circulating autoantibodies in the blood of these liquidators: These are very complex, very pathogenic proteins, which induce several autoimmune disorders in various organs.

In conclusion, the immune systems of liquidators from Chernobyl have been impaired. We find various disorders of the immune system in these people.

Related Topics

- ▶ Disasters
- ▶ Displaced populations
- ▶ Environmental exposure
- ▶ Environmental health
- ▶ Nuclear trauma
- ▶ Occupational health

Suggested Readings

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Suggested Resources

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Child

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Child immigrants are children who immigrate, as distinguished from children of immigrants, who are the children of adult immigrants (and may be immigrants themselves, or may be born in the country to which the parents have migrated). A child who immigrates is born in one country and at some point following their birth migrates to another country to live. Child immigrants usually move to a new country (the “receiving country”) with their parents and/or other family members, but may migrate alone for a number of reasons (see Unaccompanied Minor entry). Child immigrants constitute a special population of immigrants because they have not reached the age of legal adult status in the receiving country, so they do not have the ability to make legally binding decisions for themselves but need to rely on adults to act for them. They are also a special population because of child development: they are experiencing many significant biological transformations physically, cognitively, and emotionally. They are a diverse group, representing many different sending and receiving countries, and having a multitude of reasons for migrating. Many aspects of the child immigrant experience are important: their status within the receiving country, especially regarding citizenship; their interactions with the child systems in the receiving country, especially education systems; and their roles within and the dynamics of their family systems.

National policies of receiving countries vary widely regarding child immigrants. Policies regarding immigrant integration in the receiving country may relate to supportive services, educational services, or immigration status. National attitudes regarding immigrants also impact the experiences of child immigrants. Receiving countries tend to be European Union (EU) countries or North American countries (the United States and Canada). Policies regarding immigrant children vary widely from country to country. In the United States, the 14th Amendment to the Constitution states that anyone born or naturalized in the United States is considered a citizen; thus children of immigrants who are born in the United States are citizens of the United States. Because the United States recognizes dual citizenship in certain cases, children born in the United States to immigrant parents may be able to maintain a legal connection to both their parents’ sending country and the United States. In Germany, historically, citizenship was only granted through a blood relationship to a German citizen. Recently, the law has been amended so that some children born in Germany to immigrants are eligible for German citizenship. But dual citizenship is still not recognized in Germany, so youth with immigrant parents have to choose a citizenship as young adults. Immigrant children will find themselves with similar choices as other children of immigrants: policies in the receiving country may support maintaining their connection to their sending country, but more often the policies will encourage establishing themselves in the receiving country by cutting ties to their sending country.

Child immigrants are often eligible for a multitude of services to ease the transition to the receiving country. Services to support the transition include language classes, educational support programs, preschool programs, vocational training programs, and translators. Immigrant children are eligible and expected to participate in the compulsory educational opportunities available to children of their age in the receiving country. Depending on their educational experiences in their sending country, they may or may not be prepared for the educational opportunities they find in the receiving country. They may need educational support to catch up with their peer group academically. Children may also be eligible for medical services, either short term or long term, depending on the receiving country.

Children who immigrate may have families that are well educated, with many socioeconomic resources in both the sending and receiving country, or their families may have less education and fewer resources than the average family in either sending or receiving country. Immigrant children will be presented with different opportunities, based on these factors. But regardless of socioeconomic differences, immigrant families tend to value education, and immigrant children tend to internalize this value and work hard to succeed in the educational system of the receiving country.

Recent research in the United States and Canada that has focused on child immigrants has found that in general immigrant children tend to do well, surpassing the academic achievements of native born children and overcoming risk factors related to neighborhood poverty and violence. Immigrant youth tend to be healthier physically, including reporting less obesity, asthma, or school absenteeism, and less risky behaviors (drug and alcohol use, sex, delinquency, or violence). While different ethnic groups report some differences in specific patterns, in general, immigration is a protective factor for children. Research in Europe has suggested less positive outcomes: immigrant children in Europe are less likely to be fluent in the language of the receiving country and less likely to experience success in the educational systems at the same rate as native born children. Some studies have shown that immigrant youth are more likely to be involved in violent behavior than native youth. It would be important to know more about the differences that have been reported regarding immigrant youth outcomes, so that the appropriate interventions can be implemented.

Related Topics

- ▶ Adolescent health
- ▶ Child development
- ▶ Child health and mortality
- ▶ Child labor
- ▶ Family
- ▶ Intergenerational differences
- ▶ International adoption
- ▶ Refugee youth
- ▶ Trafficking
- ▶ Unaccompanied minor
- ▶ United Nations Convention on the Rights of the Child

Suggested Resources

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UNICEF Innocenti Research Centre. Retrieved February 21, 2011, from http://www.unicef-irc.org

Child Abuse

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Child maltreatment includes several distinct but sometimes co-occuring acts: physical abuse, emotional abuse, sexual abuse, and child neglect. *Child physical abuse* consists of intentional or reckless injury including cuts, bruises, fractures, thermal burns, at times with violent forces such as hitting, kicking, slapping, throwing a victim. For infants, shaking and/or impacting the head has been recognized as shaken baby syndrome, non-accidental head injury and abusive head trauma. Among and within various cultures, corporal punishment is considered distinct from physical abuse, as intentional infliction of physical pain as part of discipline with the goal of changing behavior (e.g., smacking and spanking). *Child sexual abuse* involves sexual activity of a child with an older child or adult— and can include indecent exposure/viewing genitalia, viewing pornography, producing child pornography, intentional sexual activity in view of a child, inappropriate touching, sexual contact, requesting or coercing such contact, as well as encouraging masturbation or prostitution. *Child neglect* is generally conceptualized as the parents or guardians not providing for the child's physical necessities, including food, shelter, or clothing; their needs for medical treatment; their emotional needs for nurturing; or their educational needs. Neglect also includes any failure to act or omission which presents the child with an imminent risk of serious harm. Child abandonment, when done illegally (rather than through Safe Haven type programs), may be considered child neglect. *Emotional abuse*, more difficult to define, co-exists with other forms of child abuse but on its own may include intentional or reckless devaluation of a child's human worth and/or violation of individual rights by terror, exploitation, threat, isolation, insult, humiliation, rejection, or failing to care or give affection. Overall, the bulk of substantiated cases of child abuse are child neglect, followed by physical abuse and sexual abuse, but there is concern of under reporting and lack of detection.

The occurrence of child abuse is multifactorial. Some of the risk factors for perpetration of child abuse include being a single-parent, being in an abusive relationship, substance abuse, and severe socioeconomic stress. Prior abusive or neglectful behavior increases risk, as does parenting skill problems. Special needs children are more likely to be victims.

Younger children are at highest risk of fatality. In the vast majority of cases, parents or persons *in loco parentis* are the perpetrators and the abuse most frequently takes place in the home. However, extended family and even community members such as teachers or religious leaders are perpetrators in some cases.

Child abuse was not recognized as a public health concern until the 1800s. Many societies had protection for the safety of animals prior to protection of children. There has been ambiguity across cultures and nations, and even across generations, regarding what is considered to be abuse and what is considered to be within the range of normal or acceptable parenting practices. In the 1920s a Declaration of the Rights of the Child was drafted. The United Nations Convention on Rights of the Child, borne out of decades of revisions of the aforementioned Declaration was opened for ratification by the United Nations in 1989. It was signed by the US Secretary of State in 1995, but unlike 194 countries of the world, the US has as yet failed to ratify. The Articles lay out the social, political, cultural, economic, and civil rights of children. Several countries have made various forms of corporal punishment illegal, yet others view this parental right preferentially. As an example, Sweden, over a decade ago passed a law that children must not be physically punished or humiliated.

As of 2007, over 20% of American children had parents who immigrated. Immigrants and their children potentially face many stressors such as lack of family, financial and/or social support, and these may elevate the risk of maltreatment.

Several American studies have considered child maltreatment reports from immigrant families in Los Angeles County (California). A study of 221 Chinese immigrant families found that the most common type of maltreatment was physical abuse of children. Another study considered rates of abuse among 170 Korean immigrant families. They found that Koreans were similarly more likely to be accused of physical abuse. This most frequently occurred in situations in which corporal punishment gone wrong. When psychological abuse occurred, it was often in the context of witnessing domestic violence. Still another LA study considered 243 case files of Cambodian refugee families. They found that compared to other Asian and Pacific Islander ethnic groups, Cambodian cases were more frequently reported. Parents often suffered substance abuse (more common in the fathers) or mental illness (more common in the mothers). The Cambodian refugees were more likely to be reported for neglect (compared to other Asian and Pacific Islander groups). Overall, however, it has been noted that the reported rates of child maltreatment among Asian Americans is low; this may be due to protective factors, or may be related to lack of disclosure of abuse.

Community support may help decrease risk of child maltreatment. Parenting education with specific knowledge of the culture has been recommended as a prevention effort.

Medical problems after the abuse or neglect will vary depending on the sort of abuse or neglect specifically suffered. Shaken baby syndrome is a form of inflicted traumatic brain injury based on shaking trauma to the infant's brain. Other children may suffer broken bones or organ damage. In addition, whether due to direct medical causes or psychological reasons, some may suffer chronic pain as adults.

Among child victims of abuse, there may be psychological consequences in addition to medical complications. Anxiety, depression, and posttraumatic stress disorder are psychiatric disorders, which may occur among victimized children. In addition, decreased self-esteem, disorganized attachment styles, and acting out behaviors may be seen. They may experience difficulty trusting others. Childhood victims of sexual abuse are at elevated risk for the development of borderline personality disorder. Emotional scars as well as physical scars need considered.

For some, in later life, a pattern of abuse is carried on through the generations. There is an age-old pattern that women often become perpetual victims in later relationships and that men often become the abusers, perpetuating the cycle of violence. Early diagnosis and treatment may help prevent furthering this cycle.

Thus, medical treatment and psychological treatment are often both indicated for victims. Medical treatment may occur in a hospital or as an outpatient, depending on both safety and the severity of the injury. Children may participate in psychotherapy, play therapy, or group therapy, depending on what is recommended for their individual situation and developmental level.

Teachers, medical professionals, police officers, legal professionals, and other professionals are often required to report cases suspicious for abuse to the appropriate agencies, often called "Child Protective Services" (CPS) or a "Children and Family Services." Other concerned members of society may also report. CPS will determine whether investigation is warranted, and if so, a case worker will be assigned. Though parents have rights, the State or Nation generally has the authority to intervene in cases in which parents fail to protect their children's safety or well-being. Recently, social services have the imperative to learn to improve practices in a culturally competent manner with immigrant and minority families.

Specific concerns identified within immigrant communities related to whether to report child abuse have included, among others, fear of government intervention or deportation, differing cultural norms of acceptable parenting behavior, and lack of social support. For example, immigrants to New Zealand may be surprised to learn that only children over age 14 may be left home alone. They may be considered to have neglected their children though their behavior was consistent with what they considered normal in their community of origin. Immigrants may have diverse customs and approaches to child discipline, child monitoring, and cultural practices in illness (e.g., cupping).

When there is concern of abuse or neglect, CPS and associated services make a safety plan, and determine whether remaining in the home is appropriate. If not, the child may be cared for by safe relatives or within the foster care or group home system. Immigrants who are lacking the social support network and kin from home may find their child removed to the foster care system, whereas their native counterparts see the child cared for by a grandparent.

Other potential complications with involvement of CPS related to immigrant status include lack of knowledge of immigration law/transnational issues, religion, culture, lack of appropriate resources, and bias. There has been a lack of sufficient research in this area, and CPS workers may find themselves unprepared for complicated cultural issues. Better practices include consideration of cultural competency, consular relations, potential for transnational placement with relatives, and provision of interpretation services.

Foster care systems may suffer some racial or ethnic disparities in delivery of care. The aforementioned study in Los Angeles also found that the Chinese children of immigrants were less likely to be removed from their home than non-Chinese children. Criminal and civil court cases may be initiated. Many cases go through the court system, and children may be removed from the parent's care temporarily or in some cases, permanently.

Parents, in collaboration with CPS, are often prescribed a "case plan" which they must complete for custody or reunification with the child to occur. Case plans may include such directives as attending drug treatment, psychiatric treatment, and parenting classes. If the child has been put in out-of-home placement, initial visits with the child may be supervised by CPS or other professionals.

In sum, in the late nineteenth century, Western civilization acknowledged child abuse and neglect as unacceptable, and by the late twentieth century recognized its manifestations and clearly codified social responsibility toward children, the criminality of the acts, and the imperative to further improve detection and service. Meanwhile, anthropological exploration of the process of raising children within many of the world's cultures overturned conventional wisdom of an extant universal standard of child maltreatment. Indeed, the rights of children vis-à-vis the rights of the group vary by society, and change over time; cultural rationalizations for acceptable treatment of children heed the perceived conditions for survival. As cultural idiosyncrasies ranging from tolerant and permissive to authoritarian and restrictive have been revealed across the world's cultures, there has been concomitant effort globally to root decisions regarding child protection in the child's "best interests" and to innervate culturally competent child advocacy. However, raising children by weaving diverse cultural norms into a novel social fabric burdens immigrant families and the social institutions of destination states in consideration of child abuse and neglect.

Related Topics

- ▶ Cultural humility
- ▶ Domestic violence
- ▶ Gender-based violence
- ▶ Homicide
- ▶ Intimate partner violence
- ▶ Trafficking
- ▶ United Nations Convention on the Rights of the Child

Suggested Readings

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Suggested Resources

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Child Development

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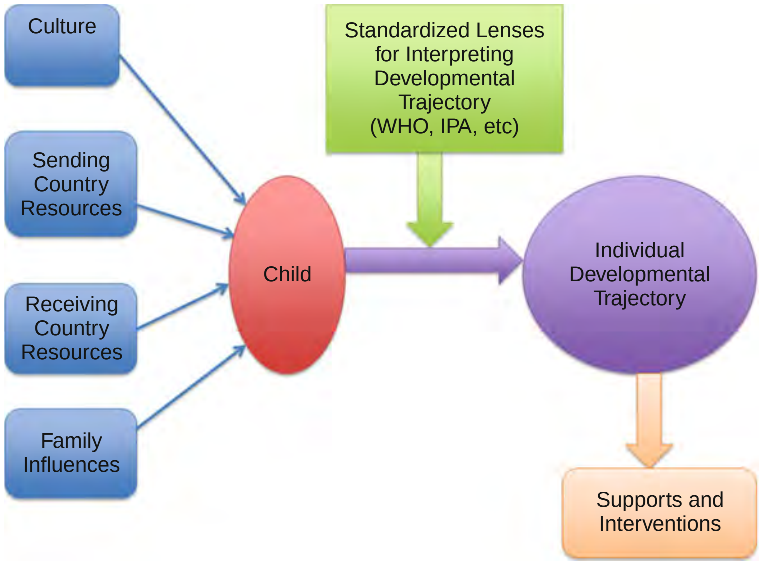
Introduction

Child development and immigration have a multifaceted relationship. It is important to understand this relationship to grasp the experience of child immigrants and develop appropriate supports/interventions. Key aspects of immigration that affect child development include the following: sending country characteristics, family, receiving country characteristics, and cultural expectations of both the sending and receiving countries. Sending country characteristics are the resources, health, safety, and education of the country of origin. Family includes kinship dynamics, resources, and separation(s). Receiving country characteristics include resources, health, safety, and education of the new country. Cultural expectations focus on attitudes, behavior, and beliefs regarding biopsychosocial development, social stratification, developmental milestones, and the interaction of these with other influences. Due to these influences, child immigrants will progress in unique, individual ways that need to be assessed and understood in order to support their optimal development. The concept of an "individualized child development trajectory" refers to the projected developmental pathway given those influences that impede/enhance that child's overall growth; while there may be many generalizations regarding developmental expectations, it is important to consider which of these are relevant for this particular child (Fig. 1). This concept is important for all children, but particularly relevant for immigrant children, as a multitude of influences surround the immigration experience.

One in five children in the USA is an immigrant, resembling rates in most high-resource, developed nations. Immigration usually occurs from low- to high-resource nations. Children/adolescents constitute a special subgroup of immigrants because they are still developing physically, cognitively, socially, and emotionally, and lack adult rights. For example, children/adolescents are dependent upon the adults around them to meet basic needs (e.g., shelter, food, clothing, and safety). Dependence on adults varies by both the age of the child and their cultural context. Based on this dependency, children/adolescents may immigrate because of a decision by their parents. They may also immigrate after becoming refugees in their sending country. Children and adolescents' experiences are impacted developmentally: their understanding, insights, ability to act, and motivations will vary at different developmental stages. Additionally, children and adolescents have particular vulnerability because their physiological and psychological development may be changed by trauma, and incorporating new influences may change their previous sense of identity.

Immigration poses a significant transitional event, regardless of the dynamics preceding it. Children and adolescents are learning how their world works, and what is valued by their world. Immigration means that there have to be shifts in this knowledge and understanding. Their ability to make these shifts, and learn how their new world works, will be instrumental in their ability to successfully transition to a new country. Immigrant children's ability to successfully transition will have long-term impacts for them, their families, and their new countries. Intervention with child and adolescent immigrants has to be grounded in both developmental processes and have awareness of the impacts of immigrant children's experiences on overall growth and well-being (see Fig. 1).

Much of the research regarding child and adolescent immigrants has found conflicting results, possibly because it fails to integrate the multiple dynamics that impact the process. Some research has found that child and adolescent immigrants are more at risk for problems. Other research has found that immigration is a protective factor for children and adolescents. The reality is that there are multiple aspects that influence the experience of immigrant children and adolescents: biological and psychological child/adolescent development, immigrant status, ethnicity or culture of origin, culture of migration/host society, and individual family culture. Research often uses single measures for complex concepts, like preferred language as a measure for acculturation. Acculturation is defined in a myriad of ways, and has been conceptualized very differently depending on the theoretical model. Simplistic



Child Development. Fig. 1 Individualized developmental trajectory model definitions and models fail to give an accurate picture because they only look at one aspect of the experience. Many immigrant children experience stress and are also doing well on many measures (e.g., academic grades, graduation rates, delinquency, or risky behaviors). Each of these reinforces the importance of considering the child's individualized developmental trajectory.

Potential Influences: Sending Countries

Resources

Sending countries tend to be limited-resource nations. The literature links children failing to meet their developmental potential in limited-resource countries to factors of poverty, health-related issues, and barriers to education. An estimated 200 million children under the age of 5 are failing to grow healthily and meet their developmental potential, leading to devastating short- and long-term implications for the value of human capital. An interdependent relationship exists among domains of child developmental growth and family preservation, all of which are affected by aspects of living in poverty (i.e., joblessness, migration), experiences of health-related issues (i.e., malnutrition, infectious diseases), and encounters with barriers to education (i.e., school access, child labor). Lack of these resources can be the primary reason families immigrate from limited- to higher-resource countries. Although the developmental effects experienced may follow that child to a new country.

Economics

Raising children in limited-resource countries can present many barriers to accessing resources to meet needs of the developing child. A parent's/provider's competence in supporting his or her family is vested in his or her ability to meet primary needs. Some countries in transition face a restructuring labor market, lack available jobs, or experience a shortage of workers with adequate skills to fill available positions, which may influence a family's decision to immigrate. Unemployment often prompts temporary (i.e., migration, child labor) or permanent family separations (child relinquishment related to death of parent(s), abandonment, or inability to meet children's primary needs).

Youth may feel some pressure to work to promote preservation of their families. In Central Asian culture, there has been an increase in individuals between ages 15 and 19 being employed. Reportedly, youth in this age group feel financial pressures to support their families financially and question the value of higher education. Millions in Asian cultures have also gone outside of their countries' borders in order to find jobs and decrease family poverty. Employment migration, in some cultures, serves the purpose of raising families out of poverty, aiding them in remaining preserved long term. It is typical to live in a multigenerational family home where kinship care supports children in their parents' absence. For immigrant families, there may have been a history of temporary migration and separation prior to immigration. This will impact relationships following reunification and immigration.

Health/Safety

Health-related issues in low-resource countries can be detrimental to children reaching their developmental potential. Common issues are malnutrition, infectious diseases, lack of access to health care, growth stunting, impaired cognitive functioning at work/school, and costly use of healthcare services. Intrauterine growth restrictions are most common in low-resource countries, primarily from malnutrition and infections. Research links this to low birth weight at delivery, lower cognitive scores, decreased problem-solving abilities, and other growth restrictions having impacts as late as adolescence/adulthood. Processes during brain growth have consequences for later cognitive functioning (e.g., school readiness, later academic performance). Children with stunted growth reportedly have a less positive affect, decreased playfulness, and increased likelihood for insecure attachment versus non-stunted children. Ongoing hunger and malnutrition is another threat to children's developmental potential, reportedly perpetuating poverty by leading to a poor physical condition, impaired cognition/school performance, and more need for healthcare services. Although children may have access to nutrition and health care following immigration, the long-term consequences of the earlier deprivation often follow immigrant families to their new countries.

Limited-resource sending countries have greater exposure to infectious diseases (e.g., malaria, HIV/AIDS). Inadequate general healthcare services compound long-term detriments of infection on children's development, often accompanying them beyond their immigration. The literature notes that children who survive severe malaria have been found to have varying degrees of neurological impairments, deficits in hearing, memory, attention, neurological effects (fine/gross motor), speech and language, and nonverbal developmental domains. Globally, over two million children under the age of 15 and more than ten million people between 15 and 24 years are HIV positive. Many children are orphaned and vulnerable (OVC) following parental death from HIV/AIDS. Nations' infrastructures have been severely impacted by the epidemic, resulting in the loss of a generation usually at their peak for economic and societal production.

Armed conflicts affect the safety of over one billion children globally. There are many impacts of war such as injury, death, orphanhood, maiming, abduction, rape, children used as soldiers, posttraumatic stress, denial of humanitarian access, and geographic displacement. Even when children and their families immigrate to a peaceful receiving country, they can suffer many long-term physical and emotional ramifications from the effects of war.

Education

Children from limited-resource countries often experience disadvantages or losses related to their education prior to immigrating. Receiving a basic education is many times beyond reach for millions of children due to families' inabilities to afford school fees (i.e., uniforms, school supplies, and books), lack of access to facilities in remote areas, few educational facilities being equipped with water/sanitation systems, and fear for children's safety due to civil conflicts/natural disasters. Discrimination against indigenous populations/minorities, children with disabilities, and students touched by the AIDS crisis often exclude some children from receiving an education in limited-resource countries. Teacher mortality rates in sub-Saharan Africa are particularly high due to the AIDS epidemic. Schools often have to share available educators who travel from community to community to meet children's needs on a part-time basis. Many of these children struggle with language and math, receiving fewer than 800 hours of instruction a year, learning in crowded classrooms, in inadequate learning environments.

Immigrant children coming from limited-resource countries are also often deprived of the right to an education in their sending countries due to gender inequalities. It is common for families to remove them from school to help support the family through child labor. Poorer families have greater difficulty in managing risk (i.e., by having savings/eligibility to borrow) related to downturns that can threaten family preservation. Girls often bear the brunt of education loss due to family poverty, with it being the norm for parents to send their male children to school if a choice must be made. This lack of prior education or substandard education by the receiving country's expectations may place an immigrant child at a disadvantage following immigration. This disadvantage may be very difficult to overcome.

Potential Influences: Family Dynamics

Kinship Dynamics

Most limited-resource countries remain preindustrial economies, lacking financial surplus to provide structured social welfare systems to care for the needs of their countries' vulnerable populations. In preindustrial societies, family dynamics encompass the larger, extended kinship network. These networks provide for the primary physical, emotional, and financial needs of the collective. The ideology of patriarchy also plays a role in gender power differentiation within the family network.

Resources/Separations

When a nuclear family leaves its country of origin through immigration, it often separates from the extended kinship group that once served as its social welfare-based system of safety nets. Once in receiving countries, immigrant families reportedly feel a sense of uncomfortable physical, emotional, and financial exposure without the safety net that they once were accustomed to having. Many times, parents of children will immigrate in advance for financial purposes, while children remain in their country of origin in kinship care with the extended family. Parents travel for employment purposes to raise money to bring the rest of the family with them or simply to send funds back to the larger kinship network for a better life. Millions of parents in Asian cultures leave their homes, with or without their children, to find better-paying jobs than in their countries of origin.

Potential Influences: Cultural Expectations

Cultural expectations have a major influence on how child development is viewed. Different cultures have different expectations regarding dependency, independence, passivity, aggression, assertiveness, language acquisition, and motor skills. These expectations may also vary depending on the age of the child and on cultural values and beliefs. Childhood can be conceptualized as a position in a social structure, which will vary depending on the social structure. Different cultures have different social structures and thus view childhood and adolescence differently. Different countries assign or legislate different expectations for children and parents. Nations decide what the rights of children and parents are, what responsibilities each has, limit or regulate their power, and decide on the age that children can legally engage in work for pay. Nations also decide on resource allocation for children (education, health, etc.). Many of these assignments are based on cultural beliefs and expectations.

When children immigrate, they are likely to move from one set of cultural expectations to a different set of cultural expectations. A child and his or her family may attempt to maintain the cultural expectations of their sending country, leading to conflicts with different systems in the receiving country. An example of this would include situations in which immigrant families do not enroll adolescents in school, expecting them to care for younger children or to bring in a wage. If a family has different developmental expectations regarding independence and interdependence than the larger surrounding culture, institutions (and representatives of the institutions) may judge the child to not be meeting developmental norms.

While every culture will have some specific differences in the expectations of children and adolescents, there are some general patterns regarding sending countries and receiving countries. Receiving countries are more likely to use "Western" concepts about the role of children as innocent and needing protection, whose place is one of safety: with family and in some kind of educational setting. In most receiving countries, child populations are declining except among immigrant groups. Sending countries may have similar expectations; or they may see children as having more freedom and not needing to meet the more rigid expectations for different genders that will exist after puberty in that culture; or they may see children as economic resources to be used for the benefit of adults. Sending countries are more likely to have poverty, forced migration, or war, which have a large effect on children because of their vulnerability. Receiving countries and sending countries often have different developmental expectations based on sex or gender. Sending countries tend to be more agrarian, and have more traditional division of labor and very different role expectations for males and females. Most sending countries value having many children, and value male children more highly than female children because both of these increase the economic options and standing of the family. Sending countries usually do not have policies that support gender equality. Receiving countries tend to have similar role expectations for male and female children, and usually have policies that regulate gender equality.

Culture has a strong influence on parenting practices, including the value that parents place on education, how parents discipline their children, what is seen as appropriate behavior for a child, the role of extended family, expression of emotion, sleep patterns, social skills, and coping styles. Cultural expectations can influence even a habit like nail biting, and how parents understand and respond to the habit. A child or adolescent who had different expectations in their sending culture may resent the new expectations of their receiving country. The difference in cultural expectations can also lead to conflicts between the child and family, if one or the other adopts the expectations of the receiving country while the other seeks to maintain the expectations of their country of origin. The different expectations between sending and receiving countries may cause confusion, conflict, or stress for immigrant youth and families. It is important to be able to understand the different cultural expectations and how they are influencing a particular child and family.

Potential Influences: Resources in Receiving Country

Resources

Resources in receiving countries impact child development through a variety of ways, including what resources actually exist, what mechanisms are used to distribute resources, the families' skills and abilities to access resources, and belief systems (both the immigrants' and the receiving countries') regarding resources. Resources in this context are not limited to those that are natural or raw, which may be in abundance in both receiving and sending countries. "Resources" reflects the amount of goods and services produced, which tend to be highest in wealthy nations, which also tend to have an abundance of well-developed systems for their distribution. Those resources in receiving countries with the most impact on child development include employment and social supports, health care, and housing and education systems.

Economics

The economies of receiving countries with their high-resource status do not usually mirror those of sending countries; immigrants may not be well prepared for the differences they encounter. Economic systems include employment and social supports, health care, and housing. Employment supports refer to job availability, job training, and having a living wage, as well as supports that effect parents' ability to both work and parent. These supports may be difficult for immigrant families to understand and access, which effects the family's economic status and further opportunities. Immigrant families are more likely to have a lower socioeconomic status, and to live in neighborhoods with more violence and other problems. While immigrant families tend to have protective factors regarding the effects of poverty and neighborhoods, they are still disadvantaged. Health care includes the quality of medical care, prevention and intervention, as well as its accessibility. Housing refers to the quality, safety, and affordability of available living accommodations. Social supports include unemployment benefits, family allowances, disability and sickness benefits, housing benefits, and other forms of social assistance. Each of these supports may be differentially accessible to immigrants. The institutionalized systems may be difficult for immigrant families to understand, impacting their use of support systems in the receiving country. In turn, these can all impact immigrant child development.

Education

Education systems affect child development by their ability to teach skills that children need to meet the demands of their environment and prepare them for adult life. For most receiving countries, this includes literacy, job skills, and cultural norms. Children may have not been in a formal education setting prior to immigration, or the education system of the receiving country may be different in its structure and expectations from those of the sending country. The education system in the receiving country may have difficulty assessing and educating the immigrant child due to language differences. The need to function in a nonnative language will lead to stress. There may also be tension for immigrant youth related to minority status. There may be disparities between educational domains for the immigrant child (e.g., high math and low reading scores) that can impact the child's sense of self-efficacy, and their developmental trajectory.

Lenses for Interpretation

Impacts of earlier discussed detriments to child development are typically evaluated over a growth continuum that ranges from infancy through adulthood in which milestones are measured by physical, emotional, and social markers. When markers go unmet, a child's full developmental potential may not be reached, leading to short- and long-term consequences. Primary, generalized tools used to measure whether children are reaching their developmental potential are the World Health Organization's (WHO) Growth Standards and the International Growth and Development Criteria (IDGC). Both sets of criteria are endorsed strongly by the International Pediatric Association (IPA). Child development theories that are often used to conceptualize psychosocial growth of children include Erikson's psychosocial stages of development, Piaget's cognitive stages of development, and Vygotsky's sociocultural perspectives on cognitive development. Theories relating to acculturation and independence/interdependence are also helpful in understanding the development of immigrant children.

WHO and IGDC

These growth standards serve as a framework for healthy, physical child growth and development to guide parents and pediatric professionals. The WHO Growth Standards are endorsed by the International Pediatrics Association (IPA), which encompasses several guiding pediatric organizations in the world. The International Growth and Development Criteria (IGDC) differ from WHO Standards as they standardize physical, emotional, and cognitive domains for a given chronological age. Both are based on long-term studies of infants/children and are multiculturally/socioeconomically applicable. These milestone-accomplishing approaches base standards on families' having ideal access to resources, a nurturing primary caregiver, and an environment in which children are most likely to reach their developmental potential. The WHO tool is gender specific, detects undernutrition and obesity, good healthcare practices (i.e., immunizations), and appropriate growth criteria for children aged 0–60 months. It offers percentile and z-score curves for length/height-for-age, weight-for-age, weight-for-length, weight-for-height, and body mass index (BMI)-for-age (see "Further Resources" to access these standards).

Child Development Theories

Theories of child development are used to assess psychosocial–emotional growth in children and tend to be based on the cultural expectations of high-resource nations. Three examples of commonly used theories are as follows: Erikson's psychosocial stages of development, Piaget's cognitive stages of development, and Vygotsky's sociocultural theory of development. Professionals in education, government, and mental health settings use such theories as lenses to view individual children and their development. A brief summary of both Erikson's and Piaget's models of development can be found at http://psychology.about.com/od/developmentalpsychology/a/childdevtheory.htm.

Erikson's and Piaget's models are very structured, noting a sequential nature to each developmental stage. While they are important lenses by which to view child development, the impacts of immigration must also be factored into children's psychosocial and emotional growth trajectories. This is especially true when the culture, values, and experiences of the sending country differ from those of the receiving country.

Vygotsky's sociocultural theory of development proposed that children's cognition and learning form through the continuous interplay of social interactions and culture. Vygotsky stressed the importance of language as an expression of culture and values. Differing from other developmental theorists, Vygotsky did not use formal stages in his model, but spoke of "zones of proximal development," that is, skills that children are capable of achieving, but cannot do without adult guidance. This emphasizes the role that culture plays in child development, and the range of behavior that children present, based on their culture. His concept of "scaffolding" children's behavior, teaching them the skills that they need in a society, is also important for professionals working with immigrant children to keep in mind.

Theories of acculturation inform professional understanding of immigrant child development. Originally, acculturation theories focused on the adaptation of the immigrant to a new cultural context. Current models of acculturation have evolved from more simplistic origins, proposing categories that include integration, marginalization, assimilation, separation, fusion, and other strategies. They also highlight varying degrees of resiliency in immigrant children where some may/may not experience adjustment problems regardless of category. Cultural tenets regarding independence and interdependence also play a role in the immigrant child's developmental processes. These concepts serve as a framework for immigrant child development by providing a context within which development takes place. Most sending countries value interdependence. Receiving countries typically emphasize independence, which is evident in both Erikson's and Piaget's developmental stages. Valuing either independence or interdependence affects the behaviors, relations, boundaries, and skills that children learn. The developmental progress of immigrant children is often judged on the basis of the receiving country's expectations of independence. Clearly, the integration of developmental concepts from both sending and receiving cultures is important for professionals working with immigrant children to use in assessing development.

Conclusion

A myriad of influences impact the healthy growth of immigrant children making it imperative that those medical, mental health, and education professionals working with them understand their complex set of developmental needs. Devising an individualized child developmental trajectory that encompasses sending country characteristics, influences of the family, receiving country characteristics, and cultural expectations of both the sending and receiving countries will support immigrant children in reaching their full developmental potential.

Related Topics

- ▶ Acculturation
- ▶ Adolescent health
- ▶ Assimilation
- ▶ Child
- ▶ Child abuse
- ▶ Child health and mortality
- ▶ Child labor
- ▶ Child rearing
- ▶ Family
- ▶ Family reunification
- ▶ Family violence
- ▶ Gender
- ▶ Hague Convention on Child Abduction
- ▶ Infant mortality
- ▶ International adoption
- ▶ Intergenerational differences
- ▶ Refugee
- ▶ Unaccompanied minors
- ▶ War-affected children
- ▶ Youth
- ▶ Youth antisocial behavior

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Child Health and Mortality

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Demographics

Nearly 3% of the world's population migrates, with one out of three persons around the globe undergoing migration. Children of immigrants are the fastest growing group in the US population under 18 years of age, with one in five children the child of an immigrant. While immigrants are 11% of the US population, children of immigrants make up 22% of the 23.4 million children under 6 years of age. As of 2005, nearly one-fourth (23%) of children lived in an immigrant family. This explosive growth, combined with the large numbers (40%) originating from Mexico, and additional areas that include 10–11% each from the Caribbean, East Asia, or Europe combined with Canada and Australia; as well as 5–7% each from Central America, South America, Indochina (Cambodia, Laos, Thailand, Vietnam, or West Asia); and 2–3% from Russia and Africa. As a group, immigrant children are changing the racial and ethnic composition of US children for the present and adults in the future. These children are also among the poorest segment of the population, with one in four immigrant children living in poverty. Their families are among the poorest, least insured, or educated with limited, or no access to health care. Poverty is a social determinant that negatively impacts health across the lifespan.

Immigrant Children's General Health

Children of immigrants are likelier to be in "fair" or "poor" health than children of natives, with their health declining more rapidly as they age. Seven percent of immigrant children under 11 have been reported to be in fair or poor health which rises to 13% among 12–17-year-olds. Poor health status increases with poverty. While 12% of poor immigrant children 5 years or younger have been reported in fair or poor health, poor health status increases to 19% among adolescents, 12–17 years.

Immigrant Infant Health

The rate of low birth weight and infant mortality are two common indicators of infant health. Findings based on linked birth/infant death data sets for a number of immigrant subgroups that include Mexican, Cuban, Central/South American, Chinese, Filipino, and Japanese have documented that children born in the USA to immigrant mothers are less likely to have low birth weight and to die during the first year of life than children born to native-born mothers from the same ethnic group. While other factors may be involved, cigarette smoking, alcohol consumption, and weight gain during pregnancy are critical determinants of difference between immigrant and native-born women and their infant's low birth weight and mortality. Since the 1980s, research has supported the "immigrant paradox" that despite risk factors that include higher poverty rates, lower education, and less access to health care, some immigrants have better birth outcomes than the native born. The immigrant paradox is most consistent with Hispanic immigrants; however, some of the largest differences in low birth weight and infant mortality rates have occurred between foreign and US-born non-Hispanic Blacks.

Congenital Anomalies

Asian American children have a lower prevalence of congenital diseases and chronic conditions in general. Among Hispanics, the incidence of congenital anomalies is no greater than in the general non-Hispanic White population. About 2% of newborns have a major malformation, with an additional 3% having such conditions discovered in later childhood. According to the American Academy of Pediatrics, immigrant children may not be screened at birth for diseases such as congenital syphilis, hemoglobinopathies, and inborn errors of metabolism.

Immigrant Preschool Health

Untreated health and developmental conditions that occur during infancy may continue during the preschool period of 2–5 year of age. The child's living environment is critical to his or her cognitive and social-emotional development not only during infancy, but also during the preschool period. Exposure to toxins such as lead can lead to developmental problems if left untreated. Unintentional injuries from accidents will also negatively impact a child's overall growth and development and especially effect children living in poverty. Consequently, screening and follow-up for developmental problems is recommended.

Asthma

Asthma is the leading pediatric chronic condition of the USA. A growing body of evidence documents a disproportionally higher lifetime asthma prevalence among children born in the USA compared to those born elsewhere. While a relatively low prevalence of asthma exists among Hispanic children as a group, Puerto Rican children have been found to have the highest prevalence compared with children in all other racial and ethnic groups. Among Asian immigrant subgroups, a wide variation can be found in the prevalence of asthma, with Filipino children born in the USA having similar rates of asthma compared with children of Black, American Indian, or Alaskan Native heritage. Asian Indian children born in the USA have a much lower asthma rate.

Interactions among genetic, environmental, and social factors have been associated with differences in the prevalence of asthma among immigrant children. Children from immigrant families with asthma often experience additional factors that exacerbate their condition. These may include pollen-sensitive forms of asthma, with migration from tropical to a temperate climate with higher and more seasonably varying pollen rates which can worsen the condition. Exposure to viral pathogens to children not previously exposed can precipitate asthma. Cultural beliefs may also affect the etiology and treatment among immigrant families.

Chronic Health Conditions

While children of immigrants in general have better health outcomes compared to children born of US parents, it is unclear whether the immigrant paradox applies to children with chronic conditions. For example, compared to asthmatic children of US-born parents, asthmatic children of immigrant parents are more likely to be uninsured, lack a usual source of health care, report a delay in medical care, report no visit to a physician, or no emergency room visit for asthma in the past year. Asian Indian children have the lowest percentage of chronic conditions.

Immigrant School-Age Health

School health issues for immigrant children range from childhood nutritional challenges that include nutrient deficiencies, obesity, diabetes, as well as infectious diseases like tuberculosis, and dental caries. Health issues of school-age children from 5 to 11 years of age are a continuation of those that were identified during the infant and preschool period with untreated chronic medical conditions such as asthma negatively affecting a child's overall educational potential and development. Immigrant children whose parents lack health insurance are especially vulnerable since this limits their access to health care, needed medication, equipment, and monitoring of the condition. While low-income immigrant children 6–11 years of age are less likely to have more behavioral problems than native children, advantages have been found to worsen with time, with no differences found among low-income children 12–17 years of age.

Infectious Disease

Infectious diseases commonly found among immigrant children and adolescents are often easily treated and rarely pose a public health threat to the school community. Children with latent TB infections may attend school, pending evaluation and treatment with skin testing recommended for students coming from endemic countries. High rates of intestinal parasites, such as giardia, are found in some immigrant populations. Children with symptoms that suggest a parasitic infection or those in situations that pose a high risk of infection or transmission in institutional care settings may warrant screening and treatment or even empiric treatment with antiparasitic medication. A less common infection includes hepatitis B among children from endemic countries. Skin infections such as fungal infections, scabies, and lice are seen in newly arrived immigrants.

Children of migrant farm workers are at increased risk for respiratory and ear infections, bacterial and viral gastroenteritis, intestinal parasites, skin infections, lead and pesticide exposure, tuberculosis, poor nutrition, anemia, undiagnosed congenital anomalies, developmental delay, intentional and unintentional injuries, as well as occupational injuries and substance abuse.

Dental Health

Tooth decay is not only the most common chronic illness among children, affecting five times as many children as asthma but the most unmet health need among children. Decayed teeth retain bacteria that can be spread throughout the body and increase a child's susceptibility to other problems which include ear and sinus infections. Oral disease can affect children's growth, speech development, nutrition, learning, and overall quality of life. The American Academy of Dentistry recommends that all children have a dental care visit within 6 months of the eruption of their first tooth. Dental problems are common among immigrant children. Elementary school–aged immigrant children have been found to have twice as many dental caries in their primary teeth as their US counterparts. Immigrant children have been found to be twice as likely as native children to receive no preventive dental care.

Nutritional Deficiencies

Anemia and micronutrient deficiencies, especially of iron, zinc, and vitamin A, are common health problems among refugee and immigrant communities. Iron deficiency anemia has been found among high-risk age groups such as toddlers/preschoolers and early adolescents from developing countries. Anemia and iron deficiency may be compounded by lead poisoning.

Obesity and Diabetes

Among school-age children, obesity has emerged as a significant problem affecting long-term health. Mexican-American and Puerto Rican children are significantly more obese than non-Latino White children. Both of these Latino subgroups demonstrate increased fat deposits in the trunk which has been associated with higher cardiovascular disease in adults. This higher prevalence has been found to start as early as 6–7 years of age and continues through adolescence and adulthood. This high rate of obesity is of concern with its increased risk for cardiovascular disease and association with Type 2 diabetes. Mexican Americans are at particular risk for Type 2 diabetes.

Type 2 Diabetes

As a consequence of the high rates of obesity, many US adolescents are beginning to suffer from diseases that have traditionally been diagnosed in adulthood. The average age of onset of Type 2 diabetes is currently 13, and minorities with the disease suffer greater rates of complications and early death than their non-Hispanic White peers. Type 2 diabetes occurs when the body does not make enough insulin or does not adequately utilize the insulin that is produced (this is called insulin resistance). Type 2 diabetes increases the adolescents' risk for serious complications including, heart disease (cardiovascular disease), blindness (retinopathy), nerve damage (neuropathy), and kidney damage (nephropathy). Nonetheless, the risk of Type 2 diabetes can be cut by 58% simply by decreasing dietary saturated fat and engaging in at least 30 min of moderate to vigorous physical activity every day. Parents, educators, and public health officials need to find new ways to engage immigrant youth in healthy lifestyles within their own cultural context.

Immigrant Adolescent Health

Adolescence in the twenty-first century is defined as the period from puberty onset to societal independence and includes the development of sexual and psychosocial maturity during that stage. Adolescence not only harbors immense health risks but also vast opportunities for sustained well-being through health education and prevention. In order to provide a comprehensive view of adolescence, health and physical development cannot be overlooked. These two factors drive the developmental changes that are experienced during this vibrant period and the sustained consequences over time of health choices. The mental health, nutrition, and risky behaviors are special challenges among immigrant adolescents.

Mental Health

Immigration imposes unique stresses on children and families resulting in depression, grief, and anxiety. Current research on depression in immigrant adolescents is inconclusive, with some studies showing higher rates of depression in this population, and others showing lower rates. Hispanic immigrants, especially of Mexican origin, have the highest prevalence of depression. Research in Texas has documented that 31% of Mexican adolescent girls experienced depressive symptoms, compared to 16% of non-Hispanic White girls. Data from the National Center for Health Statistics in 2000 found an increased risk for suicide in this population, with 20% of Hispanic adolescent girls attempting suicide compared to 9% of non-Hispanic White girls. The rates of death from suicide are much higher for boys (83%) than girls (17%), but girls are more likely to report attempting suicide than boys in data from the Centers for Disease Control and Prevention. Regardless, depression is a serious health risk among adolescent immigrants. Among Hispanics, foreign-born youth (first generation in the USA) have been found to experience lower self-esteem and higher levels of suicide thoughts, while those born in the USA of immigrant parents show more serious health risk behaviors and conduct problems. It is worth noting that depression increases the risk for serious depression later in life, and is associated with poor health outcomes, such as risky sexual practices, pregnancy, violent behavior, and suicide. Recognizing depression in the adolescent could prevent further, more severe depression later in life, and other serious negative outcomes.

Nutrition

Overall, the nutritional status of foreign-born children upon entering the USA is associated with their socioeconomic circumstances in their country of origin. Limited data exist on nutritional status in general. More is known about Hispanic and Asian children than about children from Eastern Europe, Russia, Africa, and the Middle East. While foreign-born Hispanic adolescents have lower rates than their US-born counterparts of risk of overweight, the rates for foreign-born youth are very high. The most recent data report that nearly half of adolescents aged 12–19 are at risk for overweight, while more than one-fourth of Mexican-origin boys of all ages and one fifth of girls are overweight.

Data concerning the nutritional status of Asian children in immigrant families are limited and complicated by the diversity of Asian countries that send children to the USA. Understanding the economic, nutrition, and health conditions of their country of origin is critical to evaluating their nutritional status. Available data document the initial consumption by Asian children in immigrant families of traditional foods as part of the dietary intake with a transition to an American diet occurring over time. Among Southeast Asians, high levels of anemia have been found with limited intake of iron-rich food and possible gastrointestinal bleeding due to active parasitic infection.

High-Risk Behavior

Research has documented high rates of tobacco use, alcohol consumption, and substance abuse among Hispanic adolescents. Other studies have documented an association between high risk behaviors and acculturation. With increased acculturation, Hispanic girls engage in sexual activity at earlier ages and are more likely to give birth outside of marriage and to drop out of school. Increased risk for HIV/AIDS cannot be overlooked among immigrant adolescents as they acculturate and engage in substance abuse and sexual activity over time. The most frequently cited risk factors for sexual risk taking behavior are early exposure to sexual pressure, depression, and low social support. Violence as a source of injury and death among immigrant adolescents cannot be overlooked. It has become a major public health problem among adolescents in the USA. Poor urban young men of color, especially Latinos and African Americans, are especially at risk for violence.

Mortality among Hispanic adolescents is associated with homicide and unintended injuries. According to the National Center for Health Statistics, Latino adolescents have a rate of death from homicide that is higher than for non-Hispanic Whites. Some of the violence is due to gang activity with the developmental needs of adolescents for peer acceptance and social support, especially among marginalized immigrant youth. Gangs provide feelings of community acceptance and belonging. More research is needed to address violence prevention that is culturally tailored and developmentally appropriate to the immigrant adolescent subgroups of the USA.

Substance abuse increases with acculturation. Hispanic adolescents who are more highly acculturated to American culture report increased substance abuse with some variation by country of origin. In general, high-risk behaviors have been found to increase for each generation for adolescents with origins from Mexico, Cuba, Central and South America, China, the Philippines, and Canada with findings inconclusive. More research is needed to examine the association between acculturation and high-risk behaviors of adolescents including the identification of cultural factors that could protect immigrant teens from such behaviors over time.

Related Topics

- ► Adolescent health
- ► Asthma
- ► Childhood injuries
- ► Depression
- ► Diabetes mellitus
- ► Health disparities
- ► Healthy immigrant
- ► Hispanics
- ► Lead poisoning
- ► Nutrition

- ► Obesity
- ► Oral health
- ► Pediatrics

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Child Health Care Access

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Access to health care remains a critical issue for underserved children, particularly for children from immigrant families. The causes of decreased access to health care differ for immigrant children. Recent studies indicate that one in five children in the United States live in immigrant families. The immigration status of these children varies widely. Some of these children are immigrants themselves and were born abroad and others are US citizens themselves (the majority). Immigration status factors play a role in their access to health care. In addition, immigrant children have differing demographic profiles from other minority children. For instance, they are more likely to come from settings with married parents and more likely to live in a multigenerational family. Because of differing immigration status of children from immigrant families, their barriers to access to health care vary. The specific areas within access to health care include health insurance coverage and then ability to access that care, particularly primary care, dental care, and vaccinations.

Insurance coverage remains a critical issue for immigrant children in the United States. There have been gains in coverage in the past two decades with rates of un-insurance dropping from 19% to 15% by the mid-2000s. One third of all uninsured children in the United States are from immigrant families. This phenomenon has been seen both for children in families where all members are citizens as well as for children who are citizens with noncitizen parents. However, for children who are immigrants themselves and live in immigrant families the gap is widening, with levels of uninsured children rising from 44% to 48%. Under federal law, the Personal Responsibility and Work Opportunity Act of 1996, all legal immigrants (including children) are barred from Medicaid or SCHIP coverage during their first 5 years in the country. As of 2007, 22 states cover legal immigrants during this 5-year period utilizing state funds. However, there is significant variability as to what benefits are available from state to state.

In addition to access to insurance coverage, immigrant children experience other issues related to access to health care. In one national study, >25% of noncitizen children did not have a usual source of health care as compared to 18% of citizen children in noncitizen families and 6% for US children in citizen families. This is well short of the Healthy People 2010 objective of 97% of all children having a usual source of care. Half of these noncitizen children had not seen a doctor or dentist in the past year. Despite the lack of primary care, these children are also less likely to be seen in the emergency department. However, there is a study that determined that when immigrant children are seen in the emergency department, they have higher medical expenditures. This may be due to families seeking medical care at later stages of illness due to lack of primary care access.

Another access issue that is well documented in the medical literature is access to immunizations. Healthy People 2010 set goals of: (a) 90% up-to-date for individual vaccines and (b) children are 80% up-to-date with the series 4DTP/DTaP (diphtheria, tetanus, whooping cough/pertussis), 3 IPV (inactivated polio vaccine), 1 MMR (measles, mumps, and rubella), 3 Hib (Hemophilus meningitis), 3 HBV (hepatitis b), 1 Prevnar (pneumococcal meningitis) (4:3:1:3:3:1) by 36 months of age. However, noncitizen children are less likely to be adequately immunized and have demonstrated decreased rates of vaccination for hepatitis B and *Haemophilus influenzae* type b. This decreased immunization rates may be a consequence of a lack of primary care and can lead to increased risk of developing serious illnesses including meningitis hepatitis B.

Another significant barrier for many immigrant families is related to communication. Immigrant children with insurance coverage are still less likely to receive medical care than their insured nonimmigrant counterparts. Language barriers may play a significant role in this, particularly for recent immigrant families. Studies of Latino families demonstrate that language barriers play a significant role in creating a barrier to accessing care for their children. These families face many barriers when encountering the health care system. These barriers start with the first encounter which typically involves (depending on their level of English proficiency) scheduling appointments. This will require an interaction with a receptionist to discuss the nature of the appointment and potential times. During a visit, a parent may have to fill out paperwork, sign consent-to-treat forms, provide medical information to multiple providers, receive health education and complete billing information. Depending on the setting and location, there may be bilingual staff; if not, there are a variety of methods for approaching families with limited English proficiency. For hospital-based settings, there may be availability of medical translators or of calling a translator service and utilizing a two head set phone with the health care provider, parent, and then a translator on the other end of the call. In community-based settings where translation services are not readily available and may be prohibitively expensive, providers will often utilize informal services of family members of the patient (sometimes older siblings) or staff who may have limited experience with the language. Lack of consistent reimbursement for translation services is a barrier for these families as well as for health care providers to utilize trained medical translators.

In addition to the aforementioned barriers, immigrant families may perceive discrimination in the medical settings. This may be due to lack of language skills, or may be related to cultural differences. In addition, cultural differences may create misunderstandings. Finally, there may be concerns related to immigration status, particularly for undocumented families. These families may be concerned that their immigration status may be reported to immigration authorities and they may face such negative consequences as deportation.

Despite these documented barriers to access to health care, there are data to suggest that these children may be healthier than nonimmigrant children of similar socioeconomic status. This is known in the literature as the "health immigrant phenomenon or paradox". This has been demonstrated most consistently among Hispanic immigrants. One example of this phenomenon is that the prevalence of low birth weight is less common among immigrant Mexican-American women when compared to that of mothers who are US-born Mexican Americans (8% versus 12%). Some of this disparity is due to factors such as alcohol and tobacco use. Similar results have been demonstrated for infant mortality rates within the Black community. Children born to African women have decreased infant mortality rates when compared to African American women (10.5 versus 12.9 per 1,000 births). Analysis has demonstrated a clear role for immigrant status in this circumstance. Unfortunately, there is less research supporting a similar effect continuing into later childhood due to the difficulty of this research. Research for other immigrant groups is limited.

Children from immigrant families that may either be citizens or immigrant themselves face many barriers to accessing and receiving health care in the United States. These barriers may include lack of insurance coverage, access to needed and required immunizations, lack of primary care and dental care, and language barriers. Those who work with immigrant children should understand their individual state's benefits for immigrant children and assist with accessing insurance coverage as well as primary care. In addition, health care providers should be sensitive to the many barriers these families have when accessing and utilizing the health care system.

Related Topics

- ▶ Birth weight paradox
- ▶ Child health and mortality
- ▶ Health care utilization
- ▶ Healthy immigrant
- ▶ Immunization
- ▶ Pediatrics

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Child Labor

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Child labor remains a widespread and persistent socio-economic reality for many young people around the world. United Nations Children's Fund (UNICEF) estimates that 158 million children aged 5–14 are engaged in child labor – one in six children worldwide. Children are involved in many different forms of work, and work relations between children and adults can vary from complete subordination to relative autonomy. The single biggest sector of child labor is in agriculture – where children either work on family farms or work, often part-time, on other local farms. There are also many child laborers who do domestic work or who work in the service sector, factories, or in office environments. Some forms of child labor are exploitative and abusive, either because they are inherently so, or because of the young age and immaturity of the child workers involved. These "worst forms of labor," as they have been termed by the International Labor Organization (ILO), include bonded labor; prostitution; child soldiering; or other extremely hazardous, unhealthy, or personally dehumanizing forms of work. While not all kinds of child work are necessarily harmful or incompatible with access to good-quality education – as often articulated by children themselves – age-related conditions may make children more susceptible than adults to certain work hazards and health and safety risks.

Working Children in Cultural Context

Work has traditionally been an integral feature of the lives of most of the world's children. Historical and cross-cultural comparisons of children's work show enormous variation in the nature and intensity of what children are expected to do, the contexts and relationships within which work is performed, and the social perception and valuation of children's work. Policy standpoints on the employment of children and young people are based, implicitly or explicitly, on models or theories of childhood. In turn, conceptualizations of childhood, and of acceptable forms of work for children at different ages and genders, are mediated by cultural and socioeconomic factors.

The idealized image of the emotionally priceless but economically useless child – the "sacred child syndrome" – of upper- and middle-class Western society rarely exemplifies the daily reality of children around the work. Even in the Global North, many children resent the prolonged dependence resulting from what they see as a questionable and unnecessary exclusion from socially relevant work. Children's work contribution often constitutes an essential part of a household survival strategy. For children in especially difficult circumstances such as in the aftermath of disasters, conflict, displacement, or economic crises, the prospect of gaining some control over their own lives and having access to an independent source of income can be both household-sustaining and self-affirming. On the other hand, these situations also create an increased potential for children to be compelled to engage in hazardous labor in an effort to ensure their own survival and that of their families. Their mental and physical health and well-being may be compromised as a result.

Health Issues of Child Labor

Children and adolescents have particular anatomical, physiological, and psychological characteristics associated with their stage of development that may make them more vulnerable to work-related hazards than adults. While scientific studies regarding young workers' susceptibility to the wide range of potential risks to which they may be exposed in their work places are not yet common, some conclusive evidence of a link between age and vulnerability is already available.

Some epidemiological studies suggest that children exhibit more severe lead toxicity at lower levels of exposure, and tend to absorb higher amounts of lead than adults do at the same level of exposure. They could also be more vulnerable to pesticide exposure (a particularly alarming finding, given that agriculture constitutes the single biggest sector of child labor), asbestos, and ionizing radiation. An endocrine system compromised before full adulthood may result in hormonal imbalances and cause negative effects on sexual maturation.

Young children breathe faster and more deeply and have a higher metabolic rate and oxygen consumption than adults. Their greater intake of air per unit of body weight results in an increased absorption of fumes, gases, air pollutants, and other potentially harmful particles often found in certain work environments.

Young workers are believed to be more susceptible than adults to hearing loss induced by exposure to high levels of noise pollution – as would be the case in work performed in certain industrial or other environments. Children also have lower heat tolerance and are thus subject to higher risk of heat stress at work. Other studies indicate higher rates of injury-related disability among young workers when compared to adults due to more frequent cases of musculoskeletal problems and accidents. Injuries to ligaments and growth plates are particularly dangerous in children and can result in a condition known as osteochondroses (localized bone tissue death), potentially leading to limbs of unequal length. Carpal tunnel syndrome, tendonitis, and long-term back strain are additional concerns.

Particular attention needs to be paid to the so-called "worst forms of child labor" which, by their very nature, are especially harmful to children, and categorically condemned by international labor and human rights instruments. Their negative consequences for children are often psychological in addition to physiological.

Worst Forms of Child Labor

The International Programme for the Elimination of Child Labour (IPEC) was created in 1992 to spearhead the International Labor Organization's (ILO) efforts against child labor. The primary policy instruments related to these efforts include the ILO Convention 138, the UN Convention on the Rights of the Child, and the ILO Convention 182. The link between child labor and health issues is clearly established in these provisions.

The ILO Convention 138, also known as the Minimum Age Convention, seeks to regulate the intensity of work (generally measured in hours) at various age thresholds. Article 1 of this Convention requires ratifying nations "to pursue a national policy designed to ensure the effective abolition of child labour and to raise progressively the minimum age for admission to employment or work to a level consistent with the fullest physical and mental development of young persons." While the Convention provides that "[n]ational laws or regulations may permit the employment or work of persons 13–15 years of age on light work which is not likely to be harmful to their health or development; and not such as to prejudice their attendance at school" (Article 7[1a and b]), a higher minimum age of 18 years is established for "work which by its nature or the circumstances in which it is carried out is likely to jeopardize the health, safety or morals of young persons" (Article 3[1]).

Taking a rights-based approach, the UN Convention on the Right of the Child (CRC) addresses child labor by recognizing "the right of the child to be protected from economic exploitation and from performing any work that is likely to be hazardous or to interfere with the child's education, or to be harmful to the child's health or physical, mental, spiritual, moral or social development" (Article 32[1]). The CRC further calls for children to be protected from a variety of exploitative activities including the use of children in trafficking of illicit drugs (Article 33); child sexual abuse and commercial sexual exploitation (Article 34); the abduction, sale, or trafficking of children (Article 35); and the use of children in armed conflicts (Article 38).

The ILO Convention 182, adopted at the International Labor Conference in June 1999, commits ratifying nations to "take immediate and effective measures to secure the prohibition and elimination of the worst forms of child labour as a matter of urgency" (Article 1). This Convention categorically condemns certain forms of child labor, which have come to known as "unconditional worst forms of child labor." These include the sale and trafficking of children; the use of children in forced and bonded labor; children in armed conflict; the commercial sexual exploitation of children in prostitution and pornography; and children in illicit activities such as drug trafficking.

While the ILO has the lead responsibility for regulating child labor issues, other UN agencies engaged in poverty reduction, education, and children's rights also have a key role to play in addressing the underlying factors that give rise to child labor. These include the United Nations Children's Fund (UNICEF), the United Nations Educational, Scientific, and Cultural Organization (UNESCO), and the World Health Organization (WHO). Further, although child labor does not appear explicitly in the Millennium Development Goals (MDGs), strong linkages between addressing child labor and fulfilling other goals are evident. These include poverty reduction (MDG 1); education for all (MDG 2); gender equality (MDG 3); combating HIV/AIDS (MDG 6); and a global partnership for development (MDG 8).

The important role played by nongovernmental organizations, trade unions, and child-advocacy and other organizations involved in activities concerning working children must also be recognized. Lack of coordination and disagreements among these organizations over the most appropriate objectives and strategies to pursue can, however, undermine their effectiveness. The major challenge in the coming years will be to better integrate child labor issues into the relevant frameworks at international and domestic levels. Measures to promote the physical and psychological recovery of children who have fallen victim of harmful forms of child labor must be an integral component of these efforts.

Conclusions

Child labor is a complex and multifaceted phenomenon requiring systematic attention to the socio-economic, cultural, and physical environment in which children live and work. While the institutional, legal, and human rights frameworks regulating child labor issues have been increasingly strengthened in recent decades, and some progress is already evident, child labor remains a concern of immense social and economic proportions. Millions of children are forced by necessity or circumstances to work too much at too young an age, or under particularly exploitative circumstances. In 2006, IPEC estimated that about 126 million children were engaged in various types of hazardous work worldwide. While there are encouraging trends in a number of nations – Brazil, Mexico, Turkey, and Vietnam, among others – child labor rates remain persistently high in much of the work. Although not enough is yet known about the links between age-related vulnerabilities and specific work hazards, it is clear that special health risks should be taken into consideration when prioritizing definitions of work appropriate for children and adolescents, and in enforcement of minimum-age regulations.

Related Topics

- ► Childhood injuries
- ► International Labour Organization
- ► Labor migration
- ► Occupational injury
- ► Trafficking
- ► United Nations Convention on the Rights of the Child

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Child Obesity and Overweight

► Pediatrics

Child Rearing

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Child-rearing practices vary widely based on cultural beliefs, education, and economics. Immigration and acculturation can affect child-rearing abilities and practices as immigrant parents face unique challenges. These include, but are not limited to, poverty, unemployment, access to public health services, limited transportation, isolation, and incomplete command of the native language. One of the goals of many immigrant families is to provide a better life for their children, but immigration is often stressful for immigrant families and children. Studies have shown that circumstances associated with being an immigrant can undermine the parenting role. Immigrant parents may want to preserve their cultural identity and traditions and their children's awareness of their former country, but also want their children to assimilate into the new country.

Child rearing in infancy begins as people in contact with the child, typically a mother or mother-figure and family, interact with the newborn. The transition from being a woman to being a mother may be an isolating experience for some immigrant women. New immigrant parents often find that they have limited social support when it comes to caring for their new child and for themselves. Even in the hospital after delivery, some cultures ascribe to specialized diets after birth, which are generally not provided in western hospitals. The social isolation can be significantly different from what they would have experienced in their native country, as some cultures place an emphasis on the family and provide significant emotional and physical support to new mothers. Lack of this support and social isolation can lead to early struggles with anxiety and depression, which may have an adverse effect on parent–child interactions. Compounding this problem, lack of knowledge of resources as well as stigma associated with mental illness often inhibit people from seeking help.

As children enter the school system, child-rearing practices can affect the child's progress. Some cultures place a strong emphasis on education; however, the parent's ability to communicate with both the child and the school can affect how well the child is able to take advantage of educational opportunities. Immigrant parents may have limited access to information about their child's new environment and experiences. They may not understand the new educational system, may use their native countries education system as a model for the education of their children, or be unable to take full advantage of the new education system. The immigrant family may become more dependent on the school for the child's academic performance due to the language barrier or lack of understanding of the system. Studies indicate that in the United States, there are generally low rates of enrollment in early education programs, especially among low income families and those families with less formal education and/or command of the language. Sometimes immigrant parents are undocumented and may be wary of institutions like public schools for fear of deportation. At the same time, there may be pressure for the child to fulfill the parent's dreams which can place stress on the child.

Child rearing can be affected by traditional values of the parents and the new values being introduced by outside factors, like school. This dichotomy can lead to intrafamilial and intergenerational conflict. Studies indicate that children typically adjust more rapidly than their parents to the new country. This is referred to as the acculturation gap and has been found to be more pronounced in families where the parents are less educated. When this occurs, there may be some level of role reversal as the child's command of language surpasses that of the parent, and the child becomes responsible for communication with outside agencies like schools, banks, or grocery stores. While this role reversal can weaken boundaries and lead to children being less likely to listen to or obey their parents, it can also have a positive effect whereby the child feels that they are contributing to the family and helping out their parents.

Different parenting styles have been described in the literature. These include authoritarian, permissive, and authoritative. An authoritarian parent stresses control and obedience and places little emphasis on child autonomy. A permissive parent allows children to make their own decisions and regulate their own behavior. Authoritative parents emphasize limit setting through reasoning, verbal give and take, clear instructions, and positive reinforcement. Studies indicate that parenting at either end of the spectrum (authoritarian or permissive) may adversely affect the parent–child relationship. However, some studies have shown that if the parenting style is congruent with the sociocultural environment, then there is no negative impact. This can become an issue when the parenting style of the immigrant no longer matches that of the new culture. For example, the Chinese parenting style is traditionally authoritarian. Upon immigration to a more liberal society, conflict may arise as the child sees other children having fewer limitations. Cultural differences related to corporal punishment can also affect child rearing in immigrants. Corporal punishment may be a normal child-rearing practice in some cultures and immigrant families may not consider this child maltreatment or abuse. Additionally, native law enforcement may not reinforce immigrant parent rules, thereby undermining the parent's authority. One study showed that immigrant adolescents had higher levels of psychological disorders and lower connectedness to families, and another suggested that family cohesiveness decreased after immigration.

Data indicate that immigrants tend to have a lower income than natives. Children of legal immigrants often have hardships in the areas of food acquisition, housing, and health care, and a greater percentage of immigrant children than native children live in poor families. Financial stress may require both parents instead of one to work, which can mean there is less often a parent home to be involved in child rearing. Often, immigrants are employed at levels below their education level and may suffer from hostility from the natives. Highly educated individuals often suffer financial and occupational difficulties, especially within the first few years of immigrating. Lack of employment or employment below the parent's education level can affect parenting as the breadwinner suffers in his role as the primary provider. This can create a tense atmosphere in the home. Socioeconomic disadvantage may lead to marital dissatisfaction, conflict, and aggression, which can adversely affect children. Unemployment and poverty can lead to grief, guilt, isolation, increased alcohol intake, increased risk of mental health problems, and neglect or punishment of children.

While immigration status can have many adverse effects when it comes to employment and finances, there are some positive outcomes. Immigrant women who must work or choose to work may become more independent, and these women may take advantage of a broader range of child care options and work opportunities than they may have had in their native country. Immigrant mothers may gain more decision making control and have multiple roles compared to their native country. Additionally, in one study, fathers reported immigration allowed them to spend more time with their children (because they were working less).

In addition to education and financial issues, certain countries may require detention of asylum seekers that do not have visas. Parents and their children can be held for months to years and may not have access to adequate physical and mental health services, education, housing, and hygiene. In addition, they may be exposed to violence and/or abuse. Adult asylum seekers have been shown to have high levels of anxiety, depression (including suicidal thoughts/intent), and posttraumatic stress disorder (PTSD), and this may affect their ability to care for their children. The children of such parents have been found to suffer behavioral regression, depression, anxiety, and suicidal thoughts.

Another event which may significantly affect child rearing in immigrant populations is raids on and/or deportation of illegal immigrants. One or both parents may be separated from their children for a period of time. While there may be a heavy reliance on extended family networks, children may be left to fend for themselves or other small children. Removal of the breadwinner can lead to decreased income (less access to food, etc.) and a more unstable home environment. It can also mean that the remaining parent must work, thereby altering the family dynamics as children are left without a parent at home. The loss of a parent or both parents can be difficult to explain to children and require adaptation to single parent families and stress associated with separation and finances.

While immigrant parents face many challenges, studies have shown that many immigrants and their families may stay away from public assistance and health services due to uncertainty. Some countries have implemented programs to aid immigrants with transition and parenting. Research indicates that programs like Strengthening of Intergenerational/Intercultural Ties in Immigrant Chinese American Families (SITICAF) tested in California, USA, which are family-based mental health programs, can be effective in reestablishing family connectedness and understanding. Canada and other countries offer educational programs for immigrants and their families on parenting and child development (for example, the Calgary Immigrant Aid Society) as well as offering family literacy programs. There remains room to make improvements to address and improve social isolation, transportation, employment, child care, partnership equality, and shared responsibility with family, neighbors, friends, and community.

Related Topics

- ▶ Acculturation
- ▶ Child
- ▶ Child development
- ▶ Family
- ▶ Refugee
- ▶ War-affected children

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Childhood Injuries

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Nonintentional childhood injuries are the leading cause of death and disability in children worldwide, responsible for 950,000 deaths, and of these 90% are preventable. In the USA, for every child injury death there are 34 children hospitalized and 1,000 children treated in the emergency department. Moreover, the health care burden attributed to non-intentional childhood injuries is nearly $300 billion each year, accounting for 15% of total medical spending for children between ages 1 and 19 in the USA. Efforts to decrease the morbidity and mortality led to an unprecedented World Health Organization Summit for Child Injury Prevention in 2005, which urged prevention and increased public awareness. While fire-related burns, falls, and poisonings are frequent causes, road traffic injuries and drowning are the source of more than 50% of childhood injuries. A brief synopsis of the injuries comprising this global public health epidemic is provided.

An estimated 720 children die daily, while ten million children are either disabled or suffer permanent disability due to child road traffic injuries each year. The main cause of death in children between the ages of 10 and 19 is road traffic injuries, which accounts for 22% of total unintentional childhood fatalities. Children are at increased risk because they share the roadway as pedestrians, bicyclists, and as passengers in cars. Immigrant children are at increased risk of pedestrian injuries in part due to cultural differences regarding roadway safety. Cross-walk improvements, bike path expansions, and neighborhood education on child roadway safety has helped reduce child pedestrian injuries. Other childhood injuries are due to inappropriate use of a car seat, or failure to wear a seatbelt or helmet. Improper installation of car seats results in high fatalities in children under the age of 8; however, appropriate car seat safety use can reduce fatalities by 71% in infants and 54% in toddlers. In addition, the overwhelming majority of bicycle fatalities involve non-helmeted riders, with nearly 47% of nonfatal hospitalized injuries resulting in traumatic brain injury. The use of helmets can reduce fatalities by 75% and head injuries by 85%. Also, globally, teenagers between the ages of 15 and 19 are at even greater risk for road traffic injuries because of increased propensity to speed, drive under the influence, failure to wear a seatbelt, and engage in other risky driving behavior.

Every day 480 children die as a result of drowning and near-drowning injuries result in serious neurological damage worldwide. Drowning is the leading cause of death in children under the age of 5 and accounts for 17% of total non-intentional childhood fatalities. In addition, there is a higher incidence of drowning among immigrant children secondary to lower rates of swimming proficiency among children and adults. Drowning can occur quickly within a few minutes and in as little as a few centimeters of water with infants. Overall, children are vulnerable to these injuries because our daily environment involves direct contact with water sources for essentials such as drinking, bathing, cooling, and water recreational activities. Bathtubs, buckets, toilets, swimming pools, and open water sites are common locations for drowning or near drowning. The bathtub accounts for more than 50% of all infant drownings under the age of 1. Further in the USA, 30 infants drown each year in buckets containing water for household chores. Meanwhile, children over the age of 4 are more susceptible to swimming pools and open water sites, with 300 pool drownings in the USA annually. Fenced pool enclosures can reduce child drowning and near drownings by up to 50%. In comparison, teenagers often succumb to water-craft-related drowning, often due to failure to wear a personal floatation device, which can reduce child drowning by 85%. Prevention strategies shown to reduce child drowning fatalities and near-drowning injuries include: child supervision near or in water, drainage of all unnecessary water accumulations, four-sided fenced pool enclosures, and use of a personal flotation devices at all times with all water-craft activities.

Similarly, 262 children die each day and 96,000 die yearly from unintentional burns worldwide. Each day in the USA there are 435 child burn injuries evaluated in the emergency department and there are two deaths. Further, the mortality associated with burns is 11 times greater in low- to mid-income countries compared to high-income countries. Daily interaction with heating, lightening, and cooking increases the likelihood of burns. For instance, the increased incidence of unintentional burns among immigrant children was often associated with food preparation. Burns are typically caused by scalding water or steam, electrical or chemical burns, and fires. Although scalds from tap water or steam constitute 75% of burns in young children, infants are at greatest risk of death due to smoke inhalation. Further, electrical burns from appliances or outlets cause 33% of burns in children under the age of 12 and residential fires cause the majority of child burn fatalities under the age of 9. Extensive rehabilitation and treatment are usually required for significant nonfatal burns. Prevention includes child supervision, child-proof lighters, anti-scalding faucet heads, lowering residential water heaters to 120°, and installation of smoke detectors on each residential floor. Specifically, fatalities can be reduced up to 82% with appropriate installed smoke detectors.

Child fall injuries are the fourth leading cause of death among children, with 130 deaths each day and 47,000 deaths per year worldwide. Moreover for every death, 690 children will miss school due to a fall injury. In the USA, on average there are 8,000 emergency room evaluations daily because of child fall injuries. Approximately 80% of fall injuries occur at home and 66% are falls from height. Meanwhile, among immigrant children, fall injuries are increased in the agricultural setting. Overall, children are susceptible to falls due to unrefined motor skills, their general inquisitive nature, and increased level of physical activity. Infants sustain most injuries from nursery furniture and baby walkers, while playground and window falls account for the majority of older children's injuries. In particular, playground falls result in 200,000 annual emergency room evaluations and 75% are due to head injuries. Prevention can reduce fall fatalities and injuries, with installation of window guards on multilevel floors, roof railings, safer play equipment with appropriate surface material, and other safe product modifications such as safety glass.

Child poisoning injuries account for 123 deaths each day and 45,000 deaths each year worldwide. In the USA, child poisoning accounts for 374 emergency room evaluations and two fatalities each day. Additionally, millions of calls are made to the poison control center each year. Children are vulnerable to poisoning because their physiology is less well developed which increases risk of toxicity. Ninety percent of poisoning fatalities and injuries occur in a child's residence due to household products and medications. The most common causes of poisoning are over the counter medications, prescription medications, household products, and pesticides. Meanwhile, 890,000 children suffer from lead poisoning, which delays growth and development, while carbon monoxide poisoning affects 3,500 children every year often due to improperly ventilated space heaters. Specifically, immigrant children are at increased risk of lead poisoning likely secondary to lead exposure from toys, pottery, jewelry, cosmetics, or herbal remedies from foreign countries. Prevention of child poisoning fatalities and injuries involves: storing medications out of the reach of children, having access to poison control center contact information, carbon monoxide detectors, undergoing health screenings for lead poisoning, and providing child education.

In conclusion, childhood injury is a health epidemic that results in significant loss of life. The *Report on Child Injury Prevention*, by the World Health Organization provides a comprehensive approach on reduction of child road traffic injuries, drownings, burns, falls, and poisonings. Together, prevention and public education can save an estimated 1,000 children from childhood injury each day.

Related Topics

- ► Adolescent health
- ► Child
- ► Child health and mortality
- ► Child health care access

Suggested Resources

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Chinatown

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Chinatowns exist in many cities throughout the world, including Asian countries outside of China. They are usually urban and densely developed. Chinatowns serve as a cultural and commercial center for Chinese populations who have immigrated into predominantly non-Chinese areas. There are Chinatowns in Nagasaki, Japan; Bangkok, Thailand; Honolulu, Hawaii, as well as in Australia and Europe. In North America, Chinatowns can be found in Victoria, British Columbia and Toronto, and in the USA in San Francisco, New York, Chicago, Houston, Boston, Philadelphia, and elsewhere.

Because they serve as ethnic "hubs" that speak the language and provide food and goods that Chinese immigrants seek, the Chinatown community may be considered broader than simply the people who live there. It may also include the many Chinese (and others) who work and come to Chinatown to shop, eat, and visit. Thus, the community may be larger than the resident population. Also, the resident population in many Chinatowns has shifted over time. As the urban territory that they occupy may become prime real estate, pressures of gentrification and development may dislocate lower-income, working-class residents.

The health issues associated with Chinatowns arise primarily from the living and working conditions of residents and workers and infectious diseases that are prevalent in Chinese populations. However, it is critical to note that there has been too little investigation to date on health of Chinatown community members and there is a risk of overlooking health problems simply because they have not been documented.

A good example is asthma, which was largely not examined among Chinese immigrants to the USA until recently. When asthma was examined, Chinese children were found to have a substantial prevalence of asthma – above national averages. A specific event that may have affected respiratory health of Chinese immigrants was the 9/11 attack on the World Trade Center buildings in New York City.

Hepatitis B is endemic in China and, therefore, also a common condition in Chinese immigrant populations, including those in Chinatowns. Hepatitis B is transmitted via blood and body fluids, but in the Chinese context much of transmission may be from mother to child during birth or between family members. Because it is widespread in the Chinese community, there have been efforts to educate members about the disease and encourage screening and vaccinations. A consequence of high hepatitis prevalence is high liver cancer rates. Another infectious disease of particular relevance to Chinatowns and Chinese immigrants is tuberculosis.

Smoking prevalence is high among Chinese immigrant men, but very low among Chinese immigrant women. This is a pattern similar to many other Asian populations. Beyond the direct impact of smoking on the health of the smoker, who is at increased risk for cardiovascular disease, lung and other cancers, chronic obstructive pulmonary disease and other illnesses, second-hand smoke exposure poses a significant risk to wives (or other family members). Lung cancers among Chinese immigrant women are a notable outcome of this exposure.

The environment and context of the Chinatown itself may also be important to consider. While there has been limited research in this area, there are some indications of health impacts arising out of the built environment. Many Chinatowns have heavily traveled streets and some have adjacent highways. Thus, exposure to air pollution from motor vehicles is a potential concern that may merit further attention. Local "hot spots" of air pollution have been shown to exist near high traffic density locations. These pollutants are known to be associated with cardiovascular disease, lung cancer, and other illnesses. In addition to air pollution, traffic generates sound, perceived as noise by many, that is linked to a variety of adverse physiological outcomes, possibly through producing stress.

Stress may be an important exposure in Chinatowns. Besides traffic noise, there are other urban sources of sound. In Chinatowns that experience major construction projects, for example, there is considerable noise and vibration associated with these projects (and air pollution releases as well). In addition, crime, walkability (including pedestrian safety), and onerous work schedules in low-paying and often unpleasant or hazardous jobs add to stress. This may be an area deserving greater attention in future research efforts.

Traffic is also associated with motor vehicle–related injuries. A study conducted in Boston's Chinatown found that both in-vehicle and pedestrian injuries were associated with times of days and days of the week and with particularly complex (confusing) intersections. While many victims were Chinese residents, the drivers were mostly from outside the community. Cross times at signals were too short for the large elderly population to cross on the green light.

Crime, including violent crime and fear of crime, are common to many urban settings, but Chinatowns have been both subjected to stereotypes about being dangerous (mysterious) places and, because of their location in urban centers and near sources of crime, actually subjected to high crime rates. Again, crime produces stress that has health consequences, but crime also is directly harmful to health. For example, violent crime can lead to injuries, and drug use and prostitution spread infectious diseases.

Housing is another critical issue in Chinatowns. Quality, quantity, and affordability are concerns. Overcrowding is, as it is with many low-income communities, immigrant or not, a significant factor. Overcrowding is, of course, driven by housing costs and ability to pay so low-income immigrants, including those in Chinatowns, are at risk. Overcrowding, besides being stressful, also may increase the risk of transmitting communicable diseases and create conditions that attract pests. Pests and water damage, leading to mold growth, are also examples of deterioration of housing conditions that could put sensitive individuals, persons with specific allergies, for example, at risk of aggravation of underlying conditions such as asthma.

Working conditions in Chinatowns are also likely contributors to adverse health outcomes. While there has been far too little attention to the risks faced by low-income Chinese immigrant workers, recently, studies have begun to probe into this area. It is clear that many of the jobs these workers do, restaurant and construction work, for example, carry high risks. And it is likely that working long and unconventional hours increases health risks in this population, as it does in others.

Thus, Chinatowns have a mix of associated health concerns that are distinctive, but have not yet been fully elucidated. The lack of firm data creates a particular risk of misjudging the most salient health concerns in these communities. Many visitors are tourists looking for food or trinkets, who do not even realize that Chinatown is home to many people. There deserves to be more research to clarify which health concerns are most critical and how to address them.

Related Topics

- ► Built environment
- ► Chinese
- ► Environmental tobacco smoke
- ► Ethnic enclaves
- ► Hepatitis
- ► Violence

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Chinese

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Introduction

About 15.2 million, or approximately 5%, of the population in the United States are of Asian descent, a number that is expected to grow to 20 million by the year 2020. Among the many diverse subgroups that make up the Asian American population, Chinese Americans represent the largest number (3.54 million), followed by Filipinos (3.05 million), Asian Indians (2.77 million), Vietnamese (1.64 million), Koreans (1.56 million), and Japanese (1.22 million). Chinese is also the second most widely spoken non-English language in the United States after Spanish. Eighty percent of the population of Chinese Americans are concentrated across five states – California, New York, Hawaii, Texas, and New Jersey – with California being the most populous, accounting for 40% alone. Within the Chinese American population, (non-native) immigrants make up 47%.

It is also important to distinguish the various subgroups that make up the Chinese immigrant population. These subgroups are largely formed around cultural and language differences based on their country of origin or regional location. Chinese immigrants from mainland China speak Mandarin; individuals from Taiwan speak Taiwanese and identify themselves differently from Mandarin-speaking Chinese; and Cantonese-speaking Chinese from Hong Kong and southern China share a regional ethnic identification (Guangdong). Chinese immigrants coming from other Southeast Asian countries may distinguish themselves based on their country of origin (in many cases Vietnam).

Health Status

In terms of life expectancy, Asian Americans have the highest life expectancy (85.8 years) of any other ethnic group in the United States, with Chinese American women having the highest life expectancy (86.1 years) within the Asian subgroups. Although there is a paucity of specific health status data on Chinese Americans, the Office of Minority Health, as well as other research studies, indicates that Asian Americans as a whole have lower risks for death and disease compared to Whites and other non-Asian minorities. Elderly Asian Americans also have disproportionately lower mortality rates compared to their White counterparts.

There is variability in health status within Asian subgroups with Chinese Americans ranking high in many categories compared to other Asian subgroups. Chinese were most likely to be within a healthy weight range; the least likely to be obese after Koreans; and 11% less likely than other minorities to be poor, although within Asian subgroups Chinese adults were more than twice as likely as Filipinos to be poor. Other health findings for Chinese Americans taken from the 2001 Health Care Quality Survey found that Chinese Americans were least likely among Asian subgroups to rate their health as fair or poor (11%) compared to 40% for Vietnamese and 29% for Koreans. Notwithstanding, there is also evidence of poorer health status in Chinese immigrants of lower socioeconomic status and those living in poverty. Trends in research data also indicate differences in disease incidence rates based on factors such as immigration status and acculturation. Findings show that foreign-born immigrants have better health status compared to their US-born counterparts; however, the differences in health status between groups diminish with increased years of residence, suggesting the influence of factors related to a Western lifestyle and environment.

Health Risk Patterns

While overall health statistics are generally higher among Asian Americans in general, the Office of Minority Health points out that the highest risks for Asian Americans are for heart disease, cancer, diabetes, stroke, and unintentional injuries (accidents).

Cardiovascular Disease and Stroke

Cardiovascular disease is the leading cause of death for Asian Americans as well as Chinese Americans in the United States, accounting for 28% of total deaths. However, there is a lack of studies specifically examining cardiovascular disease prevalence and risk among Chinese Americans. In China, the statistic is even more startling; mortality rates related to cardiovascular death accounts for over 40% of total mortality. In China, it has been found that the incidence of stokes were higher in China than in Western countries. Among Asian Americans, 6.9% have heart disease, 4.3% have coronary heart disease, 19.5% have hypertension, and 2.6% have had a stroke.

With respect to hypertension, which is strongly related to coronary and cardiovascular health, data from the Multi-Ethnic Study of Atherosclerosis (MESA) found that, among Chinese participants, the prevalence of hypertension is higher than among their White counterparts after controlling for age, body mass index, smoking, and prevalence of diabetes mellitus. However, it has also been found that being born outside the United States, speaking a language other than English at home, and living fewer years in the United States were associated with a decreased prevalence of hypertension. Research also reports that Chinese (17%) or Korean (17%) adults are less likely than Filipino (27%) and Japanese (25%) adults to have ever been told that they had hypertension.

Cancer

Health research has shown that Asian Americans generally present the lowest incidence of cancer compared to non-Hispanic Whites. Research looking at age-adjusted cancer incidence and mortality rates of Asians residing in California from 1997 to 2001 showed that Chinese presented the lowest incidence rates for all types of cancers studied. Other research findings on cancer incidence and mortality rates among five Asian subgroups in California found that Chinese Americans present the lowest rates of all cancers combined compared to Korean, Filipino, Vietnamese, and Japanese ethnicities.

While some data shows that Chinese Americans have some of the lowest, age-adjusted incidence and mortality rates for all types of cancer as a whole, other studies show that Chinese Americans are at increased risk for cancers of the colon and lung, and have the greatest risk for cancers of the liver. Incidence patterns for liver cancer in Chinese Americans are associated with Hepatitis B, although liver cancers in Whites are associated with alcohol. Incidence rates for cancers of the colon, liver, and lung were high in Chinese Americans compared to the other Asian subgroups. In particular, Chinese women were found to have the highest lung cancer incidence and mortality rates of all the Asian ethnic subgroups in California; Chinese men had liver cancer incidence and mortality rates more than twice as high as in Japanese men. Also, Chinese men have the third highest incidence and mortality rate for colorectal cancer among the Asian ethnic subgroups.

These findings are consistent with other reports investigating the incidence of prostate cancer in men across 15 countries; Chinese men have the lowest incidence rates which contrast with Black men in the United States who have mortality rates 12 times higher than Chinese men in Hong Kong. These findings offer additional support for research findings, which identify China as having the highest death rates for liver cancer compared to 50 other countries. China ranked high in death rates associated with cancers of the esophagus and stomach; conversely, death rates for prostate and breast cancers ranked the lowest among the 50 countries.

Sharp differences exist in incidence and mortality rates for certain types of cancers for Chinese living in the United States compared to Chinese living in Asia. Cancers of the colon, breast, and prostate all show higher rates in Chinese American immigrants living in the United States compared to those living in China. Such contrasts in incidence rates imply possible risk factors associated with a Western lifestyle or environment.

Diabetes

Data based on Family Core and the Sample Adult Core components of the 2004–2006 National Health

Interview Survey found a prevalence of diabetes among Chinese to be 6%. Worldwide incidence rates of insulin dependent diabetes mellitus (Type 1) show that China has the lowest rates of Type 1 diabetes compared to 100 other populations in both adults and children. However, despite the very low rates of diabetes in China, the World Health Organization predicts a two- to threefold increase in prevalence rates of diabetes within the next few decades.

Tobacco

Tobacco use behaviors from the National Center for Health Statistics indicate that most Asians report never having smoked; Chinese American adults are most likely to have reported not smoking (84%) compared to Korean adults (65%). Among Asian smokers, Korean adults (22%) were two to three times as likely to be current smokers as were Japanese (12%), Asian Indian (7%), or Chinese (7%) adults. Another study noted similar findings where Chinese Americans reported lower rates of current smoking behavior compared to Whites, as well as other Asian subgroups except Japanese. Among Asians generally and Chinese in particular, smoking is largely associated with males than females. However, smoking behavior also varies based on acculturation. Research looking at four Asian subgroups finds that more acculturated youth and less acculturated male adults have higher smoking rates. For females, the opposite is true – smoking behavior is more highly associated with greater acculturation. Also, smoking behavior was associated with low education, use of non-Western physician or clinic, lack of knowledge of cancer and health risks, and being foreign born rather than US born.

Health-Seeking Behaviors

Health-seeking behaviors of Chinese immigrants are a complex process that is influenced by demographic, financial, and cultural barriers. Generally speaking, health-seeking behaviors are heavily influenced by degree of acculturation. The more highly acculturated the Chinese immigrants are, the more positive attitudes they have toward healthcare services and higher levels of actual service utilization. Chinese immigrants also suffer disproportionately from a lack of knowledge of health issues and awareness that symptoms are signs of a health problem. For instance, research looking at cardiovascular health and disease awareness among Chinese immigrants finds low awareness of warning symptoms of heart attack and stroke and what to do in response in a hypothetical situation.

The process of health seeking involves acknowledging that symptoms are severe enough to seek treatment. In terms of symptom severity, Chinese immigrants often delay accessing formal healthcare services in lieu of home remedies and traditional forms of medicine. When Chinese immigrants do access formal healthcare services, they often present with more severe symptoms when other more culturally acceptable forms of treatment have been exhausted. For most Chinese people, this pathway to accessing Western healthcare treatment is rooted in the desire to keep problems and issues secret within the family.

Chinese cultural values and norms influence the perception and interpretation of physical symptoms as well. As opposed to interpreting physical symptoms as a health or mental health problem, individuals may perceive their problem as a spiritual condition or as a personal weakness or deficiency to be overcome. Moreover, Chinese culture imparts a tendency to minimize individual suffering and avoid dwelling on negative conditions; instead, willpower and personal determination are encouraged which may negatively impact their health-seeking behaviors.

Healthcare Service Delivery

Decades of research have reinforced common themes associated with healthcare service delivery for Asian minority populations. Persistent patterns of underutilization of healthcare service among Chinese immigrants are related to a lack of understanding in navigating the healthcare system, an inability to communicate effectively, and factors related to costs of healthcare and perceived benefits. Chinese families also have a tradition of utilizing family networks first to keep private concerns within the family. Underutilization of services by Chinese immigrants is strongly influenced by the stigma and shame associated with physical and mental illnesses. The association of illnesses with individual character flaws and personal weakness is still strong in immigrant Chinese communities, and the fear of shame and of “losing face” within the Chinese community keeps many families from seeking external social services.

Another problem is the issue of racial discrimination and stereotypes of the Asian "model minority." Perceptions of Chinese immigrants are shaped by the model minority myth which reinforces the notion that Asians as a whole have higher socioeconomic status, educational achievement, more stable families, and lower crime rates. This type of stereotyping ignores the heterogeneity within the various ethnic subgroups within the Asian population. It fails to recognize the bifurcation within the Asian population, polarized at the ends of the spectrum by those well educated, affluent, and upwardly mobile and by those uneducated, less acculturated, and of lower socioeconomic status. Thus, this misappropriated label applied to Asians serves to obfuscate the problems and needs that many Chinese immigrants and other Asian minorities face; and while population-level indicators may point to the overall success of Asians, it fails to call attention to the needs of many Asians living in the United States. In addition, research on the experiences of racial discrimination by Asian Americans found it to be associated with chronic health conditions such as heart disease, pain, and respiratory illness.

Barriers to Healthcare Utilization

The research evidence on the barriers to healthcare utilization among Chinese Americans is well established. Access to healthcare is influenced by the nature in which services are delivered. Often healthcare facilities are not located near areas populated by Chinese immigrants. Immigrants of lower socioeconomic status may also lack access to transportation to access services. Low awareness of health issues and inadequate availability of healthcare services persists in Chinese immigrant communities due to limited access to health information presented in their native languages.

Cultural and social contexts also shape the way Chinese immigrants conceptualize their health, health problems, and utilization of healthcare services. An example of this can be seen by the manner in which many Chinese immigrants may conceptualize mental health problems as physical ailments caused by organic factors and describe their condition as such. This leads many individuals with mental health problems to present to healthcare providers in primary care settings. Also, the Chinese language does not have equivalent terms to describe some mental health terms like depression, so patients may use Chinese idioms and metaphors to describe their physical condition. Thus, the somatization of mental health problems, compounded by a lack of common terms used to describe mental health conditions, often results in misdiagnoses and ineffective treatments.

The role of language poses a major barrier in the overall quality of healthcare service delivery for Chinese immigrants. After English and Spanish, Chinese is the most common language spoken in homes in the United States. However, the absence of professional translators in healthcare settings exposes significant gaps in cultural competency with respect to the language barriers. This may cause Chinese patients to experience feelings of greater disconnect, suspicion of treatment and of their healthcare providers, and decreased levels of overall satisfaction with services. This is particularly true when there is also a practice of ad hoc use of translators and because there are different dialects of Chinese. Using the correct dialect is critical because speakers of one dialect usually will not understand another.

Barriers to healthcare utilization among Chinese-Americans are also created by the cost of insurance and healthcare. While Chinese Americans have been shown to have better overall health compared to non-Asian ethnic groups, they are also less likely to have healthcare insurance compared to Whites. With the perceived high cost of individual health insurance plans, many Chinese immigrants who work in smaller, family owned business, such as restaurants, grocery stores, etc., who do not have access to more affordable, employee-sponsored insurance plans opt to go without health insurance coverage or utilize public insurance if they qualify.

There needs to be more training and development of Chinese-speaking medical interpreters along with the promotion of greater diversity in healthcare staff. Ethnic matching and language matching in health treatments would facilitate trust building and might improve the utilization of services. Support for the development of community-based healthcare clinics to increase access would be helpful as well as the development of language-specific health promotion literature to be distributed among the Chinese populations in the United States to encourage them to get help for their health problems.

Related Topics

- ▶ Cancer
- ▶ Cardiovascular risk factors
- ▶ Diabetes mellitus
- ▶ Ethnic minority group
- ▶ Health beliefs
- ▶ Health care utilization
- ▶ Health services utilization
- ▶ Language barriers
- ▶ Somatic symptoms
- ▶ Stroke

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Chinese Exclusion Act of 1882 (U.S.)

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The Chinese Exclusion Act of 1882 (hereinafter "the Act") is considered as the first and only federal piece of legislation that prohibited a specific race, nationality, and ethnicity from entering the USA. Signed by President Chester A. Arthur on May 8, 1882, the Act excluded Chinese unskilled and skilled laborers from entry into the USA. Originally lasting a 10-year period, the Act was extended by the Geary Act in 1892, and thereafter extended indefinitely. The Act served as a starting point for the exclusion of citizens of other Asian countries from immigrating to the USA. Through a combination of other Asian exclusionary acts such as the Gentlemen's Agreement of 1907, Immigration Act of 1917, the National Origins Quota of 1924, and the Tydings-McDuffie Act of 1934, the legacy of the Chinese Exclusion Act of 1882 extended well beyond 1943, when the Act was finally repealed in a propaganda struggle against the Japanese during World War II.

The impact of the passage of the Act was felt immediately as Chinese immigrants who were considered laborers were categorically excluded. There was also ongoing litigation as to the re-entry rights for immigrants who were residing in the USA but were out of the country at the time of the passage of the Act. The trickle of immigrants entering thereafter consisted of merchants and students. The ultimate impact of the Act and its legacy Acts was the halting of Asian immigration. No other racial group has been singled out in such a systematic and blatant way for immigration purposes in US history. Though repealed in 1943, the ban on Chinese immigration and restrictions on immigration from other Asian countries continued for all practical purposes because the annual allotted immigration quota was so small (e.g., China 105/year) in comparison with huge quota for European countries (e.g., Germany 25,814). Not until 1965 was the institutionally racist "national origins quota" formula abandoned in favor of an immigration quota system that allocated an equal number for countries in the eastern hemisphere. The 1965 Act did not, however, cure the decades of Asian exclusion. Therefore, shortly thereafter a huge backlog of immigration applications existed for those countries that had been racially excluded. This is why the Asian Pacific Islander population is such a low percentage in the overall US population. For those Chinese and other Asians fortunate to be in the country prior to the passage of the Act, they were not allowed to become naturalized US citizens since the 1790 Naturalization Act had limited naturalization only to "free white persons." Even when people of African descent were allowed to become citizens of the USA through the passage of the 14th Amendment to the US Constitution in 1868, the ban continued against Asians. This ban was not lifted country by country until the 1940s and up to 1952, when the ban was removed finally for all Asian nationalities.

Although not nearly as infamous, the passage of the Page Act of 1875 did more to negatively impact the healthy development of family life and social formation in the Chinese community than other legislation. The Page Act was a federal law that prohibited the entry of Chinese, Japanese, and Mongolian contract laborers, and women for the purpose of prostitution, and felons. The section regulating the prohibition of prostitutes was applied against Asian women through a general assumption that Asian women were prostitutes attempting to enter the USA for immoral purposes unless they could prove otherwise. Whether it was cultural beliefs that women needed to stay behind in the home country to care for children and elders, or the enormous travel expenses, or the increasing anti-Asian hysteria, men were the primary immigrants in the nineteenth century. The many exorbitant fees levied upon each Chinese immigrant in the state of California alone became prohibitive to one working and living in the state, no less attempting to have a family life in the USA. With a huge disparity in the gender gap, these conditions became ripe for the prostitution industry. Such were the precursors to the passage of the Page Act. Health reasons were cited particularly for the regulation of Chinese brothels and eventually justifying passage of Asian exclusion Acts since Chinese prostitutes were looked upon as spreading venereal diseases and other germs amongst the White male population. The implementation of the Page Act greatly restricted the entry of Asian women into the USA. According to US Census data, the percentage of Chinese females in 1870 was 7.2% of the total Chinese population. By 1890 the figure dropped to 3.6%. The unavailability of Chinese women and thus potential mates served as a major impediment to the establishment of Chinese communities and a healthy family life. Many Chinese males working and living in the USA would travel back to China to get married, and possibly father a child but never or rarely have the occasion to see their family members due to restrictions on the exclusion Acts. Other Chinese males attempted to have family life in the USA but were forbidden from marrying White women due to various state anti-miscegenation laws as well as the federal Cable Act of 1922 (which had the effect of revoking the US citizenship status of any female who married an Asian man).

The Chinese Exclusion Act should not be considered only as a single piece of legislation, but as a culmination of a national anti-Asian movement and "Yellow Peril" xenophobia that started in the West Coast through a series of California state legislation that attempted to prevent and discourage Chinese immigration and democratic participation in everyday life. In California, there were head taxes for disembarkation from ships, special taxes and fees for Chinese in certain industries, laws that prohibited Chinese from testifying for or against Whites in court, and a tax on the Chinese for just residing in the state. Infamous cases such as *Ho Ah Kow v. Nunan* (a pig tail "queve" cutting ordinance against Chinese prisoners that had violated the "Cubic Air Ordinance" that forbid overcrowding housing conditions in San Francisco in 1870) and *Yick Wo v. Hopkins* (a series of San Francisco ordinances in the 1880s that regulated the licensing of the laundry industry operating out of wooden buildings) were initiated by local San Francisco officials under the guise of addressing health and safety issues while the ultimate impact was discriminatory practices against the Chinese only. Similar laws modeled after the Chinese Exclusion Act were passed in Australia (the Immigration Restriction Act of 1901) and Canada (the Chinese Immigration Act of 1923).

Related Topics

- ▶ Anti-Asian violence
- ▶ Chinese
- ▶ Discrimination
- ▶ Xenophobia

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Christianity

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General Issues

Christianity originated in the geographical area that is now known as the Middle East. Christianity arose in Palestine during the first half of the first century among the followers of Jesus of Nazareth, who was called the Christ. Christ's followers believed that He was the Messiah and the Son of God. Although Christ's first followers were almost exclusively Jews, this new faith spread quickly throughout the Mediterranean basin and soon attracted many non-Jewish converts. During the first three centuries, it remained a minority religion. The practice of the faith was prohibited by the Roman imperial government, and its adherents were often subjected to persecution. In the year 313, the Emperor Constantine declared Christianity to be a legal religion.

Christianity is a monotheistic religion that believes in one supreme God and is based on teachings from the Holy Scriptures. It comprises three major branches: Roman Catholicism and Eastern Orthodoxy (the two split from one another in 1054 AD), and Protestantism, which came into existence during the Protestant Reformation of the sixteenth century. Protestantism is further divided into smaller groups called denominations.

The fundamentals of the Christian faith can be found in the Old Testament; the New Testament, composed by followers of Jesus during the first century; and the patristic literature, which comprises the writings of early church leaders and theologians until the end of the fifth century. During this era, the beliefs and practices of the new faith were articulated and refined; such controversies included issues relating to the divinity of Christ and the nature of redemption. Gradually, a core set of beliefs developed within the orthodox structure and was promoted through church organization. Both the faith's doctrine and hierarchy were established by the late fifth century; both the doctrine and the hierarchy differ in some respects between Western Europe and the Byzantine culture of the East.

Christian identity is rooted in the experience of the Holy Spirit. Life is considered to be a sacred gift from God that should be protected, transmitted, cultivated, cared for, and fulfilled in God. For many Christians, the ultimate reality is the Holy Trinity: the Father, source of the other two fully divine persons; the Son, forever born of the Father; and the Holy Spirit, forever proceeding from the Father. Human beings are created as a composite of body and spirit, as well as in the "image and likeness" of the Holy Trinity. "Image" refers to those characteristics that distinguish humanity from the rest of the created world: intelligence, creativity, the ability to love, self-determination, and moral perceptivity. "Likeness" refers to the individual's potential to become "Godlike." The work of redemption and salvation is accomplished by God through the Son, the second person of the Holy Trinity who, with the exception of sin, took on human nature as the person of Jesus Christ. Christ taught, healed, gave direction, and offered Himself upon the cross for the sins of humanity. His resurrection allowed him to conquer the powers of death, sin, and evil.

Applied Christian Values

Christianity and the Principle of Justice and Equity

Even within a developed region such as Europe, disparities exist between different countries in terms of the quality of health care and the ability to access health care systems. Many relatively wealthy countries that are able to provide comprehensive health systems must nevertheless deal with issues of rationing and the fair distribution of resources. Therefore, the principle of equity is central to any consideration of health care.

Justice is both a social concept and an important Christian concept. Christianity does address the issues of equity and fairness in health care. The Holy Scriptures' focus on justice may be best understood by the modern reader as charity or love. The Old Testament reflects the concept of justice through its conferral of equal status of all men and women before God. Every human being is believed to have been created in the image of God; this quality belongs to all individuals, independent of any other differences. The Prophets repeatedly remind the people of Israel to do justice and that the true service of God is the pursuit of justice. Justice is primarily related to God. According to Christianity, human justice is a response to God's justice that human beings can experience between each other. However, Jesus ordered his disciples to practice strict adherence to this law, but asked them to go beyond the strict requirement of the law. Justice is not denied as an important value but love goes beyond justice demanded by law. Justice gives a person what might be considered to be due to him or her after weighing all relevant considerations. In contrast, love presupposes the implementation of justice and then may allocate to the individual more than would be demanded by justice alone. As an example, the Old Testament speaks of the Sabbath Year, during which the Israelites were to provide rest for themselves, their animals, their land, and forgive debts. In essence, the law functioned as a mechanism for the redistribution of wealth. In comparison, Jesus warned about the dangers of accumulating materially and asked individuals to distribute their wealth to the poor. This advisory was not for the purpose of effectuating social change, but was rather for the purpose of achieving spiritual perfection. The concern was not with equity, but with love.

Christianity and Caring for the Sick

From its beginnings, Christianity has been concerned with health and hospitality. Philanthropy and charity provided the foundation for the establishment of hospitals starting in the fourth century in the East, until modern times in the West. Medical tasks have often been central to the church's missionary efforts.

Christianity often views the source of suffering as outside of the sufferer. The source of an individual's suffering is often perceived to be the thing that is causing the pain, the pain itself, the individual's life circumstances, or a stroke of fate. On the other hand, suffering almost always involves a self-conflict. Both on a religious and a secular basis, it is not unusual for suffering persons to believe that their suffering is a form of selfless service to others. This is why the meaning is essential to suffering; the suffering associated with a threat to an individual's physical integrity necessarily raises the issue of the meaning of the pain and its implications. As an example, the crucifixion of Jesus, which was an evil, was transformed by God into

Christianity's central saving act and a demonstration of the power of love over suffering.

A Christian Protestant perspective asserts that God is in control and that there is a greater meaning or purpose in illness of which we may not be aware. Some Christian Protestants pray for miraculous cures as a sign of God's authority. Many believe that a miracle could occur but also believe that God works through human ingenuity and technology to cure illness and relieve suffering. Believers are warned not to attribute to physicians and medical interventions more power than they actually have and to remember that it is God who is in control.

Although Christian theology views physical health as important, it maintains that it may be an obstacle to the supreme good, which is believed to be spiritual health. It is believed that the soul is more valuable than the body, and that care for the body should not conflict with care for the soul. Christians are counseled to accept and appreciate both sickness and health. Sickness can correct or restrain one from engaging in sin, help an individual to increase patience and reduce pride, and facilitate the individual's reliance on God.

Within orthodox Christian theology, the origins of human death and disease are perceived as the consequence of divine judgment on human sin. When illness occurs, Orthodox Christianity affirms an ethical duty to struggle against sickness, which if unaddressed can lead to death. The moral requirement to care for the health of the body indicates it is appropriate to use healing methods that will enhance health and maintain life. Depending upon the particular denomination of Christianity, spiritual healing, such as prayer, and different forms of medicine may be utilized concurrently.

Christianity and End of Life Values

Christians have an obligation to attend to the sick and the poor of the community. To do so signifies not only Christian love but also a respect for life that is rooted in the belief that every human being was formed in the image of God. Accordingly, all human life is deemed to be of value, and therefore needs to be addressed with compassion and care.

Christianity maintains that we have a duty to protect the life given to us by God; accordingly, suicide, active euthanasia, and "mercy killing" are prohibited. However, there is a distinction between ordinary and extraordinary measures; a person is obligated to use ordinary measures but can choose whether or not to accept extraordinary measures.

A persistent theme in Christian reflection on death is the view that death serves to transform the individual into another form of existence; it is not the annihilation of the self. In other words, it is believed that the individual human being survives death, perhaps for all eternity. Death may represent a life that is free of sorrow, suffering, and separation. Some may believe that death does not have the power to cut them off or separate them from the life of the community and the life of God. Accordingly, death is viewed as a meaningful stage in the life cycle.

In general, Christianity traditionally defines death as the moment the spirit leaves the body. Signs of the spirit's departure include the absence of breathing, a heartbeat, and a pulse. Many Christian theologians have accepted a brain-oriented definition of death, sometimes analogizing this to the departure of the spirit from the body.

Christianity and Immigrants

Christianity and Immigrants' Integration into the Host Country

Some scholars have argued that after the first generation, immigrants in the United States would abandon their native languages and ethnic traditions but retain their religions and use religion as a way of melting into America's heterogeneous population.

In fact, religious identities may increase in importance among immigrants compared to its role in their nations of origin because of the role religion can play in preserving ethnic identities. Religion can be used not only to construct a religious identity, but also to develop or retain an ethnic identity. For example, studies involving Korean Christians have demonstrated how religious organizations can help to preserve ethnic traditions by combining and making religious and ethnic rituals synonymous. Campus-based evangelical Christian organizations have been shown to provide Asian Americans with cultural resources for reinforcing the image of Asian Americans as model minorities.

Churches may also serve as important social and educational centers that support the development and maintenance of relationships between individuals who speak the same language and share the same culture, thus providing group ties, identity, and acceptance. The practice of a religion in the destination country may also serve as an empowering resource for women, taking less patriarchal forms in organizations in the United States than in the immigrants' countries of origin. One ethnographic study demonstrated how a Taiwanese evangelical Christian church provided a space for women to construct a distinct sense of self as separate from the family.

Christianity also plays a role in developing social identity from a citizenship point of view. Development of an identity as a citizen first requires that one be a citizen. Gaining citizenship involves navigating the application process, which may be impeded by language barriers and other impediments to gaining legal status as an American citizen. Christian organizations often provide social service resources, such as assistance with learning the English language and help studying for the US citizenship exam. This has been demonstrated to be helpful in a study that was conducted with Asian Americans living in the five metropolitan areas with the highest numbers of immigrants.

The differences between the Orthodox and Catholic churches are important and may potentially influence the immigrants' lives. First, Eastern Orthodoxy never developed a worldwide central authority equivalent to the Papacy of Roman Catholicism. Orthodox Christians consider themselves to be part of one worldwide church that shares the same faith and sacraments; however, in church governance Orthodox Christianity is actually a unity of independent national churches. Unlike Roman Catholicism, Orthodox Christianity never developed an institutional unity that could transcend national, ethnic, and linguistic barriers.

Second, in the United States, Orthodox Christianity generally arrived later than Catholicism. Although monks from Russia established an Orthodox mission in Alaska in 1794, most Orthodox families came to America after 1900. They have integrated into American society more slowly than have Catholics because of the stronger ties between religious affiliation and ethnic community among the Orthodox. Ethnic consciousness appears even today to be more important for American Orthodox individuals than for Catholics. Further, various Orthodox church rules and traditions may contribute to Orthodox individuals' sense of ostracism from present-day mainstream American society. Thus, orthodoxy in the United States has supported more strongly the retention of immigrants' religious identity than their integration into the host country.

In the process of migration, a family or a person may lose a social network and the social and human resources on which they depend for both daily and long-term needs. An immigrant often experiences a sense of disorganization and disorientation that has been referred to as cultural exhaustion or shock. Others' behavior and symbols no longer mean what they meant before migration and the new immigrant must expend considerable energy to understand their meaning. Attending to the basic needs of housing, obtaining food, learning the banking system, and mastering English all require much energy. This sense of disorganization may diminish over time. The extent to which an individual experiences this sense of disorganization and confusion depends upon the individual's level of education, occupation, social status, formal social ties with the host country, personality traits, motivation for migration, and the extent of differences and similarities between the immigrant's country of origin and the receiving country. The immigrant's religion and religious community may serve as important sources of strength and may provide support during this period of difficulty.

Religious beliefs are powerful determinants of demographic events such as marriage, divorce, and childbearing. Religious teachings relating to partnership, sexuality, and fertility can affect demographic patterns both directly and indirectly. As an example, church leaders may oppose the use of contraceptives, which may impact the birth rate within a particular community. Accordingly, Catholics once had a significant fertility advantage over Protestants among White Christian Americans, but this advantage lessened during the second half of the twentieth century. Evangelical Protestants continue to have higher fertility rates than those from more liberal Protestant groups. In the United States, the high numbers of individuals immigrating from predominantly Catholic Latin America helped to mask conversions and departures from Catholicism to Protestantism and secular nonaffiliation.

Christianity and Immigrant Health

Many immigrants prefer to receive health information in a church setting. In the United States, the church has been found to be the most preferred location for attending a health education session compared to a community center, a hospital, or a local school. Studies have shown that churches and health care organizations can collaborate to implement successful health promotion programs and health education interventions. These programs and interventions focus on a wide range of health topics, such as smoking cessation, diabetes prevention, nutrition, physical activity, and cancer screening. Many church leaders provide immigrants with practical assistance, such as accompanying a church member to physician appointments, providing translation services, assisting with completing forms, etc., and consider this to be a core component of their Christian mission.

Over 70% of Koreans in the United States attend churches on a regular basis, in contrast to only 14–30% of Koreans residing in Korea. Therefore, Korean churches in the United States may play an important role in health research for this immigrant population.

Related Topics

- ► Gender role
- ► Health care
- ► Health care utilization
- ► Religion, religiosity, and spirituality

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Chronic Disease

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Immigrant status and nativity (i.e., country of birth) are strongly related to health, mortality, and incidence/prevalence of chronic illness. Compared to US-born, non-Hispanic Whites, immigrants tend to have a health advantage, including a longer life expectancy and lower mortality rates. However, in some cases immigrants from ethnic groups experience higher rates of chronic illness.

Chronic illness is characterized as any illness that persists over time and requires management through medical treatment (e.g., medication, surgery) or lifestyle changes (e.g., dietary changes, exercise). Many chronic illnesses are caused in large part by stress and poor health behavior choices such as having a poor diet, sedentary lifestyle, or other negative health behaviors such as smoking or drug/alcohol abuse. The major chronic illnesses attributed to lifestyle behaviors include heart disease, cancer, type 2 diabetes mellitus, and HIV/AIDS. Although medical treatment such as surgery or medication may be necessary, the main aspect of management for these chronic illnesses includes maintaining healthy lifestyle changes such as eating a healthy diet, getting adequate exercise, and medication compliance.

Heart disease. Heart disease is a major cause of death for many ethnic minority groups in the USA. New immigrants tend to have a lower risk of heart disease than minorities and nonminorities in their host country. However, over time this risk becomes similar to or greater than the risk of heart disease for native-born individuals.

Cancer. Overall, nativity and immigrant status do not appear to have strong links to cancer, but among different ethnic groups, the link between immigrant status and cancer is strong. In some cases, these links appear to be genetic, such as Asian immigrant's offspring tendency to have lower rates of ovarian cancer. In other cases, however, the links between immigrant status and cancer are due to poor health behaviors, such as higher rates of oral cancer in Asian immigrants from habitual use of tobacco, or higher rates of cervical cancer in Latino and Haitian women due to lower knowledge about and screening for HPV (human papillomavirus).

Type 2 diabetes. Research is mixed regarding the association between immigrant status and the development of type 2 diabetes, which occurs as a result of poor lifestyle behaviors. Some research suggests that nativity has protective effects, such that some ethnic groups appear to have lower rates of diabetes due to genetic factors. However, similar to heart disease, there is a general tendency for the incidence and prevalence of diabetes in immigrants to be highly correlated with incidence and prevalence of diabetes in their host culture.

HIV/AIDS. Research on the prevalence of HIV/AIDS in immigrant populations suggests that in general, immigrants and native-born individuals have similar rates of HIV-infections, although women from Sub-Saharan Africa tend to have higher rates of HIV/AIDS and Asian Pacific Islanders have lower rates of HIV/AIDS. Longitudinal data also suggests that many immigrants tend to become infected with HIV post-immigration.

Cultural Influences on Immigrants' Health

Although data clearly suggest that social and behavioral factors influence the incidence and prevalence of illnesses in immigrant populations, research on chronic illness still has a tendency to neglect the extent to which culture can influence an individual's chronic illness experience. Sociocultural theory provides a strong framework for understanding immigrants' chronic illness experience. Each culture has different values, beliefs, and normative behaviors that carry over into cognition, development processes, social functioning, and comprehension. Taken together, an individual's identity, self-image, and reality are a product of their culture. Thus, when immigrants are living with a chronic illness, the extent to which they identify with their native versus host culture (i.e., acculturation) can strongly influence how they understand, cope with, and manage their illness. In addition, their illness experience will also depend, in part, on the extent to which they are able to seek out adequate health care, have access to adequate health care, and receive quality health care that is sensitive to their cultural values and norms.

Acculturation and Chronic Illness in Immigrants

Acculturation is the process and result of an individual from a minority group adopting the cultural norms and beliefs of the dominant group or host culture. The stages of acculturation include contact, accommodation, and assimilation. Therefore, becoming acculturated includes behavioral and attitude changes such as changes in language preference, the adoption of common attitudes and values, and changes in political or ethnic identification.

Research generally suggests that immigrants are healthier than both their US-born counterparts and US-born Whites. This advantage is due, in part, to both a healthier lifestyle in their country of origin and selectivity of healthy immigrants. When immigrants first arrive in the USA, cultural factors such as religiosity or support networks tend to act as a buffer to the negative health behaviors and negative health events immigrants are exposed to (e.g., smoking, poor dietary behaviors). However, these health advantages tend to diminish as acculturation and duration of residency increase.

Health Behaviors and Risk Factors

A great deal of research finds a positive association between acculturation and the decline of health behaviors, including being overweight or obese, eating unhealthy foods, having a sedentary lifestyle, and engaging in negative health behaviors such as smoking and unsafe sexual practices. For example, as some immigrants become acculturated they have higher rates of being overweight or obese. As these negative health behaviors are primary causes of many major chronic illnesses, it is likely that as immigrants become acculturated their risk for developing heart disease, cancer, type 2 diabetes, and HIV increases as well.

Immigrants may have less knowledge about signs and causes of chronic illness due to language barriers and cultural beliefs. Some immigrants may not engage in preventive care, such as regular mammography or Pap smears, because they lack knowledge about the importance of the behaviors. There may be a lack of knowledge about where to obtain health care, fear of a language barrier between patient and provider, or fear of not receiving adequate care because of their inability to communicate effectively. In some cases, immigrants may be suspicious of their host country health care providers because the health care system in their host country is different than the health care system in their native country. As immigrants become acculturated, they may engage in better preventative health behaviors and illness management because their knowledge and trust of the host country's health care system increases.

Once diagnosed with a chronic illness, immigrants may have a difficult time making or maintaining lifestyle changes associated with illness management because of cultural influences, including traditional foods or religious beliefs. Immigrants with type 2 diabetes may modify their diet to an extent, but they may engage in deliberate deviations from their diet when culturally traditional foods, that are not necessarily healthy, are concerned. Many immigrants rely heavily on religious institutions as a means of emotional and instrumental support. Religious institutions often provide a sense of indirect social control in that members of the religious institution feel obligated to avoid behaviors that are not condoned by most churches, such as sexual promiscuity, excessive drinking, and smoking. As immigrants become acculturated, religiosity may become less important to them and therefore behaviors that were once restricted may no longer be seen as taboo.

Gender/Social Roles

Gender role theory suggests that men and women are socialized to engage in gender-specific behaviors from the time of childhood, and these behaviors often carry over into their adult behaviors and attitudes. Men tend to be independent and agentic, and are often seen as breadwinners of the family, whereas women are more often seen as communal as they engage in many of the caregiving aspects of the marital/familial relationships. In many Western and developed countries, it is becoming common for gender roles to be less pervasive in relationships and for men and women to be more egalitarian. However, in many traditional cultures, gender roles are still very persistent, and sometimes play a more dynamic role in the management of health and chronic illnesses.

Compared to non-Hispanic White cultures, Black and Hispanic cultures are generally more familial and have small, close-knit social networks. Immigrants coping with stigmatizing chronic illnesses such as HIV may not be able to disclose information about their illness to family members due to fear of rejection and social isolation as a result of the behaviors often associated with HIV-infection (e.g., homosexuality, drug use). As a result, immigrants may lack the social resources needed to cope with their illness, and they may also fail to engage in appropriate health behaviors such as medication compliance or attending regular health appointments in an attempt to hide their illness.

Many immigrant cultures place emphasis on the role of a woman as the caretaker of her family. As a result, the personality characteristic of unmitigated communion, or focusing on others to the detriment of the self, may be fostered in immigrant women. In this sense, immigrant women place so much emphasis on the health and well-being of their family that they do not tend to their own health care needs, including both preventive medicine and chronic illness management.

Health Care Utilization

The experience of chronic illness may be impacted by immigrants' utilization of health care. Although utilization of the health care system may be in part attributable to individual-level factors affecting the decision about whether or not to seek care, a number of factors at varying levels contribute to such utilization decisions and behaviors. In particular, not only are decisions impacted by structural factors like global access to care and the quality of the care once it is sought or received, but also the social and cultural context within the lives of specific immigrant groups.

Compared to nonimmigrants, immigrants are more likely to underutilize and delay the utilization of health care services. In addition, immigrants are less likely to discuss health promotion behaviors with physicians, and are less likely to get appropriate preventative services. For instance, female immigrants seek out preventative gynecological services less regularly.

A behavioral model of health services use, or the Anderson model, has been proposed to organize the themes of barriers to access and use of services. The model considers predisposing factors, enabling factors, as well as need. For instance, nativity, according to this model, is a predisposing factor to access and use of services, while health insurance and language, ease of making an appointment, and availability of providers are examples of enabling characteristics. Need might be based on illness and chronic illness as well as sex- or age-appropriate screenings and preventive care which can predict service use.

Access to Care

There is some evidence from nationally representative studies of US-born and foreign-born adults that having insurance and a usual source of care are less predictive of seeking both preventive and non-preventive health visits. Yet, other findings indicate that unmet medical needs are greater among those who lack insurance than among those insured – whether immigrant and nonimmigrant. Indeed, foreign-born individuals living in the US, and especially those who are noncitizens, are less likely to have health care insurance. This includes children as well as the elderly. Similarly, these individuals are less likely to have a usual source of care. This patterning corresponds with the trends found for rates of actual health care seeking; in particular, those who are noncitizens (undocumented and legal status) seek less health care than citizens. This is generally true for preventive care as well, such as mammography and Pap tests.

It is perhaps more even more difficult to access services when living in rural locations, where immigrants (e.g., Hispanics) are increasingly found. Thus, it may be that utilization of health care is attributable more to access, which is positively correlated with socioeconomic status. For example, after studies adjust for factors such as demographics, insurance, regular source of care, and other similar factors, immigrants appear equally likely to get preventive care.

It is also possible that acculturation issues and better health in combination with fewer health-enabling issues explain lower health care service use. These factors may be barriers to service seeking and many negatively impact the course of chronic illness. There may also be some fear on the part of the immigrant of negative or limited treatment due to their minority status. Data on African people living with HIV in the US have shown barriers to care that include individual perceptions such as fatalistic views about HIV and fear of isolation. Other barriers included fear of deportation and lack of knowledge of the health system and HIV-related services.

Quality of Health Care

In addition to understanding how health care access affects immigrants' chronic illness experience, it is also important to acknowledge immigrants' experience once inside the health care system. Quality of health care is the extent to which services are aligned with professional knowledge, and the extent to which individuals receive appropriate services in a competent and communicative way. To this end, typically expected characteristics of quality may include shared decision making between the patient and the health care provider, as well as sensitivity to cultural differences and concerns. Such quality is important because it contributes to a greater likelihood of continued service use and better health outcomes.

The Anderson model of service access and use includes quality of care. Considering the patient and physician interaction as a context for determining quality of care, specific indicators of quality might include patients' perceptions of (1) whether the doctor listened to the patient, (2) whether the patient understood the doctor, (3) whether the patient had questions that went undiscussed, (4) patient trust of physician, (5) whether the doctor treated the patient with respect, (6) whether the doctor involved the patient in decision making, and (7) whether the doctor spent the amount of time with the patient that is wanted. Considering the association between nativity status and patient perceptions of the patient–physician interaction, foreign-born, as compared to US-born individuals, are at increased odds of reporting their physician as not involving them in their care as much as they would have liked. In addition, foreign-born persons are at increased odds of reporting their physician did not spend as much time with them as they would have liked. Additional reports of research show that at times immigrants perceive health care as not helping to the fullest degree.

Given the role of language in communication, language differences and other cultural differences can contribute to immigrants' quality of care as well. Language appears to increase the difficulties with patient–physician communication when the patient is an immigrant. For instance, individuals who are less proficient in English tend to receive fewer of the appropriate tests and preventive screenings than those more English-proficient. Those less proficient in English tend to have worse health and more distrust that physicians understand their medical problems. Further, those who have difficulties with language and communication report less adherence to medical regimen and chronic illness management. Foreign-born individuals also are more likely to report perceived discriminatory experiences in the health care system; being non-White and a noncitizen is related to more such reports.

Other Cultural and Social Contexts

Several other factors related to cultural and social contexts might contribute to health care utilization and subsequently the chronic illness experience among immigrants. For example, lower service use and the fewer enabling factors to service seeking may be exacerbated within the social context of intimate partner violence in the lives of immigrants. Considering women in particular, partner violence puts immigrant women at risk for some chronic health conditions such as sexually transmitted diseases. Further, legal issues related to being undocumented may prevent these women from seeking health care. Moreover, in some cultures, partner violence may be perceived as extremely personal and not within the realm of topics to be discussed with health care providers. In this social context of private partner violence and a distrust of the health care arena, individuals may feel helpless to change their situations or appropriately handle other health-related concerns.

Immigrants' personal and familial relationships may contribute to health care use and the illness experience. Some research has shown, for instance, that immigrant women's adult daughters may play an important role in their health care and health care seeking. This pattern may be especially true when the daughter is more proficient in English language skills and is able to help navigate the health care system. In fact, some evidence suggests immigrants may connect with other immigrants as well as with family and friends to navigate the health care system. This solidarity may contribute to a greater likelihood of receiving adequate health care. Further, the challenges or barriers to care reported above may also apply to children of immigrants, whether or not they themselves have chronic conditions which require treatment. Thus, access to care and quality of care, as well as cultural issues contributing to perceptions of the health care system impact not only individual immigrants who may be suffering with chronic conditions but also can influence families as they navigate the health care system.

Another contextual reality for immigrants is that chronic illness is often comorbid with other illnesses, including mental illness. Mental health problems may be greater among immigrants particularly as they remain in their host country for longer periods of time. This link between acculturation and mental health perhaps reflects greater risk for psychiatric disorders with increased exposure to minority status. Further, immigrants' experiences of having less access to health care, less quality health care, and greater stigma and fear of deportation associated with health care, can contribute to greater psychological distress. Finally, in many cultures, mental health problems are not acknowledged or addressed. As immigrants acculturate to their host country, they may feel more comfortable seeking mental health treatment. Some variations in mental health patterns by gender and ethnic category exist, leading to the question of whether factors related to specific immigrant groups contribute to mental health. The National Survey of American Life found that Caribbean immigrant men fared better psychologically than their US-born Black counterparts, whereas Caribbean immigrant women fared worse as compared to US-born Black women.

The combination of increased mental health issues and lowered mental health care seeking could exacerbate the negative experience of immigrants with chronic illness. An increased focus on immigrants' health care needs and utilization in the context of mental health needs and care seeking seems necessary. In this realm of mental health and psychiatric care, it is perhaps an additional charge of the primary healthcare system to address such issues that are not traditionally in the preview of health care and yet may be ever present. Indeed, immigrants and US-born alike disproportionately use the general medical sector for treating mental health problems. Given the lowered utilization of mental health care, perhaps integration of psychologists into primary care could reduce the stigma associated with seeking care. To illustrate, Asian Americans experience various emotional or behavioral problems, and yet underuse existing mental health services except when culturally and linguistically sensitive. Culture-bound syndromes and misdiagnosis can occur. Due to Asian traditions of viewing the body and mind as one rather than two separate systems, individuals tend to focus more on physical than emotional symptoms, leading to overrepresentation of somatic issues. Perhaps the integration of psychology into primary care practice can address both the physical and mental health contexts.

Need for Cultural Competence in the Health Care System

It is important for researchers and health care professionals to understand that while immigrants and individuals from minority populations may integrate and incorporate beliefs from their host environment, they will retain some of their traditional beliefs and practices. As such, each ethnic and minority group within a larger culture develops a unique mix of social and cultural roles, expectations and beliefs, and frameworks that shape the health behaviors and health decisions of individuals coping with chronic illness. The differences in immigrants' and minorities' cultural belief systems may contribute to the health disparities seen in many immigrant and minority populations.

One way to address the health disparities seen in the incidence of, treatment for, and health care usage in chronic illness in minority populations is through increasing cultural competence in researchers, medical professionals, and health care providers. Cultural competence can be conceptualized as a systematic set of behaviors, attitudes, and policies that enable professionals or agencies to work effectively in culturally diverse settings. This can be implemented through cultural competence education in physicians and other health care professionals. Cultural competence can be best implemented and most effective if resources are available to provide appropriate care, medical professionals and health care providers know the population they are providing care to and respond to the needs of their patients appropriately, and health professionals are committed to providing high quality and comprehensive care across culturally diverse settings.

A potentially effective method for becoming knowledgeable about the population to whom physicians are providing care may be to conduct focus groups with individuals who experience challenges to seeking care and yet successfully navigate the health care system, obtaining care that is needed and helpful. This strategy has been used with results showing that many immigrants feel embarrassed, helpless, and discouraged from seeking care and yet can overcome obstacles into the system through solidarity with other immigrants, friends or extended family, and connections with health service personnel. These networks of care enabled Latinas to access a complicated health care system and offer lessons for providers and policy makers concerned with improving the delivery of care to this population.

Interventions

In addition to a call for cultural competency in the health care professions, research should also keep culture at the forefront of their research programs. Although the roles of culture and ethnicity are becoming common considerations for clinicians and researchers, few culturally sensitive interventions have been implemented. Instead, the traditional "one size fits all" method of interventions tends to prevail. Instead, researchers need to design interventions based on what types of interventions will work best for *whom* and *under what circumstances*. The process of conducting culturally sensitive research and interventions involves consideration of cultural contexts across all phases of the scientific research process, including ethnographic methods such as focus groups, translating measures into culturally appropriate language, data collection that includes comparison groups, and culturally appropriate analysis and interpretation of data.

Conclusions

Immigrants often experience lower rates of illness until they have acculturated to their host country. Many immigrants do not have or develop the knowledge about health and preventive behaviors needed to prevent many of the major chronic illnesses. Immigrants are less likely than nonimmigrants to seek out and utilize health care for a variety of reasons, many of which reflect challenges of being an immigrant such as less access to enabling characteristics to service use, and cultural and contextual issues. The challenges to needed care that immigrants encounter, particularly in combination with lower perceived quality of care, may further contribute to feelings of stigma and avoidance of the health care arena. These patterns could indicate an eventual negative health impact for immigrants, as lack of use of the health care system could contribute to an exacerbation of symptoms and health risk over time.

Additional conclusions based on limited but promising research, however, suggest that variations in health care–related factors may be indicated for specific immigrant groups, locations, or regions. Despite the challenges to health care, some immigrants do successfully navigate the health care system. These findings suggest the need for further investigation into the ways in which health care is accessible and of good quality for immigrants, as well as the characteristics of the immigrant groups who are successful at navigating the system. Information garnered from such investigation can be used to implement better health care situations for other immigrants.

Related Topics

- ► Acculturation
- ► Acquired immune deficiency syndrome
- ► Behavioral health
- ► Cancer
- ► Cardiovascular disease
- ► Diabetes mellitus
- ► Health care utilization
- ► Healthy immigrant
- ► Lifestyle
- ► Nativism

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Homeland Security, Division of Immigrant Health Services. Retrieved from http://www.inshealth.org/

Kaiser Family Foundation, Minority Health. Retrieved from http://www.kff.org/minorityhealth/index.cfm

U.S. Department of Health and Human Services, The Office of Minority Health. Retrieved from http://www.minorityhealth.hhs.gov/

Chronic Pain

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Pain is an unpleasant feeling, which can range from mild, localized discomfort to agony and is usually a symptom of some injury, disease, or disorder. Pain can be acute or chronic. Acute pain is typically a response to an injury and lasts only until the injury is healed. Unlike acute pain, chronic pain persists past the resolution of an injury or is the result of a longstanding condition. It can be a continuous discomfort of varying degrees or a recurrent pain. Depending on the doctor, chronic pain is diagnosed after the individual experiences the pain for between 3 and 6 months.

Chronic pain can stem from different sources and can be physical and/or neurological. Chronic pain can be caused by damage to, or inflammation of, the joints. Examples of this type of chronic pain are osteoarthritis and rheumatoid arthritis. Chronic pain can also result from nerve conditions. Individuals with diabetic neuropathy, failed back syndrome, or spinal cord injuries suffer from this type of chronic pain. Another common source of chronic pain is muscle conditions. Epicondylitis and temporomandibular joint disorder (TMJD) are examples of muscle conditions that can result in chronic pain. Organ damage can cause chronic visceral pain. Liver cancer, gallbladder disease, and bowel inflammation can result in visceral chronic pain. Studies have also suggested dietary deficiencies, specifically a lack of vitamin D, can result in a higher incidence of chronic pain. Such a deficiency may place immigrant groups at a greater risk for chronic pain. It has been theorized that immigrants are at a higher risk of 25-OH vitamin D deficiency due to darker skin color, low sun exposure, diet, and traditional dress.

In addition to injuries, chronic pain can result from a disease. Individuals with diseases such as cancer, AIDS, or multiple sclerosis usually experience chronic pain. Repetitive use can cause painful chronic conditions like carpal tunnel syndrome or cubital tunnel syndrome. Even the aging process can result in conditions that are painful and chronic, for example, degenerative joint disease, degenerative disc disease, and arthritis.

Some people, however, suffer chronic pain that does not have an identifiable source. Psychogenic or psycho-physiological pain does not have an identifiable source or the level of the pain being experienced exceeds any obvious cause. Examples of this type of pain include fibromyalgia and reflex sympathetic dystrophy.

The forms of chronic pain vary and can depend upon the cause of the pain. Symptoms can include muscle pain, cramping, spasms, soreness, and swelling. Some individuals suffer from headaches, migraines, joint pain, sciatica, and pain that can be sharp, aching, burning, and/or tingling. Chronic pain sufferers may experience weakness, easy fatigability, numbness, and a lack of energy.

Chronic pain is a very complex condition, as it often involves more than the mere pain symptoms experienced by the individual. Chronic pain often affects the individual emotionally as well as physically. Problems often experienced by individuals with chronic painful conditions include depression, anxiety, fatigue, a weakened immune system, and a decreased ability to sleep. Irritability, anger, and feelings of helplessness are also common in people with chronic pain. Individuals with chronic pain tend to be more aware of their physical conditions, their pain, and often worry about their pain or health. This creates a propensity for depression, fear, anxiety, and feelings of hopelessness and helplessness. As emotional states can affect how pain is felt, stress, anxiety, and/or depression can amplify the pain.

Chronic pain can affect how the individual sees himself or herself and the ability to participate in activities of daily living. It can reduce the individual's quality of life. Sufferers of chronic pain often see their relationships with family, friends, and even coworkers change or diminish altogether.

Chronic pain can be treated. However, the success of the treatment varies from individual to individual. The most common form of treatment for chronic pain is a medication regime. It is often recommended that sufferers of chronic pain take anti-inflammatory medication. Such medication can be purchased over-the-counter or in a prescription form. Aspirin and acetaminophen are also common over-the-counter medications used as part of a medical regime for chronic pain.

A chronic pain sufferer's medical regime will probably also include prescription medication. The type of prescription medication varies from patient to patient and is based upon the source of the chronic pain (i.e., joint inflammation versus neuropathic pain) and the patient's response to the medication. As with any medication, different individuals will respond to, and tolerate, the medication available in varying manners.

For nerve-related pain, the individual's medication regime may include tricyclic antidepressants, anticonvulsants, and/or antiarrhythmics. Although originally developed to treat conditions like depression and seizure, these classes of medications have proven beneficial in the treatment of nerve-related chronic pain.

Opioids, like morphine and oxycodone, are often part of a medication regime. The utilization of opioids to treat chronic pain is not without controversy. Prolonged use of this type of drug can lead to side effects and secondary conditions, such as loss of benefit, hyperalgesia (a condition wherein the person has an abnormally increased sensitivity to pain), and testosterone deficiency. Fifty-one percent of all patients utilizing opioids experience at least one adverse side effect. Moreover, as the medication is a narcotic, there is a higher potential for abuse as the individual's tolerance level increases. Tolerance to opioids tends to occur over a period of months to years. As their tolerance increases, many people will misuse the medication to achieve the desired effect. In the United States, between 1999 and 2006, opioid poisoning was noted to be the second leading cause of injury death, overall, and the leading cause of injury death in those between the ages of 35 and 54. Given the dangers associated with opioids, it has been argued they should only be included in a treatment regime if the medication is shown to both provide relief and increase the individual's level of functioning. Many practitioners are now requiring patients to enter into an agreement or treatment contract, whereby the patient agrees to the objectives of treatment, to refrain from obtaining medication from another source, and to use the medication only as directed.

In addition to a medication regime, there are other forms of therapy that should be included in the treatment regime for chronic pain. A home exercise program is highly recommended. A lot of people with chronic pain avoid additional movement and exercise due to the pain. It is generally agreed, however, that such a program helps prevent further weakness and deterioration. Regular exercise can also increase the individual's energy level, ability to sleep, and production of natural endorphins.

Hot and cold compresses are encouraged for individuals suffering from chronic joint or muscle pain. Massage is another treatment option people with chronic joint or muscle pain find beneficial. Acupuncture may ease chronic pain, especially in those suffering from headaches, low back pain, and osteoarthritis. Electrical stimulation, through a transcutaneous electrical nerve stimulation (TENS) unit or an implanted spinal cord stimulator, is an additional option for chronic pain sufferers. Finally, cognitive behavior therapy, psychological/psychiatric therapy, support groups, and stress management techniques are often utilized when treating chronic pain.

Cognitive behavior therapy teaches a chronic pain sufferer skills to help cope with the pain. Stress management techniques, such as biofeedback and relaxation therapy, aid the individual in learning to influence the body's physical response to pain. Psychological or psychiatric therapy provides the individual with a tool to help come to terms with the fact they will live with chronic pain, the changes that may occur in the ability to work, dependency, or relationships with others, and any resulting depression.

Depending upon their access to health care, immigrants may be able to try some, or all, of the above therapies. However, many immigrants do not have access to doctors willing to treat chronic pain and/or are able to afford prolonged treatments. Additionally, immigrant populations often tend to have less trust in the health care system and unfamiliar treatment regimes. Instead, immigrants may turn to therapies with which they have more cultural familiarity. For example, Chinese immigrants tend to be more familiar with acupuncture and, therefore, are more willing to undergo this form of treatment. Although acupuncture has been shown to provide some relief with certain types of chronic pain, it is possible that a higher degree of relief could be obtained with a different treatment or a combination of treatments.

When the treatment is not effective, the individual's problems are often compounded by secondary conditions. Depression, insomnia, fatigue, hopelessness, a loss of purpose, and a decrease in general physical functioning can all occur when an individual is not able to successfully cope with, and treat, his or her chronic pain. A downward spiral can result when chronic pain and these secondary conditions occur; each feeding off of the other. Suicide is not unheard of when the individual no longer feels he or she has any value, is a burden upon others, and cannot continue to cope with the pain. This is why treatment for chronic pain, as illustrated above, is often multimodal and should address more than the pain alone.

It has been estimated that chronic pain affects one out of every ten adults. In addition to the effect it can have both physically and emotionally, chronic pain can also have an effect on an individual's memory, concentration, or ability to problem solve (cognitive functioning). Studies suggest most people with chronic pain complain of cognitive difficulties. Specifically, problems with memory and attention were reported. The studies have suggested objective cognitive deficits in the domains of memory, attention, speed in performance of structured tasks, speed in responding to stimuli of a cognitive task, verbal ability, and mental flexibility.

As chronic pain, by its very definition, can last a long time, if not a lifetime, the costs for treatment of the condition can be quite high. The cost of treatment can, and does, affect the chronic pain sufferer's access to health care and medication. This is especially true when the chronic pain is so disabling that the individual cannot work. The effects of the cost of treatment for chronic pain and, therefore, the ability to access such care may not be as devastating in countries with some form of universal health care. However, in countries without universal health care, such as the United States, individuals with chronic pain may find themselves without access to health care and medication if they do not have access to insurance through a job or spouse, cannot afford the insurance, and do not qualify for Medicare or Medicaid.

Immigrant groups, especially undocumented immigrants, often have reduced access to the health care system. The cost of the prolonged treatment for a chronic condition also makes the care prohibitory for many immigrants. Additionally, even in countries that have a form of universal health care, language barriers and an inability to understand and navigate the health care system can further limit immigrants' access to care for chronic pain conditions.

The inability to access to health care and medication leaves an individual with few choices. Many turn to illegal drugs and/or alcohol. Self-treatment with alcohol is not a truly effective tool in pain management, as it acts as a depressant, effects the individual's mental and physical ability to function, and wears off after a relatively short period of time. Regular misuse of alcohol leads to the development of tolerance and, with prolonged use, painful conditions such as alcoholic myopathy, alcoholic neuropathy, and liver disease.

Marijuana is another drug that is turned to for self-medication. The act of buying and possessing marijuana is a crime in many countries. Additionally, marijuana use for chronic pain has drawbacks. Smoking marijuana can affect the lungs and prolonged usage can result in dependency and memory loss. However, studies have shown that the active ingredient in marijuana, tetrahydrocannabinol (THC), can have some benefits with regard to pain control. The medical benefits of the drug have resulted in legalization in some places. In the United States, several states have enacted, or are in the process of enacting, legislation permitting use of proscribed medical marijuana. Some countries, such as Canada and Austria, have made the use of medical marijuana legal. Other countries have essentially decriminalized it when used in small amounts for medical purposes. Medical marijuana is available in both cigarettes and pill form.

In summary, when the pain lasts for a prolonged period, it is classified as chronic pain. Chronic pain varies from individual to individual in both symptoms and severity. The underlying condition, therefore, must be considered when determining the best treatment approach. However, it is generally agreed the treatment regime should be multimodal and include more than pain medication. Chronic pain is not uncommon and can have life changing consequences. Consequentially, ensuring access to affordable health care is essential to providing individuals with chronic pain a positive quality of life.

Related Topics

- ► Acupuncture
- ► Chronic disease
- ► Cortisol
- ► Depression
- ► Disability
- ► Pain
- ► Stress

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Suggested Resources

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The Mayday Pain Projects. http://www.painandhealth.org

CIOMS

► Council for International Organizations of Medical Sciences

Citizenship

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A citizen is a person who is a native or naturalized member of a State or nation and who owes allegiance to its government and is entitled to its protection. In some countries, individuals may also derive citizenship through their parents if the specified conditions are fulfilled. Citizenship means to have the status, rights, privileges, and duties of a citizen. Conversely, an alien is one who has citizenship in a country other than his or her residence. In addition to having the status of citizen or alien, a person may also be a national, which means a person who, while not a citizen, owes permanent allegiance to a country.

Each country has its own requirements to be a citizen. The Fourteenth Amendment of the United States Constitution provides that all persons born or naturalized in the United States, and subject to the jurisdiction thereof, are citizens of the United States and of the State wherein they reside. In the United States, the Immigration and Nationality Act of 1965 (INA) provides the guidelines for who is a citizen and who may become one. Also, in 2000, Congress passed the Child Citizenship Act (CCA), which allows any child under the age of 18 who is adopted by a United States citizen and immigrates to the United States to acquire immediate citizenship.

An individual is a natural citizen of the United States if the person is born in the United States; is born abroad to parents who are both United States citizens, one of whom has had a residence in the United States or one of its outlying possessions prior to the birth; is born abroad to at least one United States citizen parent who has been physically present in the United States or one of its outlying possessions for a continuous period of 1 year at any time prior to the birth of such person; or is of unknown parentage found in the United States while under the age of 5 years, until shown, prior to his attaining the age of 21 years, not to have been born in the United States. It should be noted that the specific requirements for deriving citizenship from a parent or parents have changed over time.

In most cases, a person seeking to become a United States citizen must have resided continuously within the United States for a period of at least 5 years, at least half of which must have been spent physically in the United States; have lived at least 3 months in the state in which the application for citizenship is being made; reside in the United States from the time he or she makes the application until the admission of citizenship; and be a person of good moral character, attached to the principles of the Constitution of the United States, and well disposed to the good order and happiness of the United States.

An applicant must understand the English language, including an ability to read, write, and speak words in ordinary usage in the English language. He or she must have a knowledge and understanding of the fundamentals of the history and of the principles and form of government of the United States. The language and governmental principles requirement shall not apply to any person who is unable to meet these requirements because of physical or developmental disability or mental impairment, is over 50 years of age, and has been living in the United States for periods totaling at least 20 years subsequent to a lawful admission for permanent residence, or is over 55 years of age and has been living in the United States for periods totaling at least 15 years subsequent to a lawful admission for permanent residence.

The right to become a naturalized citizen is not absolute. Citizenship can be refused. Any person who at any time during which the United States has been or shall be at war has deserted the military or has gone beyond the limits of the United States with the intent to avoid any draft into the military is permanently ineligible to become a citizen of the United States. No person shall become a naturalized citizen of the United States who advocates, or is a member of or affiliated with, any organization that advocates opposition to all organized government, or who is a member of the Communist Party or any other totalitarian party, or of any foreign state, or who, advocates or is a member of any organization that advocates the overthrow by force or violence or other unconstitutional means of the Government of the United States. However, any person who establishes that such membership or affiliation is or was involuntary, or occurred and was terminated prior to reaching 16 years of age, or that such membership or affiliation is or was by operation of law, or was for purposes of obtaining employment, food rations, or other essentials of living and where necessary for such purposes may be allowed naturalization.

Citizenship may also be lost. A United States citizen, whether by birth or naturalization, may lose his or her citizenship by obtaining naturalization in a foreign country after having reached 18 years of age, by making a formal declaration of allegiance to a foreign country, by serving in the armed forces of a foreign country if such armed forces are engaged in hostilities against the United States, by making a formal renunciation of nationality, by committing any act of treason against the United States, or by attempting by force to overthrow or bearing arms against the United States.

In 2008, 1,046,539 people became naturalized United States citizens. Of the people naturalized in 2008, 1,032,281 were civilians and 4,342 were military personnel; 121,283 petitions were denied. This is a marked difference from 1998, when 461,169 people became naturalized citizens, and 137,395 petitions were denied.

A person's citizenship status may impact the quality of life in many ways. For example, a person who is not a United States citizen may be limited in the types of employment available to him or her, certain governmental benefits, such as financial assistance and medical assistance, may not be available to a noncitizen; and if the noncitizen is in the United States illegally, he or she may be even more limited in access to employment or healthcare for fear of discovery and deportation.

Related Topics

- ► Immigration processes and health in the U.S.: A brief history
- ► Public health insurance

Suggested Resources

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United States Constitution, 14th Amendment

Civil Rights Act of 1964 (U.S.)

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On July 2, 1964, the US Congress passed landmark legislation called the Civil Rights Act. Signed by President Lyndon Johnson, the law made racial segregation and discrimination illegal in the USA. The Civil Rights Act had five major components: (1) it barred unequal application of voter registration requirements; (2) it outlawed discrimination in hotels, motels, restaurants, theaters, and all public places; (3) it encouraged desegregation of public schools and granted the US Attorney General the authority to file suits to force desegregation; (4) it authorized the withdrawal of federal funds from programs that practiced discrimination; and (5) it made discrimination in employment illegal for any business with more than 25 employees and created the Equal Employment Opportunities Commission, a body set up to review employment discrimination complaints.

The Civil Rights Act of 1964 was driven by a desire to improve the quality of life for African Americans and other minority groups in the USA. There was a significant buildup of events that preceded the passage of civil rights. Two of the earliest occurrences included large numbers of Black Americans moving into northern cities to live and work and Black soldiers serving in World War II. Prior to these two events, people in many parts of the USA, excluding the South where Black Americans predominantly lived, were mostly unaware of the issues that Black Americans faced and the important contributions they made during the war. In addition, even as early as 1945, legislation designed to enforce equality helped lay the groundwork for the eventual passage of civil rights legislation. For example, there were presidential orders that ended discrimination in the military and in federal employment, including work done under government contracts. In 1954, the Supreme Court made a critical decision that had enormous effects on the civil rights movement: it struck down legal support for school racial segregation in what was coined “separate but equal” in the case of *Brown v. Board of Education* in Topeka, Kansas. *Brown v. Board of Education* was born out of a demand for better conditions at schools for African American youth. Black children were segregated from White children in the education system: they were not allowed to attend schools near their homes and instead were bused to other schools. Often, those schools were inferior both structurally and in the quality of education. For example, teachers of schools for Black students were severely underpaid compared to other teachers, and teaching resources and materials were far fewer. However, as important as this case was in setting the stage for strong federal support for civil rights, *Brown v. Board of Education* did not address the treatment of African Americans.

In the early 1960s, Congress and President John F. Kennedy’s administration also made advances that added to the trajectory that eventually led to the passage of civil rights legislation. In 1961 and 1962, presidential executive action was taken to ensure minority rights in housing, transportation, education, and employment.

Social conditions during this period were also very influential. There were many protests and marches in cities and towns across the nation that brought attention to the concerns of and for African Americans on a number of social inequalities. These included how segregation prevented them from using public facilities on an equal basis with White people, and how they were restricted from using public transportation, parks, and restrooms, and their limited educational opportunities all based on years of systemic and accepted racism. Along with the protests and marches, boycotts and sit-ins were also carried out, many of which were organized by African American community and religious leaders and others. Dr. Martin Luther King, Jr., who became the most prominent Black leader of the Civil Rights Movement, led several boycotts and sit-ins. He lent much legitimacy and increased awareness and visibility of the civil rights movement across the nation. Although Dr. King and many other organizers and leaders insisted on peaceful and nonviolent demonstrations, many acts of violence occurred, including riots, often spurred by angry counterprotestors that required using federal troops to restore calm and order.

The nation's media outlets focused much attention on the social unrest and events, bringing scenes which often included beatings, protestors being sprayed with fire hoses and even killed, into the homes of Americans everywhere. It soon became undeniable that the social conditions of this period required government intervention. Congress and other elected officials could no longer ignore the social unrest. Churches everywhere and elected officials also became vocal on the issue of civil rights. National polls reflecting the positive attitudes of Americans toward racial integration had risen to 72% in 1963 representing a 30% increase over the last 20 years. President Kennedy began to come out strongly in favor of legislative action by Congress to address racial segregation in the USA. The Justice Department was tasked with the responsibility of crafting what would eventually become the Civil Rights Act. It was critical that this work was conducted in a bipartisan fashion, considering the concerns of both Democrats and Republicans, in an attempt to avoid filibusters or legislative defeats. Even though the polls showed that the vast majority of Americans favored ending racial segregation, not everyone was in favor of these changes. On June 19, 1963, a bill was submitted to Congress for a vote. The House of Representatives debated the bill, and nearly 100 amendments that attempted to weaken the bill were rejected. The House eventually passed the bill after 70 days of public hearings and 275 public testimonies. The bill then moved to the Senate where it was debated again at length under threats of filibusters by opposing senators, but it eventually passed with 289 votes and was signed by President Johnson on July 2, 1964.

In the following year, the US Congress also passed the Immigration and Nationality Amendments Act of 1965. Instead of using nationality and racial criteria to admit immigrations, this new legislation implemented a system based primarily on family reunification. The Civil Rights Act was a fundamental tool for the new immigration legislative and policy changes because for many, the new changes in immigration laws were seen as an extension of the civil rights movement. Foreign policy concerns were also considered as the USA preferred to be seen by other countries as a place where equality and respect for all people was the standard.

Related Topics

- ► Discrimination
- ► Racism

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Civil Surgeon

► Medical examination (for immigration)

Civil War

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At its simplest level, a civil war is defined as a conflict between opposing groups of citizens from the same country who are fighting over who has the legitimate right to govern. This definition does not necessarily take into account many of the complexities involved in modern civil wars, which may involve several groups located in the same geographic region of a country that have never seen themselves as sharing a common identity. Many of the most recent civil wars have begun following the collapse of a former European colonial system of government (e.g., Angola), the fighting produced by Cold War proxy conflict (Vietnam), and/or the end of the Cold War (e.g., Bosnia). The colonial system and the Cold War created strong central governments that maintained order, but at times arbitrarily nationalized various ethnic groups that oppressed other groups within the national boundaries (e.g., Rwanda with Tutsi and Hutu, Yugoslavia with Bosnians and Serbs). These "civil wars" occur in "nations" where the goal of the fighting is not simply to maintain political power (e.g., Khmer Rouge in the Cambodian civil war), but also to facilitate the ethnic cleansing of the region based on tribal identification (e.g., Rwanda), religious divisions (e.g., Bosnia), or longstanding historical grievances (e.g., Bosnia). Narcoterrorism has also produced civil wars in Latin America (e.g., Mexico, Colombia), as have radical differences between right- and left-wing forces attempting to govern (e.g., Chile, Argentina, Peru, Nicaragua, and Honduras).

Civil wars are often brutal, resulting in mass causalities, as seen with "the killing fields" of Cambodia, where over one million people were slaughtered, and the genocide in Rwanda, where an estimated 800,000 were killed. Such brutality leads to the commission of systemized war crimes intended to disrupt the cultural and personal identity of groups of people and to shatter their sense of self-worth and belonging. In Rwanda, there was the systematic rape of women and girls and the slaughter of males in an attempt to ethnically cleanse the Tutsi from the region. In addition, torture, beatings, and mental coercion are used to intimidate the remaining local populace and maintain power and control over their territory.

Immigrants from civil wars are often reluctant to discuss the torture that occurred because of their concern that such reports might affect their immigration status or produce some form of retaliation from their "home" country or countrymen.

Immigrants from civil wars present unique and complex challenges to the countries that provide them with asylum and naturalization. Depending on the nature of the conflict the immigrant is coming from, they often have few resources, little family/social support, and less education than traditional immigrants. Immigrants from civil wars also typically have greater need for health care services. Many have physical/traumatic wounds (e.g., amputees) and suffer from the long-term effects of malnutrition, infectious diseases (e.g., tuberculosis, cholera, leishmaniasis), and long-term psychiatric conditions (e.g., major depression, anxiety disorders, organic mental states secondary to head injury, and torture). Many studies indicate that the psychological effects caused by a civil war can persist for decades. The resulting effects produce long-term economic and social service problems for the host countries.

Civil war immigrants held in refugee camps prior to immigrating are at high risk for experiencing revictimization while in the camps, which further increases their likelihood of physical or psychiatric complications. Refugee camps are often crowded, disorganized, and may have serious problems maintaining adequate levels of sanitation and security. Individuals in refugee camps are often the victims of violent crime and sexual assault. The "legal limbo" that most camp refugees face adds additional stress on an already vulnerable individual. Fear of death, displacement, physical violence, rape, isolation, and return to the parent country all breed fear, anxiety, mistrust, demoralization, and marked feelings of uncertainty and helplessness in refugees, which can further compound or produce the most commonly experienced mental health problems seen in civil war immigrants, chronic major depression and posttraumatic stress disorder.

Other factors associated with higher rates of mental illness in civil war immigrants include: poor fluency in the language of the new country in which they settle; being single (e.g., widowed, separated, never married), unemployed, "retired," physically disabled/injured; and lacking financial resources (e.g., poverty). Older immigrants are more likely to experience these problems than younger individuals and also have more difficulty resolving them. The elderly have greater difficulty acculturating to their new country (e.g., learning the language, customs, and skills) and obtaining work or work at levels equivalent to that which they had before immigrating. They lose more during the process of immigration (e.g., position in the community, finances) and have more physical ailments and infirmities. All of these factors make their adjustment to their new society more difficult.

Providing medical and psychiatric care to immigrants who speak a different language is difficult. This is especially true for immigrants escaping a civil war who are often mistrustful of both foreigners, as well as their own countrymen. Trained translators are needed, but are often in short supply due to often large and unexpected influxes of immigrants and/or refugees. In general, it is best not to rely on family members to act as translators because the patient may be unwilling to discuss important concerns, painful recollections, failings, or symptoms to save face in front of their family or spare the family from learning about certain painful or humiliating information. Also, the family members serving as translators may not directly translate the patient's comments out of a need to protect the patient and/or family from embarrassment, retaliation, or possible deportation. Untrained third-party translators may understand both languages, but may not recognize the importance of repeating questions or responses verbatim, instead of summarizing. They may lack an understanding of medical terminology and may converse with the patient, inserting their own thoughts and opinions, rather than just translating what the doctor and patient are discussing.

Refugees from civil war may fear revealing information about themselves or making errors that could result in their return to their homeland and further prosecution, torture, or death. The fact that they fled and claimed special refugee status could in and of itself result in their imprisonment and/or death in some cases.

Related Topics

- ▶ Acculturative stress
- ▶ Asylum
- ▶ Behavioral health
- ▶ Convention Against Torture
- ▶ Ethnic cleansing
- ▶ Refugee
- ▶ Refugee camp
- ▶ Telephone interpretation services
- ▶ Torture
- ▶ War-affected children

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Clinical Breast Examination

- ▶ Breast cancer
- ▶ Breast cancer screening
- ▶ Breast self-examination
- ▶ Mammography

Cocaine

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Cocaine is a psychoactive drug, highly addictive, and one of the most dangerous and widely consumed drugs.

Cocaine is an alkaloid extracted from the leaves of *Erythroxylon coca* bush cultivated in South American countries. According to United Nations Office on

Drugs and Crime (UNODC), in 2008, the production of pure cocaine hydrochloride was of 845 tons, of which 51% originated in Colombia, 36% in Peru, and 13% in Bolivia. Currently, organized criminal groups in Colombia control the worldwide distribution of cocaine. Cocaine may also be obtained by chemical synthesis, but this method is more expensive and less common.

Most of the illicit trafficking of cocaine in the USA is held by the border with Mexico. On this route, Colombian traffickers use Mexican drug trafficking organizations to bring cocaine into the USA, to the South Texas region. However, in recent years, the quantity of cocaine seized on this route decreased sharply (from 22.656 kg in 2007 to 17,085 kg in 2009) as result of reduced cocaine production in Colombia, the joint efforts of the US and Mexican official agencies to reduce illegal cocaine trafficking, and diversion of the illegal cocaine trafficking to Europe. As a consequence, the availability of cocaine on the illicit US market decreased, and Europe became the most rapidly growing cocaine market. Currently, cocaine is distributed in the US illicit drug market mainly by Dominican, Colombian, and Mexican drug organizations.

Cocaine is illegally trafficked using various vehicles such as trucks, aircraft, vessels, and also by body packers. The body packer strategy consists of ingestion or introduction of small packages of drugs into the body in the vaginal or anal cavity, with the aim of transporting them into a foreign country, cocaine being the drug most commonly transported in this way. In recent years, trafficking cocaine by body packing method has become a common problem in European airports. People who take this route to transport drugs may be the country’s citizens, tourists, legal or illegal immigrants. The main danger faced by the body packers is death by overdose caused by breaking of the packages or drug diffusion due to the low quality of the cover of the pack.

The use of cocaine for its psychoactive properties has been documented for about 5,000 years, coca leaf chewing being a millennial habit among South American Indians and continued due to its stimulant, anorexic, and euphoric effects. In 1859, C. Niemann extracted the cocaine, as pure substance, from coca leaves.

In 1878, Bentley recommended the use of cocaine as a substitute in the treatment of morphine addiction, opening the way for a more dangerous addiction. In his paper *Uber Coc,* published in 1884, a botanical monograph containing data on the origin, stimulant and antidepressant properties of cocaine, Sigmund Freud recommended it for the treatment of psychiatric disorders such as: hypochondria, hysteria, and melancholia. In 1884, Karl Koller, an Austrian physician, demonstrated the local anesthetic effects of cocaine, which contributed to its widespread use in medical practice.

Following the alarming increase in cocaine use in the USA (a fivefold increase between 1890 and 1903), largely based on nonmedical consumption, it was classified in 1914 as a narcotic drug and included in the prohibited substances list. Currently, in the USA, cocaine is included in the Controlled Substances Act Schedule II (DEA. Title 21, Section 812.) due to its addictive potential and the possibility of its use in medicine as a highly effective topical anesthetic. Cocaine was also included in Schedule I of the Single Convention on Narcotic Drugs, issued by the United Nations in 1961.

According to the National Survey on Drug Use and Health conducted in 2008 in the USA, 5.8 million people aged over 12 years have used cocaine at least once in the past year and 1.1 million people over 12 years used crack at least once in the past year. Official statistics stress that cocaine and crack cocaine consumption in the USA has stabilized in recent years, albeit at high levels.

In the European Union countries, there has been an increase in the cocaine consumption over the last 10 years, cocaine being the most used illicit drug after cannabis. About 13 million Europeans aged 15–64 years have consumed cocaine at least once during their lifetimes. The highest prevalence of cocaine consumption during the last year was recorded in the age group 15–34 years (7.5 million). An increased prevalence of cocaine use in the EU is recorded in Spain, United Kingdom, Denmark, Italy, and Ireland.

With respect to immigrant populations, research shows that US Hispanics have a high rate of deaths caused by the consumption of drugs, especially marijuana and cocaine, and the Puerto Ricans show the most prevalent consumption rates. US Hispanic teens have higher cocaine consumption rates than White and African American teens (5.7% versus 3.8% and 2.2%).

Cocaine is a white powder with a specific odor. It can be taken by snorting, smoking, subcutaneous or intravenous injection.

Crack cocaine is the freebase cocaine which is taken only by smoking. The entry of crack cocaine into the US market led to lowered prices and increased the availability of the drug on the market, leading to expansion of cocaine consumption from high and middle classes of society to minorities in cities.

In the short-term, cocaine has psychoactive properties producing: euphoria, increased self-esteem, improved physical and mental performance, increased aggressivity, increased body temperature, blood pressure, and heart rate. Death may occur due to overdose by central respiratory depression or severe cardiac arrhythmia, or suddenly, during the first administration of the drug ("cocaine shock") due to the paralysis of the respiratory center in individuals with particular sensitivity.

Cocaine addiction, mostly at a psychological level, occurs after a few weeks or months of repeated intake of doses. At this stage, the cocaine addict suffers from hallucinations, perception and thinking errors, and behavioral disorders. After 5–10 years of cocaine use, the drug addict reaches a state of physical and mental deterioration, abandons her/his social and professional life, and may commit various felonies, such theft or violence, in order to get money for buying drugs.

Cocaine or crack use during pregnancy, often associated with a disorganized lifestyle and adverse environmental conditions (disharmonious parental relationship, stress, violence, poverty) may affect fetal development in variable degrees. Newborns may show: prematurity, low birth weight, small head perimeter, and various neurobehavioral deficits (so called "crack babies"). Cocaine-using pregnant women have higher rates of miscarriage and placental rupture at birth.

Children exposed to cocaine in utero are not a homogeneous group in terms of their short- and long-term physical and behavioral development. The environment in which the children grow up can affect their long-term development, the drug-induced biological vulnerability, making them more vulnerable to adverse environmental conditions. Poverty plays an important role in this relationship, and studies show that many children exposed to drugs in utero are from poor class of society. In some U.S. states, drug use during pregnancy is equivalent to child neglect or child abuse, which can lead to loss of custody.

Immigrant women often face financial problems, especially at the beginning of their stay in the host country. This limits their access to prenatal care and to treatment for addiction and may determine, along with cocaine abuse, damage to fetus. From a social perspective, their access to health resources is limited due to stigma associated with drug use in pregnancy. Illegal immigrant status, fear of expulsion from the host country, and the possibility of allegations of neglect or child abuse decrease the chances that pregnant immigrant women who use cocaine or crack cocaine can access the health care system and admit their drug addiction.

Related Topics

- ► Addiction and substance abuse
- ► Drug abuse
- ► Drug use
- ► Substance use

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Cognitive Testing

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Cognitive tests are used to assess cognition: the mental act of perceiving and manipulating information. Generally, cognitive tests measure two specific types of mental abilities, crystallized and fluid. Tests of crystallized abilities assess domains such as verbal knowledge, semantic memory, higher reasoning skills that involve conceptual relatedness, episodic memory, visual–spatial manipulation, mathematical ability, and executive function skills such as judgment and problem solving. Fluid abilities allow us to attend to, perceive, process, store, and retrieve information, and they are the means by which we collect, organize, and accumulate knowledge, the basis of crystallized abilities.

Cognitive Assessment

In the clinical setting, cognitive test data are used to assist in the diagnosis of conditions resulting from developmental abnormalities, traumatic brain injury, stroke, mild cognitive impairment, vascular or frontotemporal dementia; and neurodegenerative processes such as Alzheimer's, Parkinson's, or Huntington disease. In such cases, a cognitive assessment, consisting of multiple tests that measure mental processes associated with one or more specific domains, is conducted by a *psychometrist*, an individual trained in the administration and scoring of cognitive measurement tools. This assessment commonly takes place in a one-on-one interview, involving stimulus materials, paper and pencil tests, or a computerized presentation device. Materials are presented in a standardized manner and information about the participant's performance and reaction time is recorded. Following the interview, the results are analyzed and interpreted to determine the severity of impairment associated with a potential diagnosis and whether specific treatment or therapy is necessary.

Historically the development, use, and validation of cognitive tests focused on White, non-Hispanic, formally educated populations in the United States. Repeated testing and systematic study of cognitive measures have occurred more recently in African American and Hispanic groups. Normative data compiled from these studies allow for the development of statistical methods that are used to make adjustments to cognitive test data based upon age, education level, gender, and race. The use of normative data is the primary method for interpreting an individual's cognitive test scores and statistical applications based on such data are used to make predictive interpretations of one's cognitive abilities.

Diagnostic Use and Interpretation

Although cognitive abilities are considered to be universal and fairly uniform across all races, the development of such skills has not only a genetic basis, but is contingent upon environmental, social, and cultural influences. Systematic study of cognitive measurement and interpretation of data in highly diverse populations has not been prolific. Consequently, there are not sufficient normative data available for most immigrant populations, and interpretation of test results using existing normative data may not be appropriate because it does not account for the linguistic, educational, cultural, and socioeconomic differences between groups. Therefore, the diagnostic use and clinical interpretation of cognitive measures in this population can result in predictive validity errors. For example, cognitive test data are interpreted as a false positive, resulting in a neurologically intact individual being misdiagnosed as cognitively impaired or in the opposite case, a false negative indicating that an impaired person has no deficits.

Fairness and Bias

Ethically, the intention of cognitive assessment is to make a fair and accurate measurement of cognitive ability. In this context, fairness equates to the absence of bias, ensures equal treatment throughout the testing procedure, and allows for an opportunity to learn the material being tested and to receive feedback about test performance. Bias is the result of systematic error inherent in the design and administration of cognitive measurement tools or in the interpretation of test results.

Two specific types of bias that may be inherent in the test itself are referred to as "construct" and "differential item functioning" bias. Construct bias may result when a test is designed to measure a cognitive construct, or domain, that has specific cultural relevance and differs between groups. Consequently, the measurement tool cannot validly measure this domain without demonstrating between group differences. This is because individual test questions are highly sensitive and do not capture important aspects of the domain as they translate to each population, or this type of bias occurs when the question is too generally worded, the domain is measured in such a broad way that the test captures extraneous or irrelevant information.

Differential item functioning bias occurs within the individual test items themselves, resulting from poorly translated words or phrases, ambiguous meaning, and the inclusion of cultural connotations. The validity of a cognitive test is questionable when more than one population repeatedly produces scores that do not have the same meaning across groups. In other words, the cognitive test's ability to make fair, accurate, and valid measurement is lost in translation.

Instrument and administration bias are also threats to the fairness principle known as equitable treatment and stem from how the test instrument captures information (for example, use of pen and paper versus a computerized tool) and the environment in which it is administered (for example, not reasonably accommodating for a disability). Bias can arise when interaction and communication between the *psychometrist* and the individual being tested impede the administration of the measurement tool.

Due to the number of biases that arise from systematic error inherent in the design and administration of cognitive tests, it is important to take into consideration an individual's educational experience, language proficiency, and socioeconomic context when making interpretations and predictions about the results of cognitive assessment in diverse minority groups, including immigrant populations.

Cognitive Testing and Social Factors

Language

Age at the time of immigration plays a critical role in language acquisition; upon immigration, children are likely to receive exposure to the new language by way of education and social interactions, which facilitate engagement in the nonnative language. Early learners of a second language are likely to develop well-versed bilingual competency when they regularly engage in their native language with family and friends or act as translators for other native language speakers.

On the opposite end of the bilingual spectrum, older immigrants may have less exposure to the majority language depending upon their age, occupation, and social-cultural role in the family or community. To varying degrees, these factors limit exposure and engagement in the majority language; this situation may be further compounded by reliance upon translation and living in ethnic enclaves.

In cognitive testing language, comprehension and fluency are important variables to consider, not only in regard to the fairness of the cognitive test and differential item functioning bias, but the difference between the cognitive activity that is required of bilingual versus monolingual individuals. Bilingual individuals are required to suppress or control engagement in one language when they are being tested in another. This behavior requires cognitive control, and the amount of effort required may vary, depending on how efficiently the appropriate information is processed, accessed, and retrieved by the brain and whether or not there is interference from the suppressed language. On the other hand, the cognitive practice that bilingual persons engage in is also believed to be a benefit to various aspects of cognition such as semantic memory and executive function.

Socioeconomic Status

Socioeconomic status (SES) is not always considered when interpreting cognitive test scores in the clinical setting. Immigrant populations with low SES may not have access to appropriate education, be subjected to financial stress, unable to find substantial employment, or have limited access to health care. Low SES immigrants may experience heightened financial, psychosocial, and acculturative stress, and are at increased danger for the development of diseases that result in cognitive impairment. Some studies indicate that controlling for SES may normalize cognitive data sufficiently and perhaps be more important than controlling for race, thus reducing predictive validity errors in cognitive measurement tools.

Current Directions in Cognitive Testing

Research and Development

Currently, there is a cross-cultural focus on the development and use of specific cognitive tools, but research that specializes in cognitive assessment of immigrants and immigrant subgroups is not abundant. In order to validate specific tools in this unique population further research is needed, via one-on-one interviews or by working with focus groups, to learn more about how group members understand cognitive test questions and whether or not the information elicited by the test question is an accurate and valid assessment of the mental processes and domains being evaluated.

Furthermore, investigation in this area should take into account differences in cognitive test performance related to sex, age, and race, as well as environmental factors that are highly influential in immigrant populations, such as regional migration patterns, familial migration history, educational experience, language proficiency, and socioeconomic status. Such research would allow for the tabulation of population-specific normative data and allow for greater accuracy when comparing an individual's cognitive performance to that of their peers, thus ensuring a more accurate assessment of one's cognitive abilities.

Related Topics

- ▶ Acculturation
- ▶ Behavioral health
- ▶ Cultural background
- ▶ Dementia
- ▶ Depression
- ▶ Education
- ▶ English as a Second Language
- ▶ Ethnic minority group
- ▶ Ethnicity
- ▶ First generation immigrants
- ▶ Intelligence testing
- ▶ Intergenerational differences
- ▶ Language acculturation
- ▶ Linguistic minority community
- ▶ Low literacy level
- ▶ Poverty

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Collectivism

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Collectivism is a learned culture-derived value and psychological alterable characteristic that is often contrasted with the value individualism. The term, which refers to the need to fit-in, is also known as interdependence, and contrasts with the need to stand-out also known as independence. Researchers have developed the independence-interdependence psychological measure to understand the influence that culture-level socialization practices have on an individual's endorsement of independence-interdependence.

Cross-cultural psychological research, conducted for over 3 decades, suggests that individuals born and raised in China, Greece, and Mexico, on average, tend to score higher on measures of interdependence when compared to individuals of Caucasian descent from Germany, Great Britain, and the United States. It is posited that on average, China, Greece, and Mexico engender individuals who will value belongingness and in-group harmony. On the other hand, it is posited that, on average, Germany, Great Britain, and the United States engender individuals who value competition, agency, and a strive for achievement. Research also suggests that individuals born and raised in a collectivist culture can reject the value of interdependence in favor of independence, vice versa, or may favor an integration of both values.

As a result of the blurring of cultural boundaries brought about by innovations in communications and technology, societies are becoming increasingly culturally and linguistically heterogeneous. Consequently, researchers are increasingly interested in measuring immigrants' health. However, a more complete understanding of immigrant health issues has been hindered by the failure to recognize that culture can be operationalized and measured beyond broad indicators such as ethnicity or race. Typically, ethnic groups are perceived as homogeneous and static regarding values and beliefs. This preconceived "homogenization" has resulted in the inadequate exploration of within and between ethnic group differences regarding the endorsement of cultural values. Thus, it is important to assess the degree to which an individual endorses interdependence and the way other factors such as acculturation, gender, and socioeconomic status influence such endorsements. Even if an individual immigrates into an individualist culture from a collectivist culture, other factors will influence the degree to which the immigrant retains or sheds values derived from the culture of origin.

Health research aimed at improving immigrants' health can explore the role that the endorsement of interdependence plays in the conceptualization and assessment of health-related constructs. For example, an individual's belief in his/her own ability to adopt a healthy behavior, also known as self-efficacy, is perceived as influenced solely by psychological aspects, which are internal to the individual. However, a recent study indicates that the construct of self-efficacy can be expanded to include aspects external to the individual such as the amount of social capital available. Researchers have found that the availability of social capital influences the self-efficacy of individuals who value interdependence.

Related Topics

- ► Acculturation
- ► Cultural background
- ► Ethnicity
- ► Gender
- ► Individualism
- ► Poverty
- ► Social capital

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Colombia

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Background

Colombia is located in the upper corner of South America, where it is bordered by Panama on the northwest, Venezuela and Brazil on the east, and Peru and Ecuador on the southwest. Colombia is considered by many to be one of the most beautiful countries in South

America due to the magnificent combination of mountains, valleys, and the coasts of two oceans.

The name of the country, Colombia, comes from Cristóbal Colón (English: Christopher Columbus), acclaimed as the discoverer of America; it was adopted by Francisco Miranda to all the territories under Spanish rule. In 1819, the Viceroyalty of New Granada, consisting of Colombia, Panama, Venezuela, and Ecuador, became known as the Republic of Colombia. After a series of political and demographic changes, this region became known in 1886 as the Republic of Colombia, the name which is retained to today.

The capital city of Bogota has more than seven million inhabitants. Cali and Medellín each claim two million residents. Barranquilla has a population of more than one million and Cartagena has close to a million residents. There are almost 46 million individuals in an area of 401.042 square miles.

History and Politics

Little is known about the history of the Indian cultures living in the area before Columbus. Two main cultures were in the area: the Tayronas in the Caribbean Region and the Muiscas in the highlands near Bogota, who were considered to be as advanced as the Incas in Peru. Many of the Indian tribes were decimated by warfare and illness, reducing the indigenous population a great deal and causing the increase of the slave trade from Africa by the beginning of the sixteenth century.

The Colombian territory was explored by Rodrigo de Bastidas from the north, Vasco Nuñez de Balboa from the northeast, and Gonzalo Jimenez de Quesada in the center of the country, where he founded the city of Bogotá. Almost from the beginning several rebel movements were commenced against the Spanish domination but they were not successful until 1804 when St. Domingue (present-day Haiti) won its independence.

In Colombia, a movement initiated by Antonio Nariño led the opposition against the Spanish government. This was followed by the independence of Cartagena in 1811. Following the rebellion headed by Simón Bolivar, independence from Spain was declared in 1819 with the creation of the Republic of Colombia; this was organized as a union of Ecuador, Venezuela, and Colombia (which included Panamá). This union did not last long and Venezuela became independent in 1829, with Ecuador doing the same 1 year later. In 1903, the Department of Panamá, influenced by the United States, became independent.

After a period of political stability, Colombia was devastated by an incredible conflict known as "La Violencia" ("The Violence") caused by bloody fights between members of the two political parties following the April 9, 1948, assassination of the leader of the Liberal party, Jorge Eliecer Gaitán. During the next several years, thousands of Colombians were killed until the military coup of Gustavo Rojas Pinilla and the government of the Military Junta. There were additional violations of human rights, including forced recruitment, the disappearance of individuals, and sexual violence.

After the military regimes, the two traditional political parties agreed to the creation of a "National Front" whereby the Liberal and Conservative parties would govern jointly. This agreement eliminated "the Violence" but many believe that the contradictions and disagreements between the parties were the forces responsible for the development of the Marxist-oriented groups such as the M-19, the Revolutionary Armed Forces of Colombia (FARC), and the National Liberation Army (ELN).

To complicate this fragile and violent sociopolitical situation, powerful and violent drug cartels developed in the late 1970s, 1980s, and 1990s. These cartels influenced and financed the illegal armed groups, thereby creating incredible instability in the government and severe violence in the nation. This led to one of the largest displacements of people in the world, with more than two million Colombians leaving the country.

In August 2000, the United States government approved "Plan Colombia," pledging $1.3 billion to fight drug trafficking. President Pastrana used the plan to undercut drug production and prevent guerrilla groups from benefiting from drug sales and expanded the rights of the military in dealing with the rebels.

As a result of the internal violence, approximately 1.6 million individuals had been internally displaced by mid-2005. In 2003 alone, almost one-half of internal displacements were believed to be the direct result of actions of the paramilitary and guerilla groups, with the remaining displacements due to the actions of other illegal groups and the Colombian military.

In May 2002, Alvaro Uribe of the Liberal Party was elected president and promised to increase the attack on the guerrillas, increasing military spending and seeking US military help. Many believe that Colombia is back on track to recuperating from years of violence and unlawful acts.

Economy

Historically Colombia has had an agrarian economy, a situation that has changed rapidly during the twentieth century. Colombia is rich in natural resources and its main exports are petroleum, coal, coffee, and gold. Also, Colombia is the world's leading source of emeralds and the largest exporter of flowers to the United States (70% of the market). Tourism is also a popular industry in Colombia with close to three million visitors per year despite warnings about security.

Despite its political difficulties Colombia has enjoyed a strong economy with a healthy growing of the Gross Domestic Product (GDP). The country had a recession in 1999 but recovered well and has one of the highest rates of growth in Latin America. Nevertheless, Colombia continues to have serious social problems, with 20% of the population having a 63% share of the income/consumption and approximately 18% of the population living on less that $2 a day.

Immigration to Colombia

Historically there has been relatively little immigration to Colombia from other countries. Spain initially discouraged immigration to the area beginning in the early 1500s, in order to prevent other countries from claiming its colony. More recently, the violence associated with the civil war (La Violencia) has dissuaded individuals from resettling in the country.

Currently, skilled workers are welcomed in the country and work visas may be available. Venezuelans make up almost one-half of current immigrants to Colombia (41%), and Ecuador follows second (8.5%). Other foreign nationals living in Colombia include citizens of Spain, Germany, Italy, Lebanon, and several Latin American countries.

Emigration from Colombia

As a result of the armed conflict, there has been massive emigration from Colombia during the past decade. Approximately one out of every ten Colombians now lives outside of the country. Primary destinations of Colombian citizens who have chosen to emigrate elsewhere include the USA; Canada; several Central American countries (Costa Rica, Guatemala, Mexico, and Panama); the Caribbean countries of Aruba, Curacao, and the Dominican Republic; various South American countries (primarily Venezuela, Ecuador, and Argentina); several European countries (primarily Spain); Australia; Japan; and Israel.

According to the Census Bureau's 2008 American Community Survey (ACS), there are 47 million Hispanics in the United States and close to 1 million of them are identified as Colombians, accounting for 1.9% of the US Hispanic population in 2008. Approximately two-thirds of Colombians are foreign born, compared with 38.1% of Hispanics and 12.5% of the US population overall. A proportion of the Colombians in the United States have received asylum or refugee status based on their persecution in Colombia. Colombia is believed to be the fourth-leading source of undocumented immigrants to the United States.

Most of the immigrants from Colombia (58.7%) arrived in the USA in 1990 or later and less than one-half (48.8%) are US citizens. The median age for Colombians in USA is 36 years, which is the same as the median age of the USA. The majority of Colombians in the USA speak English proficiently and have a higher educational level than the Hispanic population overall. They are also more likely to be married and live mostly in Florida (31.9%) and in the New York–New Jersey area (29%).

Remittances from the emigrants to their families in Colombia have risen by more than 20% per year since 1999. These remittances are believed to total more than three times the country's revenue from coffee exports and two and one-half times the revenue from coal. It is believed that more than three-quarters of these remittances are spent on the essentials of daily living, such as food, rent, and education.

Related Topics

- ► Asylum
- ► Hispanics
- ► Internally displaced persons
- ► Labor migration
- ► Latinos
- ► Refugee

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Colon Cancer and Screening

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Colorectal Cancer Incidence Among Immigrants

Colorectal cancer incidence, defined as the number of new cancer cases occurring within a defined time period, varies widely. In more developed countries, the colorectal cancer incidence is substantially higher than in less developed countries. Risk factors for colorectal cancer are increasing age, inflammatory bowel disease, a personal or family history of colorectal cancer or colorectal polyps, rare genetic syndromes and lifestyle factors, such as lack of physical activity, low fruit and vegetable intake, a low-fiber and high-fat diet, overweight and obesity, alcohol consumption and tobacco use. As immigrants move from less developed countries to more developed countries, they adopt the lifestyle of their host country, such as low fiber intake and high meat consumption, which increases their risk for colorectal cancer. For example, Chinese and Filipino persons who are born in Asia and later immigrate to the United States have a higher risk of colorectal cancer than their counterparts who remain in Asia. They have a lower risk of colorectal cancer than the general population in the United States because they may be slow to adopt the lifestyle of the host country. Studies of recent immigrants in the United States have shown an increased colorectal cancer incidence within one generation. There is very little information on colorectal cancer screening among immigrants in other countries. Therefore, this entry is limited to immigrants in the United States. In the United States, colorectal cancer is the third most common cancer and the second most common cause of cancer death. Most of the immigrants who arrived in the United States after 1970 were from countries in Latin America and Asia. The most recent statistics (2007) show that 54% of the foreign-born US population is from Latin American, 27% from Asia, 13% from Europe, and 6% from other areas, including Africa and Oceania.

Colorectal Cancer Screening Among Immigrants

Through screening, health care providers can capitalize on the relatively long premalignant phase of colorectal cancer. The progression of polyps into cancerous lesions is often slow; therefore, if found early, precancerous polyps can be removed. Additionally, colorectal cancer prognosis is tied closely to the stage at which the cancer is diagnosed. Almost 90% of colorectal cancer patients survive for at least 5 years if their cancer is diagnosed in its early, localized stage, but only about 10% survive for at least 5 years when the cancer is diagnosed at a late stage, when it has spread to other parts of the body. Thus, colorectal cancer screening tests are indispensable tools for identifying individuals early in their disease, when they are often asymptomatic, and allow for treatment that prevents further progression and metastasis. The US Preventive Services Task Force (USPSTF), an independent panel that issues guidelines on cancer screening, recommends routine screening of all men and women 50 years and older. This recommendation is based on several randomized trials that showed that regular screening after 50 years of age greatly reduces deaths from colorectal cancer.

Colorectal cancer screening is unique in that a number of different types of screening tests are recommended. The Fecal Occult Blood Test (FOBT), also called stool blood test, analyzes fecal material for the presence of occult (hidden) blood. For a stool blood test, individuals must collect a small stool sample and send it to a provider for analysis. Two types of stool blood tests are currently available. Guaiac FOBT uses the chemical, guaiac, to detect heme, a component of red blood cells; immunochemical FOBT or Fecal Immunochemical Test (FIT) utilizes antibodies against human hemoglobin protein to detect the presence of blood in stool. Alternatively, screening by endoscopy is more invasive and more expensive. In an outpatient procedure, a long, flexible instrument equipped with a video camera is inserted through the rectum to inspect the lower colon (sigmoidoscopy) or the entire colon (colonoscopy). With endoscopy, lesions can be visualized and those appearing precancerous or cancerous can be removed during the screening procedure. The ability to detect and remove lesions in one session makes this the preferred choice for health care providers and, in the United States, screening by colonoscopy is increasing in the general population. However, because stool blood tests are lower cost, more convenient alternatives, interventions to increase screening in larger populations often advocate their use. The US Preventive Services Task Force recommends annual stool blood tests for individuals 50–75 years old *or* sigmoidoscopy every 5 years *or* colonoscopy every 10 years. Other screening options are also available, such as virtual colonoscopy, double contrast barium enema, and digital rectal exam. Additionally, research involving experimental screening methods such as wireless capsule endoscopy showcases the technological advances in possible cancer screening modalities.

Despite the recommendations and multiple choices of screening tests, colorectal cancer screening is underutilized. In the general US population, colorectal cancer screening prevalences are substantially lower than screening prevalences for breast or cervical cancer by mammography or Pap smear. Several campaigns promote colorectal cancer screening and the proportion of the population that has received a colorectal cancer screening test according to the guidelines has steadily increased (from 20–30% in 1997 to almost 55% in 2008). However, screening disparities among racial/ethnic groups continue to persist. Based on a large California population-based survey (California Health Interview Survey), the prevalence of colorectal cancer screening increased significantly among Whites and Latinos but not among African Americans and Asian Americans between 2001 and 2005. Screening prevalence varied substantially among Asian subgroups, with Koreans, Filipino, and Vietnamese Americans having the lowest prevalence. Many members of these Asian subgroups are immigrants. In contrast, Japanese Americans who have a long history of living in the United States had one of the highest screening prevalences.

Another study conducted using data from the 2000 National Health Interview Survey concluded that foreign-born individuals not only had lower colorectal cancer screening prevalences than US-born non-Latino Whites, but also had significantly lower screening prevalences than US-born members of their ethnic community. In addition, a recent analysis of colorectal cancer screening in Filipino American immigrants suggests that within ethnic subgroups, more educated and acculturated persons with higher income may tend to obtain endoscopies, whereas more recent immigrants with lower levels of education and income tend to obtain stool blood tests. Thus, even within an immigrant group from the same country, disparities may exist with respect to the type of colorectal cancer screening test received.

Factors Associated with Colorectal Cancer Screening

Studies in general population samples have found certain demographic variables, such as higher education, higher income, having health insurance, and being married, to be positively associated with colorectal cancer screening and other cancer screening tests. Factors such as lack of symptoms, lack of time, inconvenience, lack of interest, cost, discomfort associated with the procedure, and embarrassment have been found to be common barriers to colorectal cancer screening. To date, only a few studies have explored factors associated with colorectal cancer screening in immigrant populations. Studies in several immigrant populations (Latinos, Filipino Americans, Korean Americans, and Chinese Americans) found that older age and longer duration of residency in the United States, having health insurance, and higher levels of education and income were associated with increased colorectal cancer screening. In these populations, barriers to screening include being unaware of cancer screening tests or underestimating their importance, lack of health insurance to cover screening tests, and not having a regular health care provider. Cultural barriers also play a role. They may include modesty (an issue when undergoing endoscopy), fatalism (there is nothing I can do to prevent getting colorectal cancer), crisis orientation toward health and illness (consulting a physician only when seriously ill), and use of Eastern medicine instead of Western medicine. For example, in one study, Latina women who were given access to free screening were more likely to get screened if they had less fatalistic attitudes. Undocumented legal status and use of home remedies instead of seeing a physician have also been suggested as barriers to screening for Latino immigrants.

A physician recommendation to get screened remains one of the most important promoters of colorectal cancer screening in the general population and among immigrants. California Health Interview Survey data suggest that Korean and Vietnamese Americans are less likely than other Asian American groups to report a recent doctor recommendation for screening. This may be due to language barriers, not seeing a physician for routine checkups, and not asking physicians for routine screening tests. In a study that explored why Korean American physicians did not recommend colorectal cancer screening to their Korean American patients, physicians identified the following barriers for recommending colorectal cancer screening: barriers directly attributable to the physicians themselves (i.e., lack of knowledge, fear of medicolegal liability), barriers associated with their patient characteristics (i.e., patient's unfamiliarity with the concept of screening and preventive medicine), and barriers that result from the limitations of the health care system or local clinics (i.e., lack of referral network for endoscopy, poor reimbursement). One study that included Latino and Chinese immigrants who were patients in a primary care clinic in New York found that the vast majority obtained a colonoscopy after a physician referral. This finding underscores the importance of a physician recommendation for colorectal cancer screening among immigrants.

Interventions to Increase Colorectal Cancer Screening

Programs and interventions to increase colorectal cancer screening have been developed and tested, although they are usually not exclusively targeting immigrants. Several interventions have been developed for Latino and Asian American populations, both of which have large proportions of immigrants. Programs may include reminder letters, educational videos and brochures, one-on-one or small-group educational sessions, and help for patients to make appointments for colorectal cancer screening and to "navigate" the health care system. Studies of clinic-based interventions, where patients are recruited at clinics and interventions are delivered by health professionals or trained peer navigators, have been shown to increase colorectal cancer screening among immigrants. These programs have the advantage that all patients have access to health care and can receive colorectal cancer screening at the program site. However, clinic based programs can only reach those immigrants who have health insurance and a regular source of care.

Immigrants who lack health insurance can be reached through programs at community-based organizations and churches that promote colorectal cancer screening. Only a few studies have been conducted among immigrants in nonclinical settings, and not all have been successful in increasing colorectal cancer screening. These programs typically include education to increase knowledge and awareness of the screening tests and discussion of barriers to screening and how to overcome these barriers. Some programs provide free colorectal cancer screening, typically a low cost stool blood test. Linguistically and culturally appropriate telephone counseling has also been shown to be effective.

Other programs to increase screening are targeting physicians to increase recommending screening to patients, and system barriers, such as instituting reminder systems at clinics. For example, the medical charts or electronic health records of patients who are not up to date with colorectal cancer screening can be flagged to remind the physician to recommend screening to these patients, and reminder letters can be mailed to these patients. In addition, health insurance coverage for colorectal cancer screening is increasing. For example, Medicare has expanded coverage to include all recommended screening tests, including colonoscopy. These programs are expected to increase colorectal cancer screening in future years in the general population and among immigrants.

Acknowledgment

This work was supported by the American Cancer Society (grant RSGT-04-210-05 CPPB).

Related Topics

- ► Access to care
- ► Cancer health disparities
- ► Cancer incidence
- ► Cancer mortality
- ► Cancer prevention
- ► Cancer screening
- ► Colorectal cancer

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Colonialism

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Colonialism is the long-term political, social, economic, and cultural domination of a people and territory by a foreign power. Modern colonialism can be traced to the European "Age of Discovery," particularly to colonizing projects carried out by the England, Spain, France, and the Netherlands that extended to the Far East and to the Americas. Throughout the nineteenth and into the twentieth century, colonialist regimes were established throughout the world, frequently with "civilizing" ideologies at their core, such as "the White man's burden," adopted by the British, and the "mission civilisatrice" of the French. Underlying these ideologies was the intent to move beyond governing to the modernization and eventual assimilation of people, often accomplished through great violence and through the establishment of cultures of terror.

Colonies took a variety of forms meant to support economic exploitation of people and land. These included (1) settler colonies, in which people from colonizing nations moved in large numbers in new territories; (2) dependencies, in which governing regimes or administrations managed local populations; (3) plantation colonies, in which land and people were used to produce agricultural products; and (4) trading posts, including forts and other quasi-military installations that controlled trading and selling in a particular area. Whatever the form, the project of establishing a colony and of producing colonial subjects entailed the implementation of power structures and division of places and people in ways that were frequently arbitrary inventions. New countries were produced through these encounters, as well as new categories of people. These hierarchies, categorizations, and other mechanisms of power shaped how colonizers and the colonized interacted and were able to move and make choices within a society, producing races, ethnicities, classes, sexualities, and ways of being in the world large. The colonized often experienced untold horrors as they were forced into imperialist projects. But as Cooper and Stoler argue in their 1997 *Tensions of Empire*, these mechanisms also produced contemporary Europe as a bourgeois society and order was remade and expanded in relation to imperialism.

It has been argued that colonialist ideologies persist in the world, under new labels, but with similar mechanisms. Escobar, for example, suggests that development and development policies have become as pervasive, effective, and controlling as their colonial counterparts. Development ideologies and projects have adopted categories that have shaped world thinking on how people are to be "helped" or pushed toward modernity, even as many of these projects do not succeed. Indeed, Ferguson suggests that development projects often fail, but something else is accomplished, often the expansion of State or governing power in realms where it was formerly thin on the ground or nonexistent.

Processes of colonialism and development (or underdevelopment) have been central to shaping our world and the possibilities that exist for all people. Many contemporary inequalities and disparities result from these processes, among them the struggles of indigenous people's throughout the world and the horrors of genocide in places like Rwanda, where the divisions that led to the mass killing were the direct legacy of the German and Belgian colonial projects in that region of Africa from the 1890s onward.

Related Topics

- ► Discrimination
- ► Racism
- ► Slavery

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Colorectal Cancer

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Incidence

Colorectal cancer is uncommon in developing countries but is the second most frequent malignancy in affluent societies. More than 940,000 cases occur annually worldwide, and approximately 639,000 people die from it each year. In the United States there were around 150,000 new cases of colorectal cancer diagnosed in 2009 and it was the second leading cause of cancer death. The risk increases with increasing age, particularly starting at age 50, and colorectal cancer is quite rare in patients under age 40.

Cause

Some studies suggest that a "Western diet," rich in fat, refined carbohydrates, and animal protein, may lead to colon or rectal cancer, particularly if combined with low physical activity. It has been proposed that a sedentary lifestyle allows greater exposure of the inner lining (epithelial) cells of the colon or rectum to carcinogenic substances in the diet. Some studies suggest that this risk can be reduced by decreasing meat consumption (particularly processed meat), increasing the intake of vegetables and fruits, and increased exercise. Immigrant populations rapidly reach the higher level of risk of the adopted country, another sign that environmental factors play a major role. Although there are inherited forms of the disease, genetic susceptibility appears to be involved in a small number (less than 5%) of cases. Patients with longstanding inflammatory bowel disease, particularly ulcerative colitis involving the entire colon, are also at increased risk.

Before becoming invasive cancer, cancers of the colon and rectum generally start out as benign (i.e., nonmalignant) growths of cells lining the colon (endothelial cells) called polyps. After further damage to the endothelial cells' DNA, their growth becomes disorganized and uncontrolled. The cells become abnormal or dysplastic, a precursor to cancer. After more DNA damage (presumably from environmental toxins), the dysplastic cells become malignant and invade into tissue; at this point the cells are called colorectal cancer cells (adenocarcinoma). Because of the relative orderly progression from adenomatous polyp to dysplasia to overt carcinoma (cancer), screening tests which detect nonmalignant polyps are an effective way to prevent the development of colorectal cancer by removing the earlier precursor form of the disease before overt cancer has developed.

Screening

The best screening test for colorectal cancer is a colonoscopy. It is recommended that all people should get a screening colonoscopy starting at age 50; if it is normal then the screen should be repeated every 10 years. Patients with a first-degree relative (parent, sibling, or child) with colon or rectal cancer should have their first colonoscopy at an age 10 years younger than their relative was at their diagnosis. Screening colonoscopies are covered by most health insurance carriers in the United States and Medicaid patients starting at age 50. Virtual colonoscopy involves a noninvasive radiographic test of the colon and rectum. It may be as effective as the colonoscopy in detecting most precursor polyps but is not yet widely available.

Other screening tests which have been shown to be effective in reducing colorectal cancer-related mortality include stool hemoccult testing and flexible sigmoidoscopy. Stool hemoccult tests (tests for blood in the stool) involve sending in three stool smears on a card, which are then tested for microscopic blood. This has the advantage of being inexpensive and easy to complete but is not very sensitive at detecting colorectal cancers, which may bleed intermittently or not at all. Flexible sigmoidoscopy is very sensitive at detecting polyps and cancers in the rectum and sigmoid colon but misses the rest of the colon, so that around 1/3 of colon tumors in men and 2/3 in women will be missed with this test. Its sensitivity can be improved, though, if a barium enema (a radiographic imaging study) is combined with the flexible sigmoidoscopy to image the rest of the colon.

Clinical Manifestations

Many patients will not have any symptoms and are diagnosed through a screening test, such as a colonoscopy. Colon cancer patients may present with symptoms of iron deficiency anemia, such as fatigue, or notice a change in stool caliber, have vague abdominal pains, or less commonly notice blood in their stools. Rectal cancer may become noticeable as pain on defecation, blood in the stools, or obstructive symptoms such as lower abdominal pains, nausea, and vomiting.

Staging

Like most cancers, colorectal cancer goes through four stages. The stage determines prognosis and is based, in part, on depth of penetration into the bowel wall. Stage I cancers invade into the layer just underneath the colon or rectal lining (submucosa) or into the muscle layer; stage II tumors go all the way through to the bowel wall but without involvement of surrounding lymph nodes; stage III cancers involve surrounding lymph nodes; and stage IV means that the cancer cells have spread (metastasized) to other organs (usually the liver or lungs). All patients with stage I, II, and III are potentially curable; most stage IV patients are not curable but there are some exceptions (see below).

Treatment

Early Stage Colon Cancer

Stages I–III are treated with surgical resection, which is potentially curable. Following surgery, those with stage III (node involvement) should be offered chemotherapy. This has been shown to significantly improve survival and reduce recurrence of colon cancer.

Early Stage Rectal Cancer

Unlike the colon, the rectum is not enveloped by a protective sheath called the peritoneum. For this reason, rectal cancer recurs far more commonly in the area of resection (locally), as opposed to throughout the body (systemically). As a result, treatment for early stage (stages I–III) rectal cancer is different than that of colon cancer. Radiation, which interferes with DNA replication and treats one small area (local), plays an important role. Chemotherapy, which is given intravenously or orally, is delivered by the blood to all the tissues of the body (systemic therapy). Because patients with early stage rectal cancer may recur locally or systemically, both chemotherapy and radiation are indicated. Combined chemotherapy and radiation should be offered prior to surgery in patients with stages II and III rectal cancer. This has been shown to result in better local control of the rectal cancer than having surgery followed by chemotherapy and radiation. These patients are all treated with curative intent.

Advanced Colorectal Cancer

Most of these patients are incurable. The exception is the patient with localized spread to one part of the liver which can be resected, along with the primary colon or rectal cancer.

Without treatment, patients with metastatic colon or rectal cancer will live about 12 months. Over the past decade tremendous progress has been made, such that the median survival now with modern therapies is about 2 years. Treatment regimens include systemic chemotherapy along with bevacizumab, an antibody which is directed against vascular endothelial growth factor, a substance which allows blood vessels around tumor cells to grow. Studies have shown that the addition of this agent to chemotherapy improves survival time. In addition, a newer class of drugs called epidermal growth factor receptor (EGFR) inhibitors also improves the effects of chemotherapy. These drugs, which include cetuximab and panitumumab, are antibodies against EGFR on the colorectal cancer cell. They are effective only in patients whose colorectal cancer cells do not have a mutation called k-ras. If the cells are mutant in k-ras, which is seen in about 40% of cases, then the EGFR antibodies will not work.

All of these patients should be encouraged to enroll onto clinical trials, as this will be the only way to make improvements in the management of colorectal cancer. This is particularly important for immigrant minorities, who are often underrepresented in clinical trials.

Summary

Cancers of the colon and rectum are particularly common in immigrants coming from affluent countries. Screening tests can detect these at precancerous, highly curable stages and so should be done in anyone over age 50, or younger if in a high-risk group. Early stage colon and rectal cancer is very curable, with surgery playing the dominant role. Advanced colorectal cancer is generally not curable but recent advances have been made which have significantly improved the survival in these patients.

Related Topics

- ► Breast cancer
- ► Cancer
- ► Cancer health disparities
- ► Cancer prevention
- ► Cancer screening
- ► Liver cancer

Suggested Resources

American Cancer Society. http://www.cancer.org/docroot/CRI/CRI_2x.asp?sitearea=&dt=10

American Society of Clinical Oncology. http://www.cancer.net/patient/Cancer±Types/Colorectal±Cancer

National Cancer Institute. National Cancer Institute website. http://www.cancer.gov/cancertopics/pdq/screening/colorectal/Patient/page2

World Health Organization. http://www.who.int/features/factfiles/cancer/10_en.html

Common Law Marriage

► Marriage

Communicable Disease Control

► Infectious diseases

Communicable Disease of Public Health Significance

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The risks of communicable diseases of public health significance reveal the need for early detection, prophylaxis, and treatment. From this point of view, dealing with an immigrant population usually means dealing with diseases with high incidence and prevalence in their origin country. For example, hepatitis B virus is endemic in Asian countries; consequently, 15% of Southeast Asian immigrants are chronic carriers of this infection and the percentage of carriers among Indo-Chinese immigrants is between 14% and 20%. This is why, currently, almost every country has a set of screening procedures for different communicable diseases of public health significance, in order to avoid the possibility of disease transmission within the population, to detect diseases early, and to treat them promptly. For example, according to American Public Health Association (2002), and to the US Centers for Disease Control and Prevention (CDC), immigrants are screened prior to their entry into the USA and prior to adjustment of status for several communicable diseases with potential impact on public health. These include tuberculosis, syphilis, HIV infection, chancroid, gonorrhea, granuloma inguinale, lymphogranuloma venereum, and Hansen's disease. Prior to entry in the USA or during the period of adjustment, intending immigrants are also required to complete or to demonstrate completion (as age-appropriate) of a set of immunizations for several vaccine-preventable diseases such as hepatitis B, influenza B, mumps and measles, pertussis, polio, rubella, tetanus, and diphtheria toxoids. Depending on the native country, other diseases might be considered, such as malaria, varicella, etc. Immigrants who are found to test positive for such diseases usually are treated. In addition, besides screening for diseases listed above, and the documentation of vaccine history and vaccination required, immigrants are also screened for drug addiction and for physical and mental health disorders that could determine harm to the person or to the others.

Besides this situation of legal immigrants who must pass through a screening filter for communicable diseases that can potentially impact public health, there is the situation of illegal immigrants. In their cases, they cannot be screened. In addition, they may not seek healthcare except for emergencies, out of fear of deportation because of their illegal status. This may have a great impact on the public health. It has been asserted that the health status of illegal immigrants is poorer than the rest of the population and that their access to healthcare is limited by different kind of barriers.

Although screening for communicable diseases that may impact on public health plays a very important role in the control of disease transmission, early detection and treatment are also critical. This suggests the need for the early detection and treatment of such diseases in the immigrant population that settles for some time in their second country. This issue relates directly to the extent to which health care is accessible to immigrants and particularly those with uninsured status, low income, illegal immigrant status, language and cultural barriers, social barriers, etc. For example, a significant decrease in the prevalence of tuberculosis (TB) has been noted among US native citizens. Unfortunately, this decrease has not been mirrored by a similar decrease in the prevalence of TB in the US immigrant population. In 2003, in New York, the rate of tuberculosis was four times higher among foreign-born citizens (especially among individuals born in China, Ecuador, Haiti, Mexico, India, and the Dominican Republic) than in US-born New York citizens.

These data argue for the need for efforts in addition to the screening currently conducted prior to or upon immigrants' arrival to their destination country. It indicates the need for health policy measures to improve and to stimulate immigrants' access to health care. Such measures may have positive consequences not only for the health of immigrants, but also on the general population.

Related Topics

- ► Acquired immune deficiency syndrome
- ► Health policy
- ► Immigration processes and health in the U.S.: A brief history
- ► Medical examination (for immigration)
- ► Panel physician
- ► Sexually transmitted diseases
- ► Tuberculosis

Suggested Readings

Kemp, C., & Rasbridge, L. (2004). *Refugee and immigrant health: A handbook for health professionals*. Cambridge: Cambridge University Press.

Post, S. G. (Ed.) (2004). Immigration, Ethical and health issues of. *Encyclopedia of bioethics* (3rd ed.). New York: Macmillan Reference USA/Thomson/Gale.

Suggested Resources

American Public Health Association (APHA). (2002). Understanding the health culture of recent immigrants to the United States: A cross-cultural maternal health information catalog. Retrieved July 1, 2010, from www.apha.org

Centers for Disease Control and Prevention. Immigrant and refugee health. Retrieved July 1, 2010, from http://www.cdc.gov/immigrantrefugeehealth/exams/diseases-vaccines-included.html

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Communication Barriers

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Communication is the process by which senders and receivers of messages establish shared meaning in a specific context. Effective communication requires that a message, verbal and/or nonverbal, oral or written, be created by the source and be successfully understood/received at the destination by the receiver/target. This may involve people, animals, or computers. This is an ongoing, reciprocal, transactional process. Transactional means that we are sending and receiving messages simultaneously, even when we are asleep. Various barriers can result in the poor or distorted reception of the message.

Poor Message Creation

The speaker or sender has a responsibility to create a message that is clear, coherent, and understandable by the receiver. If the sender does not consider the interests and educational level of the receiver, the result may be confusion and/or rejection of the ideas in the message. Poor reasoning, disorganization, irrelevant or confusing examples can all result in messages that are not effective for the receiver. The receiver is an important part of this process and can contribute positively by paying attention to the messages. The environment must be conducive to message exchanges. It should be free of distractions and interruptions. Barriers in the communication cycle may occur at any point and may be attributed to the message, sender, receiver, or the environment.

Noise

The term noise is often used to refer to disruption or interference in the communication process. Noise may be external as poor technical reception, interference in the environment such as a door slamming, a phone ringing, loud music, people talking loudly near you, or other factors that make it impossible for the receiver to clearly hear the message being sent.

More often the “noise” is internal. This may be psychological noise such as daydreaming or wishful thinking. Instead of paying attention to the other person, minds wandering, thinking about things that need to be done or plans that need to be made may disrupt the receiver’s attention. Sometimes the language being spoken is not familiar or comprehensible. Lack of a common language quickly reduces the communication exchange to a series of hand signals and other nonverbal signs. The same language may be used but the meaning of the words being used is different. Vocabulary words like “expediency,” or “dissonance,” or “integrity,” may be strange to the receiver. This is called “semantic” noise. Inability to accurately assign meanings in a timely manner destroys the communication process.

Double Meanings

Messages between senders and receivers are usually both verbal and nonverbal. In any language, the use of the voice – through pitch, inflection, tone, and timing – adds nuances and meanings to the words so that what is understood as having one meaning on the verbal level actually takes on a different meaning on the nonverbal level. “Come see us again,” said in a flat tone of voice may suggest that the return visit should not be any time soon. Thus, greetings that have special cultural contexts and meanings may be offensive if not used correctly and trigger unexpected or negative responses.

Disconfirming Communication

In interpersonal communication intentionally or unintentionally barriers may be created by poor listening and by the type of responses given to the other person. When listening, do you give the other person your full attention or are you trying to do several things at the same time? Can you repeat back in your own words accurately what the other person has said? Are you leaving out part of the message? Adding bits and pieces? Or simply incorrectly stating the content?

When someone is talking to you, do you look bored by averting your eyes and yawning frequently? Do you ignore what they are saying? Do you make an unrelated response or simply change the topic, content, or direction of the conversation? Such responses are perceived very negatively and result in poor communication, creating barriers to future effective communication.

Aggressive Communication

Sometimes receiver responses are hostile and have a negative emotional element. Persons may intentionally use “trigger” words and say things (perhaps through name-calling) to emotionally arouse and annoy the other person and initiate a conflict. Picking an argument and blaming it on the other person by showing dissatisfaction with a selected restaurant, movie, or television show, for example, is an aggressive approach that is a strong communication barrier.

An effective communication exchange involves both cost and rewards. It takes time to stop and talk with a person. Are you satisfied with the return? Was the exchange positive or negative? Did you feel satisfied after the communication or did it cost you time you didn’t have? Did it cost other resources? Did you have to buy dinner or forego some other activity of interest? Repeated cost escalation will ultimately become a barrier to effective communication. Rewards of effective communication include the satisfaction of being clearly understood and of developing positive successful relationships.

Positive or Negative Arousal

People like to hear positive, confirming, complimentary messages. Criticism, disagreement, or hostile remarks are uncomfortable. Senders and messages that create this “negative arousal” may generate avoidance. Remembering names and remembering conversations, for example, indicates active listening and interest in the other person and is positive arousal. Negative arousal, however, poses a significant communication barrier.

The Environment

The communication environment affects the effectiveness of the communication process. Noisy, crowded public places make it difficult for persons to hear each other and concentrate on what is being said. If the room is too hot or too cold, or the furniture is uncomfortable, persons may find it impossible to concentrate. A culturally different environment may result in discomfort. A pleasant, quiet restaurant or a walk in the park on a nice day may provide the needed comfort and privacy to offset such barriers.

Blaming

Blaming the other person is a common barrier and occurs when we do not take responsibility for our reactions to messages. “You’re just stupid” (name-calling), as an example, could be restated more productively as “I’m sorry but I don’t understand what you are saying.” Saying “You make me so angry” (blaming the other person), for example, could be stated more effectively as “I feel disrespected when my car is returned with no gasoline in it,” or “I feel unimportant to you when you keep me waiting for an hour for dinner.”

Lying

While small untruths or omissions of information may be viewed as acceptable to protect the feelings of another person or to keep a confidentiality, telling blatant untruths (fabrication or falsification) or failing to report known information (omission) or intentionally dodging or avoiding an issue by making irrelevant responses or changing the topic creates negative and unproductive communication.

Inappropriate Disclosure

As people explore the process of getting acquainted, they typically reveal information layer by layer, a little at a time, and by taking turns. Safe, factual information about themselves is revealed initially and, after some time, more personal, intimate details about themselves not known to "the public" is disclosed. This process involves risk and trust with a danger that the other person may not like them when the information is revealed. There is also a risk that one or both of the parties will not keep certain information confidential. Conversely, if a person reveals too much information too quickly, discomfort will result because the receiver does not know how to handle so much new information at one time.

Information Load

Too much information received too quickly exceeds the individual's ability to handle or manage the information and it becomes overwhelming to the receiver. Too little information, however, creates a boring or uninteresting situation for the receiver. Individuals have their own rate and capacity for handling simple or complex information.

Disrespect

The individual point of view (ethnocentrism) is a common human characteristic. Attitudes are based on values, beliefs, and experiences that have evolved over time. With aging, the more likely such attitudes are to be "locked in" to our personality. Disrespect or disdain for persons who do not share these attitudes, may be a tremendous barrier to effective communication. It may result in contempt or anger for those holding opposing viewpoints. Such emotions and attitudes can be barriers to effective communication.

Conclusion

An understanding of interpersonal communication is important so that barriers such as aggressive communication, blaming, disrespect, and other causes of poorly constructed messages may be avoided. The following perspectives can be helpful in creating positive communication: (1) Fearful environments such as job interviewing or a threat of deportation may require extra care in message creation. (2) When cultural norms and nonverbal expressions are unfamiliar, communication may breakdown. (3) Language may be a significant barrier to overcome. (4) Positive arousal, negative arousal, and double meanings of words are all intensified by language. (5) Lying, blaming, and disrespect may occur when cultural differences exist or life experiences include a history in which immigrants have been lied to or disrespected. (6) Disclosure may be difficult when an individual has a history of punishment or is threatened with deportation. (7) Often immigrants have interpreters to reduce these problems, especially in health care circumstances, but sometimes these are children or other family members who may misinterpret. Immigrants may often experience an unfamiliar culture as well as a foreign language that exacerbates the communication challenges. Communication is an essential process and each person has an important responsibility to make it successful!

Related Topics

► Language
► Language barriers
► Low literacy level
► Media
► Telephone interpretation services

Suggested Readings

Floyd, K. (2009). *Interpersonal communication: The whole story*. Boston: McGraw-Hill.

Haun, M. J. (2010). *Communication theory and concepts* (7th ed.). Dubuque: McGraw-Hill.

Wood, J. T. (2002). *Interpersonal communication: Everyday encounters*. Belmont: Wadsworth.

Suggested Resources

http://www.colorado.edu/conflict/peace/problem/cultrbar.htm

http://ezinearticles.com?Culture-As-A-Barrier-to-Communication&id=55341

http://ezinearticles.com?Overcoming-Communication-Barriers-Between-People&id=119628

Community

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Immigrant and Refugee Populations: A Brief Demographic Portrait

To understand the evolving composition of immigrant communities, a brief portrait of current immigrant/refugee population patterns is useful. According to a recent United Nations (UN) report on migration, there were close to 200 million immigrants in 2006, about 3% of the world's population. The distribution and nature of immigrant communities is intricately connected to the overall pattern of *globalization* and its inherent flow of labor. The countries with the highest number of immigrants include the United States, the Russian Federation, Germany and other European nations, Canada, Saudi Arabia, India, and the Ukraine. However, countries with the highest percentage of immigrants are primarily in the Middle East, reflecting labor requirements. Regions that are the major sources of immigrants include Asia (e.g., China, Indonesia, India, Philippines), Latin America/Caribbean (e.g., Mexico, Central America), and Africa (e.g., West Africa, Congo, Somalia, Sudan, Ethiopia). Refugees are also migrants, but forced migrants, not moving for reasons of labor or family but to escape violence, disaster, or political persecution. The source countries for refugees vary considerably depending on political situation, but most recently include Afghanistan, Iraq, Somalia, Democratic Republic of the Congo, and others. Depending upon the nature of available labor as well as (for refugees) resettlement patterns, immigrant communities may be urban or rural, though predominantly the former.

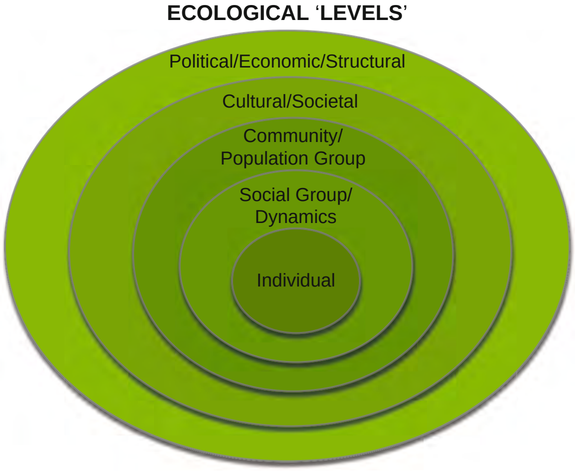
Defining Immigrant/Refugee Communities

The term "community" is used in so many contexts that before outlining its meaning in terms of immigrant/refugee health, it is worth reiterating some of that usage. "Community" can refer to:

- A geographic and social space that has boundaries of some kind where people live and interact.
- An emotional feeling – for example, one can feel a "sense of community" with other individuals due to a situation (e.g., a shared emergency) or shared commitment (e.g., with respect to faith). Anthropologist Victor Turner referred to this sense of social togetherness as *communitas*.
- A group of individuals who share an interest or lifestyle pattern, and who interact with each other regarding that interest, as in "the community of recreational fishing boat owners."
- A self-identified ethnic or national population, as in "the Italian community," which may or may not refer to people living in a specific geographic space, but could in fact be global. It could also be an "imagined community" whose existence can be seen as a construction in the popular imaginary.

There are also other kinds of definitions: *intentional communities* for example, are voluntarily formed by groups of people who want to put in practice a particular philosophy of living together, whether religious, environmental, or utopian; *virtual communities* are groups of people who interact regularly via the Internet around games, issues, or interests.

For this essay, since the focus is on public health, "community" may include any of these to some degree, but primarily we are referring to a geographically bounded space that can be understood as a *social ecology*. That is, within that bounded (yet porous) space, there is a particular combination of individuals who live and/or work there, social groups, cultures and practices, economic relationships, environmental conditions, and resources, all interacting to form a certain kind of interdependent sociocultural unit. Moreover, this "unit" is nested within larger political, economic, social, and cultural structures, so it cannot be considered in isolation. Community is defined in this way in part to interact, theoretically and in practice, with the *ecological model* of health determinants now prevalent in public health literature, which can be visually depicted as, for example, concentric circles illustrating multiple levels of influence on a particular health issue – moving from the individual, to social groups and networks, to community and society, culture and political economy (Fig. 1). It is also intended to encompass



Community. Fig. 1 "Levels" in the ecological model of health

the structural relationships between communities and the social orders of which they are a part.

Studying Communities: Anthropology, Sociology, and Media/ Communications Perspectives

Both anthropology and sociology have long traditions of studying urban and rural communities in ways that have had increasing impacts on public health approaches. In sociology, the focus has been on social networks, social capital, hierarchy and class, and patterns of social relations. Studying communities as unique sociocultural settings and as representative of particular cultures was indeed the domain of traditional ethnographic work in anthropology, in remote, rural, and urban communities. It is only more recently that anthropologist Robert Redfield's portrayal of relatively self-contained "little communities" has changed, with more recent work addressing the nature of specific urban or rural communities in relation to broader and transnational structures of power and globalization, and in keeping with the broadening of anthropological inquiry beyond place-based strictures. Much of the work on health issues within medical anthropology takes this latter perspective. In addition, contributions from media and communications studies show that those transnational structures must also include the broad reach of media and online activities, which can have multiple impacts on immigrant communities, from increasing assimilation, to fragmentation that occurs when different (e.g., generational) segments of the community use those media in very different ways. These impacts affect health and health-related behavior.

Challenges in Defining Immigrant/ Refugee Communities

Multiple population groups and subgroups. Defining a community in the context of immigrant/refugee health presents complex challenges, even as the nature and composition of a given community is tied to important factors affecting health, including language issues, access to care, beliefs/practices, social and cultural capital, and socioeconomic status. Most communities with immigrant/refugee populations do not consist of just one such population, although in some cases – such as Hmong communities in California in the USA – there is primarily one population. A community in which the author collaborates for public health interventions, for example, includes peoples from South Asia, the Caribbean, West Africa, and Southeast Asia, along with a predominant Central American/Latino segment. Moreover, even within specific immigrant groups in a community, there are subgroupings of significance. In the same community referred to above, the Central American population includes immigrants from El Salvador, Guatemala, Honduras, and Nicaragua, as well as immigrants from neighboring Mexico. Each of these groups present significant differences: the Guatemalan immigrants, for example, are largely indigenous peoples, some whose first language is not Spanish. In the metropolitan area overall, the Vietnamese immigrant population encompasses people who came to the USA in successive refugee "waves," each of which involved different circumstances, personal resources, and demographic characteristics. The Thai and Korean metro area populations, on the other hand, did not come as refugees. As another example, in the urban Caribbean immigrant communities of Amsterdam, The Netherlands, there have been separate populations from Suriname, Curacao, and Aruba – all from former Dutch colonies in the Caribbean/South America. Yet even the two Antillean immigrant communities (From Curacao and Aruba) have their differences.

Urban versus rural/small town. Most immigrant/refugee communities are found in "gateway" urban or suburban settings, but this is not always the case. There are important rural and small-town immigrant/refugee communities, for example, in the West, Southwest, and East Coast areas of the USA, in Canada, in South Africa, and other locations. Often these communities are linked to employment sources such as agricultural work, food processing, mining, or light assembly/manufacturing. In the case of refugees, they may also be located in certain areas because of organizations that were involved in their resettlement.

Generational issues. The successive immigration waves are connected to generational segments in the community, which are much more of a factor for immigrant/refugee populations than for others. Typically, for migration from less-developed to developed countries, first generation immigrants arrive in the host country with better than average health, but may then experience a decline over time. The decline is related to a number of factors that can be seen as an immigrant/refugee health *trajectory* First generation adults often bring with them diet and other health practices that may or may not be protective (e.g., high salt or carbohydrate intake), but which had different impacts in the home country where physical activity was connected to daily work and transportation patterns were different. In addition, the process of migration itself may have involved trauma and severe deprivation, which have health consequences after arrival. Depending upon the kinds of services available in the host country, access to care may be very limited. Finally, the first generation is more likely to be comfortable with indigenous, home-country health beliefs and practices, and may not utilize biomedical-based services.

Children of these first-generation immigrants, on the other hand, are more likely to adopt developed country dietary and lifestyle patterns, including fast food and sedentary free time. The parent generation may not know about the risks associated with such practices and may even value them as signs of attainment in the new country. In addition, family organization in a community may be affected by language, where the largely home language-speaking first generation becomes dependent on its more fluent and acculturated children for certain needs.

Legal issues. As another key dimension, some immigrant/refugee communities include significant numbers of undocumented members, while others do not. This often depends upon the political circumstances surrounding emigration, and whether those circumstances were recognized by the host government as enough to warrant support for asylum, resettlement, and other assistance. The degree to which legal status is an issue for one or more populations in an immigrant community affects a range of health-related factors and plays a key role in social marginalization.

Transnational relationships. Moreover, immigrant communities are typically *transnational* – including individuals and families who move back and forth from their home countries, and where host and home-country populations are linked by *remittances* – transfers of money and resources to the home community. These remittances in turn create a social and economic infrastructure linking the sending and receiving communities and countries across formal borders. According to the World Bank, total remittances flowing to the developing world amounted to $316 billion in 2009, with a 6.2% increase expected for 2010, despite recent economic conditions.

Health Interventions and Communities

The interplay of immigrant/refugee populations and sectors within communities forms one of the most delicate and political dimensions affecting health and health interventions, and may be one factor either impeding or supporting community efficacy with respect to addressing health issues. As explained further under the entry entitled "Community Programs," gaining some understanding about the complex composition of these communities is an important starting point for planning any health-related intervention. Based on the epidemiological data, it is then necessary to determine whether interventions need to be directed to:

- All subgroups within the geographically defined area (the entire community)
- One or more social or cultural subgroups in the geographic area
- A subset of individuals who are involved in specific risk behaviors (e.g., injection drug users, sex workers)

- In some cases, a subset connected to a particular organizational or employment category/type (e.g., day laborers or restaurant workers)
- Economic, political, and social structures (business, the health care industry, policymaking bodies, community-based organizations) that have an impact on the health problem in that community

Thus, whether it is for immigrants/refugees or any population, the necessity of understanding the nature of the community as an overall phenomenon, as well as in relation to specific health concerns, is a key part of health program planning and implementation.

Related Topics

- ► Acculturation
- ► Assimilation
- ► Barriers to care
- ► Health determinants
- ► Transnational community
- ► Vulnerable populations

Suggested Readings

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Portes, A. (1996). Globalization from below: The rise of transnational communities. In W. P. Smith & R. P. Korczenwicz (Eds.), *Latin America in the world economy* (pp. 151–168). Westport: Greenwood Press.

Portes, A., & Rumbaut, R. G. (2006). *Immigrant America: A portrait*. Berkeley: University of California Press.

Redfield, R. (1967). *The little community, Peasant society and culture*. Chicago: University of Chicago Press/Phoenix Books.

United Nations. (2010). *International migration 2009*. New York: United Nations Department of Economic and Social Affairs, Population Division.

Suggested Resources

The Community Toolbox. http://ctb.ku.edu. (An on-line resource for planning, developing, implementing and evaluating community programs, managed through the University of Kansas. Useful in understanding a wide range of issues to consider in working with communities).

Community Health Workers

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Background

For over 300 years many communities around the world have been utilizing lay health workers as a source of regular health care services in the absence of trained medical professionals. The 1978 the World Health Organization's (WHO) *Declaration of Alma-Ata* emphasized the use of community health workers (CHWs) as a key strategy for the delivery of basic health care services. CHWs are distinguished from other health professionals because they are hired primarily for their understanding of the populations and communities they serve, conduct outreach a significant portion of the time playing multiple roles, and have experience in providing services in community settings. In the USA, formal participation of trained workers in this role has been documented since the 1950s. By the late 1960s and early 1970s, CHWs were experimentally utilized in some of the low-income communities as a model of intervention for disease prevention and health education. Within this model, individuals with good personal and community skills and some health care training became valuable members of a health care team and help to improve patient communication and disease prevention in underserved communities facilitating early diagnosis of diseases and providing a more effective patient follow-up and improved health outcomes.

The federal Migrant Health Act of 1962 and the Economic Opportunity Act of 1964 mandated outreach activities that included employment of community-based service aides in many neighborhoods and migrant worker camps. The largest system to formally use the skills of CHWs in the USA was established in 1968, when the Indian Health Service adopted the fledging Community Health Representative Program from the Office of Economic Opportunity. The program was designed to bridge the gaps between people and resources and to integrate basic medical knowledge about disease prevention and care.

The Community Health Worker National Workforce Study published in March of 2007 by the US Department of Health and Human Services Administration (US HRSA) described the evolution of the CHW workforce in four periods:

1. The early documentation period (1966–1972) is characterized by engaging CHWs in low-income communities and was more related to developing antipoverty strategies than to specific programs for disease prevention and health care.
2. The period between 1973 and 1989 was characterized by special projects funded by short term public and private grants, often linked to research with universities.
3. The State and Federal Initiatives Period followed between 1990 and 1998 when standardized training for CHWs received greater recognition. Many bills were introduced for CHW but none passed.

The latest period (1999–to present) is significant for public policy actions. Legislation addressing CHWs' training and certification was passed in several states and the Patient Navigator Bill was signed into law as a major piece of legislation at the Federal level addressing the work of CHWs. Of note is that the 2003 Institute of Medicine (IOM) report on reducing health disparities made recommendations regarding CHW roles in impacting health disparities.

Coordinated efforts to professionalize the field in the USA began in the 1990s when CHWs from across the country agreed to use the title "Community Health Worker" as an umbrella term for the dozens of job titles that were in use among the workforce. At the same time, CHWs began to initiate local and national efforts to organize into professional networks and associations. Standardized training for CHWs also started to be developed in different areas of the country in the 1990s, including the Community Health Education Center (CHEC) of the Boston Public Health Commission. A second CHW training program, the Outreach Worker Training Institute (OWTI) of the Central Massachusetts Area Health Education Center (CMAHEC), was initiated in 1999 with its courses starting in 2001. Massachusetts and Texas are two examples of the participation of the CHWs/*Promotores de Salud* at the community and health system level. Texas has ~3,500–5,000 CHWs/*Promotores de Salud*, the majority of whom are of Hispanic ethnicity. The Texas Department of State Health Services (TDSHS) certification training includes 160 h of training and 20 h of CEUs every 2 years to maintain state certification. The curriculum meets 8 competency areas: communication skills, interpersonal skills, service coordination skills, capacity-building skills, advocacy skills, teaching skills, organizational skills, and knowledge base on specific health issues. Institutions continue to provide program-specific training additional to the certification training. Clients of CHWs/*Promotores de Salud* are generally immigrants, women, those uninsured, homeless, rural residents, migrant workers, and colonia residents.

In 2001, the American Public Health Association passed an official policy resolution, "Recognition and Support for Community Health Workers' Contributions to Meeting our Nation's Health Care Needs," which identified the need to "brand" the profession in order to promote policy, program development, program evaluation, and the growth of the field.

In light of the increasing need for delivering effective health care to the low-income minority populations, the Health Resources and Services Administration (HRSA) and Bureau of Health Professions of the US Department of Health and Human Services (USDHHS) conducted an extensive study between 2004 and 2007 on the CHW workforce as a component of cost-effective strategies addressing the health care needs of underserved communities. The Health Resources and Services Administration 2007 study identified five roles of CHWs in the health care process: (1) member of health care delivery team, (2) navigator, (3) screening and health education provider, (4) outreach/enrolling/informing agent, and (5) organizer. These roles were not always mutually exclusive. This model of care enhances productivity of the medical team in certain situations, such as patient-provider communication and tracking patients with unreliable addresses or transportation.

Promotores De Salud

All of the world's cultures have a lay health care system made up of people who are natural helpers-community members whom neighbors approach for social support and advice. CHWs work throughout the world in countries such as Africa, Brazil, Korea, India, Ethiopia, China, Vietnam, Bangladesh, Haiti, Kenya, and Mexico. They work in areas such as surveillance, respiratory treatment, immunizations, birth control injections, chronic disease management, eye care, TB, neonatal mortality reduction, vaccinations, child survival, Malaria, and anemia.

In Latin America and Latino communities in the USA, the term *Promotores de Salud* refers to CHW, community members who advocate for the well-being of their community and have the necessary training, experience, and dedication of their time to help improve the health and wellness of their community members. In the USA, *Promotores de Salud* are lay members of the community, who work either for pay or as volunteers in association with the local health care system in both urban and rural environments. They usually share ethnicity, language, socioeconomic status and life experiences with the community member subgroups they serve. They are usually of Hispanic/Latino descent, live in the Hispanic neighborhoods and immigrant communities, speak the Spanish language, and desire to help educate and empower the community on health issues. They come from all walks of life; they may have little education or be trained nurses, dentists or doctors from their countries of origin such as Mexico.

Nationwide, there were approximately 86,000 CHWs/*Promotores de Salud* in 2000. Approximately 17 states are currently in some stage of state certification (Alaska, Arizona, California, Connecticut, Florida, Indiana, Kentucky, Massachusetts, Mississippi, North Carolina, New Mexico, Nevada, Ohio, Oregon, Texas, Virginia, and West Virginia). There are currently 6,300 estimated employers of CHWs/*Promotores de Salud* for the nation as a whole. Nationally, paid positions range from $7–$15/h. In some areas they are paid via stipends, other incentives such as mileage reimbursement, or other types of compensation.

Implications for Immigrant Health

Because the health of immigrant populations has the potential to deteriorate when they move to the host country there is the need to assist them with culturally appropriate services. *Promotores de Salud* have been granted the roles of health educator, client advocate, outreach, and health system navigator because they share the same cultural identity and can relate to the needs of the new comers in the host country. Similar levels of acculturation in terms of shared language and years of residence by the *Promotor* and the immigrant persons can play a vital role in improving immigrant's trust and addressing their concerns. Unlike physicians, nurses, and other allied health professionals that work primarily in clinics or offices, *promotores* work mainly in community-based settings and in clients' homes. This community-based work allows them to reach deep into their communities and to connect people who are isolated and hard-to-reach with needed health and human services such as immigrants.

The potential of *Promotores de Salud* to assist immigrants and to improve their health have attracted the attention of several organizations that are funding innovative approaches to deliver health and social services to immigrants with the participation of *Promotores de Salud*. Examples of health services and health promotion activities include: (1) the Blue Cross and Blue Shield of Minnesota Foundation Healthy Together initiative that promotes the mental health and social adjustment of new Americans; (2) the Deaf Community Health Worker project, in St Paul Minnesota that provides community health worker services to deaf immigrants and their families to help them navigate the health care system; (3) The Vietnamese Social Services of Minnesota, in St. Paul, that provides mental health and social adjustment support for newly arrived refugees from Burma through the use of a community health workers; (4) the Faribault Diversity Coalition that engages immigrants and long-time residents in creating inclusive, welcoming communities in Faribault; and (5) the Mayo Clinic, Rochester, Minnesota project that documents how community health workers in primary care medical practices improve patient health outcomes.

The CHW/*Promotores de Salud* are definitively making a difference and improving the health and the lives of immigrants and newcomers in communities in the USA and throughout the world.

Related Topics

- ▶ Community-oriented primary care
- ▶ Community programs
- ▶ Cultural competence
- ▶ Promotora
- ▶ Social networking

Suggested Readings

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Community Organizing

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Immigrant health efforts are frequently more successful when community members play a significant role in goal setting, planning, and implementation. Community organizing refers broadly to any effort to bring together members of a given community to assist in the creation of social change. In practice, community organizing efforts vary greatly. Some community organizing efforts are expert-driven, beginning in a social service agency or academia, while others trace their (grass)roots to community members themselves. Targeted participants may include individuals, established organizations, or both. The goals of the organized group may approach multiple issues or a single issue, with varying degrees of specificity. Further, community organizing efforts vary tactically from conflict-based, wherein one or more community entities are specifically opposed, to consensus-based, wherein agreement from all stakeholders is seen as key to achieving the group's goal(s). "Community" in this context often refers to a particular geographic location, but may also be based on shared interests or characteristics (e.g., ethnicity, immigrant status).

In all cases, the principal benefit of community organizing is the combination of multiple perspectives and resources to affect change. This benefit is an increasingly common focus in public health practice, including efforts at health promotion and policy change for immigrant populations. While broader efforts at community organizing have arguably existed for millennia, the term itself is emergent from immigration and poverty discussions in the late 1800s, having first come into use alongside social reform efforts such as the settlement house movement in England, the USA, and Russia. Labor, civil rights, and other social movements worldwide throughout the nineteenth and twentieth centuries served to add to evidence of the effectiveness of community-based social change strategies. Today, such strategies are deemed by health and development agencies to be crucial not only for creating change, but for building community capacity to ensure sustainability and future problem-solving ability.

Community organizing is defined broadly by some as an overarching term synonymous with "community development" and "community-building," but specifically by others as a methodological practice within community development, with community-building as an intended outcome. Evidence-based medicine, community-based participatory research, and the proliferation of the coalition model are all similar methodologies designed to bring multiple perspectives and/or resources to bear in support of public health efforts, including immigrant health programs, and have all been encouraged by the World Health Organization (e.g., the Healthy Cities Movement) and other health and development agencies. Community organizing includes these benefits and may make use of the methodologies mentioned above, but differs in that community members play a role in community organizing efforts beyond that of serving merely as consultants or focus group/survey/interview respondents. This is especially important in immigrant health efforts, as such efforts are in danger of further marginalizing those they purport to serve absent immigrant voices in planning and implementation.

Elements of Successful Organizing Efforts

Successful community organizing efforts frequently begin with the identification of key community stakeholders – individuals or organizations within a given community whose networks are strong and who have a clear desire to create change. There is ample evidence that organizing efforts focused on immigrant communities should involve members of the immigrant population as early in the planning process as possible. Ideally, the organized group grows as additional stakeholders are added through member networks and purposeful flow of information about the group's existence into the broader community. Effective leadership, diverse participation, and clear goal setting are seen as crucial elements of successful community organizing. Leadership skills such as conflict management, resource mobilization, and communication have all been found to correlate positively with effectiveness of community groups. Many successful immigrant-focused community organization efforts can be traced back to one or more dynamic leaders *within the immigrant community* with the time, energy, interpersonal skills, and community rapport necessary to coordinate change efforts and influence community participation. Agencies that have sought to create community organization efforts have often encountered success by turning over group leadership to a community member.

Diverse participation is critical in both conflict- and consensus-based organizing efforts. Diverse participation combats marginalization by ensuring that multiple perspectives are included in any discussion of social change, heightens the chance of collateral benefits of organizing efforts in terms of increased community connectedness, and serves as a source of group momentum and influence. Diverse participation, however, requires that communicative barriers arising from different socioeconomic status, culture, historical background, and ethnicity be openly acknowledged and addressed. Members of oft-marginalized community groups, immigrant groups included, may, for understandable reasons having to do with historical and ongoing inequity, be reluctant to fully discuss their perspectives, holding back "hidden transcripts" that would be of great value to the change effort. Open discussion leads to the rapport required to bring hidden transcripts into group consciousness. Effective community organizing efforts do not ignore inequities and power imbalances in the community for fear of creating offense, but instead address them freely and openly, acknowledging that such differences continue to exist in society. Similarly, and especially in the context of immigrant health efforts, leaders should avoid viewing individual group members as spokespersons for the entirety of a particular ethnic or cultural group, preferring instead to continually expand group membership to include a wide variety of perspectives that reveal the complex interaction of gender, age, ethnicity, socioeconomic status, and other factors in shaping perspectives. Effective community organization efforts begin with this inclusiveness in mind, but also remain vigilant in ongoing recruitment in order to keep the group from becoming insulated from the broader community.

As noted above, the goals of a given community organizing effort may vary in their specificity. Highly specific goals (e.g., hosting a health fair in a community with a high immigrant population) are effective in keeping a group moving in a unified direction, but may not achieve involvement from community members who have other priorities. Broad goals (e.g., improved fitness and nutrition for a city's entire immigrant population) may appeal to a larger cross section of community members, but differing expectations of how to achieve said goals may result in frustration and barriers to effectiveness. In all cases, it is recommended that goals come from the immigrant community itself, not from a specific sponsoring agency or group. As many public health efforts are grant-driven, this may necessitate work alongside members of the immigrant population in grant writing, as well. The freedom of immigrant and other community members to establish their own priorities results in more community involvement and greater program efficacy. Second, goals should be clearly communicated to each group member and reinforced frequently. This practice helps ensure that the group doesn't spend time and resources on efforts that some group members see as tangential, thus avoiding departures as member expectations aren't met. Finally, goals should be periodically addressed and, if needed, redefined in accordance with changing community perspectives and resources.

Conflict-Based Versus Consensus-Based Organization

Both initial and ongoing stakeholder identification may require community organizers to envision one of two theoretical pathways: conflict- or consensus-based organization. Conflict-based organization, such as that popularized in the 1970s by Saul Alinsky's Industrial Areas Foundation and similar efforts and used still today in some immigrant-focused organizing efforts, typically entails opposition to one or more established groups, such as policy makers or businesses that are seen as directly opposing or blocking the change community members desire. Protests and the media often play central roles in conflict-based organization, which tend to be designed to force change through pressures created by increased community awareness of a particular practice. Conflict-based organization is largely based on a perceived power disparity between the community and those the group is fighting, and may be best indicated in situations where there is ample evidence that those in power have no interest in creating change. Supporters of conflict-based organization posit that this strategy improves the group's focus by creating a common "enemy," thus giving community members added motivation for participation in the group while simultaneously building a commonly held sense of community connectedness or ownership ("communitas" and "social capital" are terms frequently used to describe this phenomenon). Scholars who advise against conflict-based organizing observe that such tactics do result in large numbers of community participants, but that said participation tends to be minimal and brief, such as attendance at a particular protest event. Further, there is the belief that negative targeting of key stakeholders in an effort at social change is ineffective in the long run as it has the potential to create ongoing animosity between targeted decision makers (who are often in positions of power) and already-marginalized community groups.

Consensus-based community organizing intentionally brings multiple stakeholders together with the expectation that effective outcomes will emerge as multiple perspectives and resources are combined. This type of community organizing is particularly useful in cases when governmental and social services agencies seek to improve outcomes by engaging the community knowledge base and creating change that is driven by the community itself, thus improving sustainability. Consensus-based community organizing may also have a non-agency, or grassroots, origin. While most consensus-based organizing efforts do not succeed in bringing *all* possible stakeholders to the metaphorical table, neither do they specifically target particular individuals or groups as enemies. Effective consensus-based organizing programs in immigrant health focus on identifying individuals and organizations that are willing to work for change, building a diverse member base inclusive of members of the immigrant community as well as those in positions of influence over, and those influenced by, the immigrant community. Through various discussion-based consensus-building interactions (meetings are most common, but newsletters, focus groups, surveys, and other information-sharing techniques have also been successful – the key is that group members both share and receive information), a clearer picture of priorities for change (community needs), resources available (community assets), and mechanisms for achieving said change is achieved. Because the organized community is defining the focus of its efforts, the potential for development of an expert-driven, "top-down," program that leaves out or harms certain community members is minimized.

There are, however, limits to the number of community voices that can be effectively heard at a given time, or in a given meeting. As such, consensus-based approaches have a tendency to involve fewer people overall than conflict-based approaches. Reticence to seek diverse community involvement out of fear of multiple perspectives hampering group momentum is a common pitfall in consensus-based efforts, and perhaps particularly common in immigrant-focused efforts as "experts" discount the value of local understandings and networks, resulting in groups that falsely purport to be representative of a given community. A capacity for increased community connectedness exists in the consensus-based approach, but differs from that emergent from the conflict-based approach in that connections are made across levels of community influence but between fewer people overall. Finally, the consensus-based approach tends to address complexities surrounding a given issue more effectively than antagonistic approaches, which often rely on less nuanced oppositional viewpoints.

Many immigrant health-focused community organizing efforts have effectively combined conflict- and consensus-based approaches. A conflict-based grassroots effort that begins by protesting the closure of a health clinic, for instance, may transition to a consensus-driven approach after said clinic is preserved and group goals broaden to include local health promotion efforts. Similarly, a consensus-based group may decide that a march on the local mayor's office is an effective one-time strategy in raising awareness of the group's existence and concerns. As in all aspects of community organizing, care should be taken to ensure that all group members are involved in decisions regarding group activities and approach.

Related Topics

- ▶ Community
- ▶ Community programs
- ▶ Community-based participatory research
- ▶ Environmental justice
- ▶ Social capital

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Community Programs

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The Scope of Community Programs

Community programs in this discussion will refer to health-related programs that are implemented at the community level and designed to address factors and characteristics of the community – in this case, immigrant/refugee communities. The term program in this sense does not generally refer to a clinical intervention or medical facility itself, but to a broad range of interventions that may or may not be linked to a clinic/medical facility, encompassing *health promotion and primary prevention* efforts, *support services* for individuals who are ill (e.g., transportation, meals), or interventions to *mitigate impacts or secondary transmission* for those already affected (e.g., tuberculosis, HIV/AIDS), or *human rights and protective* programs (e.g., protection against exploitation of women). Most community programs fall in the first category of health promotion or primary prevention. These programs include education, public information/awareness campaigns, screening, outreach, patient advocacy and language interpretation, policy and public advocacy, and targeted behavior change efforts, and are typically implemented by community-based (CBOs) or nongovernmental organizations (NGOs), with funding from a government agency, global NGO, or foundation; evaluation as well as technical assistance are often provided through the latter organizations, a private consulting organization, or a college/university.

What Is a Community?

While there are many definitions of *community* for public health purposes the definition provided in the separate entry entitled "Community" is useful here: Community refers to a geographically bounded space that can be understood as a *social ecology*. That is, within that bounded (yet porous) space there is a particular combination of individuals who live and/or work there, social groups, cultures and practices, economic relationships, environmental conditions, and resources, all interacting to form a certain kind of interdependent sociocultural unit. Moreover, this "unit" is nested within larger political, economic, social, and cultural structures, so it cannot be considered in isolation. This definition is intentionally aligned with the *ecological model* of health determinants now prevalent in public health literature, which refers to multiple levels of influence on a particular health issue – individual, social groups and networks, community and society, culture, and political economy. It also includes consideration of the structural relationships between communities and the social orders in which they are embedded.

Communities are complex, and composed of multiple subgroups and layers. In immigrant/refugee communities, the interplay of subgroups can be crucial to marshaling the necessary resources to address an issue programmatically. Moreover, immigrant/refugee populations have unique patterns of health and health risk that include health beliefs/practices from the home country; trauma and distress related to difficult migration experiences, including refugee camps; victimization during migration; loss of resources; and, when in the new country, loss of status and multiple barriers finding income and housing, much less health services, and generational or immigration "wave" differences.

One truism for community interventions is that the intervention itself is almost always just part of the picture. Because a community is involved, the interests, needs, politics, resources (or lack thereof), and social structures of the community will inevitably play a role, in several ways:

- *The politics of selecting target population(s) and health issue(s) to be addressed*. As noted, in any community there are a number of health issues that are important in some way. Specific health issues may have political dimensions, in the sense that an advocacy group or particular interests within the community are trying to increase attention and resources directed to that issue. At the same time, the health issue of focus may be determined by available funding sources – state, local and global.
- *Coalitions and community structures of power*. Even beyond the selection of target populations and health issues, implementing a community program is typically done through – or at least in collaboration with – community structures of some sort. These may include: government agencies or a specific decision maker; community leaders; task forces or committees; a *community advisory board*; faith community representatives; businesses; advocacy groups; grassroots community organizations; professional groups, including organizations or associations of health providers; and community coalitions.

Any of these kinds of groups and partnerships may have their own motives related to the politics of the community, of preserving or enhancing their position in the community, of gaining control over a particular (health) issue in order to be able to set the agenda, or other reasons. In addition, any of these groups may have internal conflicts and divisions that stem from individual rivalries or different goals/interests.

Community expertise. Despite all the complexities, there is no better expertise on the community than expertise from the community itself, and the diverse groups within it. These are the individuals who know community habits and customary practices, knowledge and attitudes, language, social groups, where things happen (locations), and much more. For this reason, it is important to establish a collaborative relationship so that the community and other program-related (outside) expertise are integrated.

Levels of Intervention

Given that communities are a mixing bowl in which multiple health-related factors interact, implementing a program typically requires some selection of contributing factors or groups. It is necessary to determine whether a program/intervention should be directed to:

- All subgroups within the geographically defined area (the entire community)
- One or more social or cultural subgroups in the geographic area
- A subset of individuals who are involved in specific risk behaviors (e.g., injection drug users, sex workers)
- In some cases, a subset connected to a particular organizational or employment category/type (e.g., day laborers, or restaurant workers)
- Economic, political, and social structures (business, the health care industry, policymaking bodies, community-based organizations, global organizations) that have an impact on the health problem in that community

Program decisions often have to do with scale. Is it more effective to address the community in general with a broad-based or multilevel intervention? Or should the program try to reach a smaller, targeted group or setting that is at high risk for a particular health problem? Broader interventions can be called *community* interventions; the more targeted kind can be called *interventions in a community.* These terms are related to the way in which the Institute of Medicine in the USA classifies different types of interventions: *universal* prevention interventions are those that target a general population; *selected* prevention interventions are those that target individuals or groups that are at high risk for a particular health problem; and *indicated* preventive interventions are those targeting families, groups, and individuals with multiple risk factors for a health problem (e.g., programs that combine multiple types of activities and treatment to address multiple factors that occur together as a *syndemic*, such as poverty, high diabetes risk, and poor diet).

In general, community interventions, if effective, tend to result in smaller changes, but over a larger (absolute) number of people. Mass media and community mobilization programs are of this type. Interventions in a community, if effective, tend to result in higher rates of change but with a smaller number of people. Outreach and specialized education or skill-building programs fall in this category. These kinds of programs can sometimes lead to broader community change if the targeted subgroup is influential or acts as a bridge to the community as a whole with respect to a health condition (e.g., sex workers and the spread of HIV/AIDS). Finally, a program might not focus on individuals at all, but on systems or policies in the community that affect access to care (e.g., requirements for gender representation, language interpretation, or culturally competent staff).

The Process: Assessment, Planning, Implementation, and Evaluation

For any kind of community program, there is basically a four-stage process involved. These same general stages are part of most planning models used for community programs in public health, including the PRECEDE-PROCEED and PATCH models, or COMBI (Communication for Behavioral Impact) in global health communications efforts (other planning resources available from the Global Health Council, www.globalhealth.org). The four stages are:

- *Assessment:* Conducting an assessment is the basis for identifying the nature of the problem, what the key contributing factors are, and who (which populations/subpopulations) is affected. Data useful for assessment may include local public health epidemiological data as well as interviews, surveys, focus groups, or other data you collect from key stakeholders and population representatives.
- *Planning:* Once you have completed (or are provided with) an assessment, the next task is to design/select an intervention that is appropriate for the problem, contributing factors and population group, and to identify and link up with the

resources, community collaborating partners, and staff needed to implement the program. It is also at this stage when an evaluation should be designed that matches what the planned program seeks to achieve. For immigrant/refugee programs, the planning stage is especially important because it is at this point when collaborations with community groups are key.

- *Implementation:* Carrying out the intervention also means collecting ongoing *process* data about how the program is being implemented, and in some cases adapting the program based on what is learned during implementation.
- *Evaluation:* There are three basic types of evaluation. The terms used occasionally vary, but the three types are: (1) *process evaluation* – ongoing program data that help determine if the program is implemented as planned; (2) *outcome* evaluation that assesses short-term changes resulting from the program (e.g., knowledge/skills change, new regulations, behavior changes); and (3) *impact evaluation* assessing longer term changes resulting from the program, such as increased utilization of health services, change in a specific environmental risk that was causing a problem (e.g., pollution sources), or actual change in the incidence/prevalence of a particular health condition. In the current program environment, evaluation is very important because that is where the *evidence base* for a particular program is derived, which in turn impacts potential funding.

Other Issues: Tailoring, Adapting Programs, and Sustainability

Built into this four stage process is the idea of *tailoring* – ensuring that the community program (1) is based on an assessment and understanding of the health problem *as it takes shape in a particular population, subgroup, or community;* (2) includes the community in designing, implementing, and evaluating the program; (3) refers, as much as possible, to situations, people, and issues relevant to the target community/population; (4) uses language and materials appropriate for the audience; and (5) schedules and locates activities so that members of the target population can participate.

Develop vs. adapt? Though every community and population is unique, a decision must be made about whether to develop a program or to adapt an existing one. There are often at least some commonalities across situations and communities with respect to a particular health problem, and programs may have been developed before that can be adapted – though this should be done carefully in order not to implement a "canned solution" to a unique situation. Potential program models for adaptation can be found through US or global agency clearinghouses, nonprofit associations focused on a particular health problem or population, professional associations, or government "model programs" databases. In the USA, such databases or compilations are available at the US Centers for Disease Control and Prevention (CDC) and through other agencies in the Department of Health and Human Services. In the global context, model program/best practice information tends to be disease-specific. UNAIDS, for example, has published such information, but exclusively with respect to HIV/AIDS programs.

Sustainability. This is a sometimes vexing issue that routinely arises with respect to community programs. Funding for such programs is often relatively short term – three or 4 years. In complex community contexts, putting a program in place, and then achieving change, may take longer than that. Thus issues of sustainability and community capacity building must become part of program planning and implementation, for example, training/hiring members of the community to operate the program; engaging community stakeholders (business, civic organizations, etc.) that will have a stake in maintenance of the program; seeking additional sources of funds; applying for continuing funds, and training community members in these skills; and linking the program to others like it as well as to practitioners in the field.

Related Topics

- ► Community
- ► Community-based participatory research
- ► Health determinants
- ► Health education
- ► Health outcomes
- ► Health promotion
- ► Refugee health and screening

Suggested Readings

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Community-Based Participatory Research

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Community-based participatory research (CBPR) is an applied research approach designed to link theory, research, policy, and practice to inform decision making and foster positive change. CBPR provides academic institutions with a model to bring students, researchers, and community members together with a shared purpose to work toward mutually beneficial goals. In addition, CBPR incorporates knowledge sharing between community and academic partners, and collective social action to address societal inequities. Unlike traditional research approaches, CBPR recognizes the value of diverse community perspectives, and the knowledge they bring to the research process. As such CBPR emphasizes community participation and power-sharing throughout the research process, as well as ownership, capacity building, and empowerment. CBPR approaches are aimed at addressing the underlying social, political, and economic inequities that impact community health and well-being.

CBPR has been described in the literature as emerging from the earlier area of action research cultivated by Kurt Lewin in the 1940s and the work of Paulo Freire in the 1970s. These approaches to research, like present day CBPR, accentuate the need to engage community voices that are not often represented in the research process, particularly those impacted by social inequities. Furthermore, early CBPR approaches such as participatory action research (PAR) sought to reduce the oppressive nature of research by promoting power-sharing, and the notion of "research with," as opposed to "research on" the community. CBPR today comes in many different forms which include but are not limited to the earlier models of action research.

The Process

Integral to CBPR is the research process – a focus on how partners come together in a joint effort to assess and identify community priorities, develop intervention strategies, and decide what strategies are used to facilitate participation, the enhancement of relationships, capacity building, and empowerment. The process in CBPR is vital, as it is centered on the development of trusting relationships between institutional and community stakeholders based on mutual respect, shared decision making, and equity among partners. Because CBPR is asset based and underscores the importance of building on existing community knowledge, all partners are encouraged to contribute throughout the entirety of the research process, learn from one another, and share resources for the creation of sustainable interventions that reflect community concerns. With CBPR, the partnership itself can act as a catalyst for change, as residents, community leaders, and researchers take collective action toward a shared vision and mutually established goals.

CBPR goals include empowering residents so they may act to advance positive social change at the community level and empowering researchers to engage in research that is meaningful. Empowerment means that communities and researchers alike feel they have the ability and skills to act on the contextual factors that shape local living environments. As such, empowered communities require opportunities for both participation and capacity building, as do empowered researchers. In CBPR, participation refers to the extent to which members of the partnership engage in project activities, fulfill their identified roles, and take on new roles. To overcome potential participation barriers, it is important to provide capacity building to assure that partners feel as though they can fully contribute. CBPR builds community capacity for self determination and leadership, through the development of new relationships and the provision of skills necessary to achieve community health goals. Capacity building provides the partnership with a shared language and strengthens technical expertise among the group by building on individual strengths and valuing the creativity diverse partners bring to the table. Developing partner capacity is necessary if the benefits of participation that facilitate empowerment are to be achieved.

Because it is focused on empowerment and participation, CBPR has been identified as a promising approach to developing interventions to tackle health inequities. Its focus on community participation in science allows for the design of health interventions that are community relevant and culturally appropriate, tailored to the values, experiences, practices, and worldview of community members. This is critical as inequities in health have been well documented, yet poorly addressed. A complex set of interrelated social, political, economic, and environmental factors are responsible for the proliferation of health inequities, and the factors that create and sustain them vary across communities among racial/ethnic, cultural, and linguistic minority groups. It is therefore necessary to engage in research that may, by design and intention, lead to evidence-based interventions to address inequities, especially in underserved immigrant and minority communities. Using CBPR, researcher content area expertise is contextualized by community knowledge, leading to the development of effective health interventions that address community health concerns. Simultaneously, community mobilization and empowerment has the power to spark local policy change to address distal factors that sustain inequities, such as inadequate education and a lack of economic opportunity.

Underlying Assumptions

There are four key assumptions upon which the principles of CBPR rest. First, partnership is authentic and as such results in “co-learning.” Working side by side in collaboration with community partners facilitates the development of new knowledge on the part of both the university researcher and the community member. While the community partner may be learning about the nature of the research process the researcher simultaneously may be learning about the distinct characteristics of the community and the ways in which historical policies or sociopolitical context shapes the health and well being of community residents. This knowledge is significant from a public health perspective, particularly given the complexity of communities and the multiple factors that determine health in a given community. A second important assumption is that the direct capacity-building efforts are built into the CBPR process. Building community research capacity is essential, as capacity is associated with participation. By building community research knowledge in conjunction with mutual respect and shared decision making, research partnerships can empower community members to participate in the decision-making process. For example, research often involves language that is not common, as well as discipline-specific acronyms. Such language can create barriers to participation and exclude those not trained as researchers. Capacity-building efforts such as trainings can be used to increase community knowledge of research terminology, thereby reducing language and disciplinary barriers that curve participation, creating a shared language. Thirdly, knowledge garnered should be of interest to and benefit all partners. That is to say that all partners should be aware of the research findings and interested in the outcomes, implying that all are involved in the design and have a stake in or ownership of the research outcomes. Finally, it is assumed that the partnership has committed for the long term. Given the complexity of health disparities and the multiple factors that contribute to both creating and sustaining them, efforts at addressing them require a commitment over time. For example, a research partnership that designs and implements an intervention may be years later using their findings to advocate for local policy change.

The Challenges

Despite its benefits, the challenges to engaging in effective CBPR are many. Researchers have described key ethical challenges for the CBPR partnerships, for example, the notion of research that is. With CBPR the study focus or research question is described as emerging from the community. However, this is not generally the case as community priorities involve improving or creating services and programs, assuring access and grassroots action, not research. More often it is the case that the community is approached by a researcher with similar interests, the challenge being how to ensure that the focus area of the researcher is that of the community. Additionally challenging is discerning who or what constitutes community. Do agency leaders and service providers make up community or actual residents living in the community and if so, who? In essence, how can we be sure that the research agreed upon is reflective of community priorities, and that the partners at the table are representative of community? This is especially true given the disconnect that often exists between community service providers and consumers of services. As researchers begin to partner with communities, particularly immigrant communities, to engage in research partnerships it is essential that they explore the notion of who/what constitutes community first.

Insider–outsider tensions are also described as a challenge in CBPR. Communities are complex, adaptive systems with unique sociopolitical histories; as such tensions can arise as the result of historical distrust of outsiders, such as researchers. Even when there is a cultural or racial concordance between researchers and the communities with which they are partnering, research holds a level of power and privilege that can lead community members to perceive them as outsiders. As such, partners must reflect on their position and what they bring to the table, recognizing their roles. Similarly, because CBPR is often practiced to address racial and ethnic disparities in health, issues of racism must be addressed – particularly as Whites are overrepresented among researchers.

Dissemination is an additional challenge faced by CBPR partnerships. Consider the different ways in which researchers and community partners disseminate their work. While researchers are interested in scholarly publications, community partners are more likely to produce reports, use findings to improve service delivery, or to advocate for additional services. These activities are associated with different time frames – where community dissemination is immediate and scholarly dissemination is time consuming. In addition, researchers may want to hold back on sharing findings until peer-reviewed articles have been published, which is an ethical dilemma if the goal of CBPR is to move from research to action. This is particularly true because a basic principle of CBPR is to share research findings using them as a tool to facilitate grassroots action.

Conclusions

Although CBPR poses a number of challenges to researchers and the community, its benefits cannot be denied, partnering with community contextualizes research and interventions giving them meaning and relevance. This is crucial if the deleterious effects of the social hierarchy that produce and sustain health inequity are to be addressed. In addition, CBPR has the potential to generate new knowledge that is community specific and the power to move findings from theory into practice. Incorporating community perspectives and expertise throughout the research process increases the capacity of researchers to engage in the community and the capacity to incorporate research findings in advocacy efforts. This is particularly relevant as community demographics shift, given that new immigrant populations may experience the determinants of health differently, calling for community-specific and culturally appropriate interventions.

Related Topics

- ▶ Community
- ▶ Community organizing
- ▶ Environmental justice
- ▶ Ethical issues in research with immigrants and refugees
- ▶ Health disparities
- ▶ Research ethics

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Suggested Resources

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http://www.cbprcurriculum.info/

Community-Oriented Primary Care

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Community-Oriented Primary Care: Past and Present

Background

Community oriented primary care (COPC) is a defined systematic approach to health that brings the community into the primary care planning and health care delivery process. COPC aims to improve the health of the community, not just those receiving direct patient care services. Unlike traditional medicine, COPC is based on principles in the fields of epidemiology and public health in addition to primary medicine and preventive care. The team of health practitioners, health professionals, and community leaders comes together to address the specific health needs within diverse communities on a local and global level.

COPC originated during the 1940s in South Africa through the efforts of Sidney and Emily Kark, two physicians that implemented a health delivery system in an impoverished, rural area of South Africa (Pholela, Natal). Appointed by the South African Government, Dr. Sidney Kark was given the task of developing a primary care system that focused on curing diseases as well as disease prevention. The framework he introduced centered around five basic questions to be investigated: (1) What is the community's current state of health? (2) What are the factors that have contributed to this health state? (3) What is being done about it? (4) What more can be done and what is the expected outcome? and (5) What measures are needed to continue health surveillance of the community and to evaluate the effects of the existing programs?

A population-based system, COPC requires: (1) a community-based, primary care practice; (2) an identifiable population or community for which the practice assumes responsibility for effecting change in health status; and (3) a planning, monitoring, and evaluation process for identifying and resolving health problems. The central tenet is to treat the patient in the community context. As an example, the first proposal for the United States Office of Economic Opportunity-funded health centers in the United States notes that: “the need is not for the distribution of services to passive recipients, but for the active involvement of local populations in ways which will change their knowledge, attitudes and motivation.”

The World Health Organization (WHO) and United Nations Educational, Scientific and Cultural Organization (UNESCO) endorsed the COPC model at the Alma-Ata Conference on Primary Care in 1978. In 1982, the Institute of Medicine in the United States convened a conference on expanding research into COPC. Following the conference, progress toward fuller implementation of COPC concepts in the United States and elsewhere were noted. COPC has continued to expand in the developed and developing world. COPC as an approach to specific clinical issues such as chronic heart disease management, application of COCP for pediatric populations and for migrant Muslim women in Germany, and evidence of COPC in Spain and Brazil underscore the expansion of COPC to vulnerable populations and communities globally.

The COPC model combines applied epidemiology, collaboration with the community to prioritize health issues, and define the community interventions, evaluation, and monitoring. This model promotes collaboration and coordination among the community and health care professionals; creating an environment whereby trust is created among the community, the health system, and health care practitioners. These linkages tie together the needs assessments, interventions, and outcomes.

Components of COPC

COPC transforms the traditional, doctor–patient health model into a health care provider–community health model. Since the 1970s, the WHO has recognized the importance of community participation and its benefits. These benefits include increased health benefits, efficiency, equity, and self-managed care. Unlike the traditional clinical practice model, the COPC program model relies heavily on input from the surrounding community and then develops a health plan that will address the community’s specific needs. The COPC model contains three basic components: (1) a primary care practice providing accessible, comprehensive, coordinated, continuous, and accountable health care services; (2) a defined community for whose health the practice has assumed responsibility; (“Community” refers to either geographic or social communities, or a combination of both; groups that form within the workplace, church, or schools; or persons enrolled in a common health plan, but not made up of the active patients in a practice); and (3) a cyclical process that includes six important steps:

Defining the Community

Defining the community is an integral part of the COPC process, since the term “community” can be defined many different ways, and relies on presumptions about geography and patient populations. Inaccurate definition of the community can impede the COPC process by misdiagnosing the population and suggesting the wrong intervention. A clear understanding of the population that will be served and making community involvement easier throughout the process is essential for success. While the Karks’ initial work focused on a geographically defined community, communities can also be defined by sex or gender, race, or other demographic descriptors; by language, religion, or other cultural groupings; by employment status, immigration status, or other legal categories; or other characteristics. While quantitative data are essential to achieving an understanding of a community, qualitative data such as focus group findings, oral histories, or key informant interviews can also play a critical role in understanding what defines a community.

Characterizing the Community

Following the definition of the community, the next task is to describe the community. The characterization of a community, using parameters such as geographic or political boundaries, languages, ages, social norms, economics, and the environment can be compared to the general population and other peer communities to help sharpen an understanding of the specific characteristics of the community. Boundaries such as census tracts, health services areas, ZIP Codes, and even political jurisdictions are considered in characterizing the community profile. Birth and death data, health care utilization data, topographical characteristics, socioeconomic data, health attitudes survey data, and any other variables which influence an individual's health can be incorporated. By gathering data on the community, a snapshot of health status will be formulated and health problems will be identified for intervention. Understanding and describing the community its groups and issues are essential before any planning occurs.

Prioritizing Community Health Problems

Identification of health problems for intervention includes weighing and prioritizing issues suggested from community leaders, health advisory boards, and needs assessments. Selecting the first among many issues to be addressed is a crucial step in the process. Community involvement plays a critical role in this part of the COPC process. Determining priority areas rely heavily on what the community views as their greatest concerns. Planners must weigh the views and perspectives and avoid prioritization schemes that favor one subgroup of the community over another. Community priorities are often directed at issues with a bearing on health status but seem to have little relationship to the medical care system. These issues can include such variables as: education, access to meaningful employment, teenage pregnancy, transportation, and safety. Clinicians who dismiss these issues as irrelevant to clinical care, or unchangeable, risk losing the support of the community stakeholders involved in the COPC process. These priorities reflect the determinants of health as defined by genetic endowment, social circumstances, environmental exposure, health care and behavioral patterns.

Detailed Assessment of the Health Problem

Health problems selected as priorities must be completely assessed by the planning team. Assessment of the problem requires the analyzing of available data whenever possible (disease incidence and prevalence data, survey results, mortality rates, etc.). However, data may not adequately describe the problems, especially in communities with lack of access to health care or where surveying the community is difficult. Estimates and anecdotal data generated by those most familiar with the community may help make up for missing data. Community members and stakeholders included in the assessment process can bring their own perspectives to the issues. For example, the community members may be able to help the planning team understand how past health interventions have fallen short, or why community members have responded to a survey in a particular way. As the team examines each health problem, relationships between seemingly unrelated health problems may emerge, noting relationships specific to this community. Unexpected opportunities for synergy, coalition-building, or efficiencies may be uncovered while assessing prioritized health problems.

Intervention

After a complete assessment of the problem has been conducted, the intervention is developed. Several approaches may be identified; however, the COPC team will analyze and choose the most successful, practical, and feasible intervention for the population. The intervention will also be problem specific. Factors such as insurance status, available resources (equipment, staff, facilities, etc.), access to transportation, potential language barriers, as well as social and cultural norms are factors influencing the implementation of the most appropriate intervention. Interventions must be scientifically justifiable, evidence-based, and shown to be effective in practice. They must also be reviewed, accepted, and approved by community members to ensure feasibility.

The provision of primary care clinical services such as adult health, pediatrics, or behavioral health are often the focus of a COPC intervention. However, especially for low-income communities or those with problems with access to health care, interventions may need to go beyond physician care to include access to prescription drugs, transportation to the site of healthcare services, help with language or cultural barriers, safety for patients, referrals for specialty or hospital care, nutritional assistance, chronic disease management education, or other health-related services. A COPC planning team that has done the work of involving the community throughout the process will be less likely to be surprised by barriers to achieving optimal health.

Evaluation

Evaluation of the intervention is a necessary component of the COPC process. By measuring specific outcomes, the COPC team can identify what components of the intervention worked, what components did not work, and why. Evaluation of the outcomes leads to a reassessment of the priorities and determines if the process merits continuation in the community Evaluation should be an aspect of the initial plan that accounts for the impacts of services and permits adjustment of services as needs change. The completion of the evaluation step includes outcomes that support the next cycle of the planning process, keeping community contacts engaged and other stakeholders available for the subsequent redefinition, and refocusing of assets and reevaluation of outcomes.

COPC Today

For over 25 years, the COPC model has been used in many types of health care environments in assessing disease risk factors, addressing previously unrecognized health problems, assessing the cost-effectiveness of strategies, and identifying and targeting the skewed distribution of various diseases. Today, the COPC model has been applied in a wide variety of clinical settings, from the rural villages in South Africa, to urban clinics in the United States and Israel, to general practices in the United Kingdom. Below are two current examples:

Hadassah Community Health Center: Kiryat HaYovel, Jerusalem

Hadassah Community Health Center has used the COPC model since the 1960s and continues to demonstrate and teach the model. As a result, there has been a measurable reduction in a nemia due to pregnancy, hypertension, cardiovascular risk, an improvement in disparities in infant development between the privileged and unprivileged, and an increase in the use of family planning.

Parkland Health and Hospital System: Dallas, TX

Parkland is one of the largest public hospitals and health systems in the United States and falls under the jurisdiction of the Dallas County Hospital District, whose primary purpose is to provide medical aid and hospital care to the indigent and needy that live in Dallas County. Parkland's outpatient clinic system utilized the COPC model from its inception in the 1980s and continues to do so. The system consists of 11 centers providing multiple primary care services (pediatrics, adult health, dental services, and adolescent health) as well as a robust homeless outreach division and a network of school-based clinics. The Parkland System has instituted clinics for refugee health, optometry, podiatry, and behavioral health care after analyzing demand for services. An annual review of outcomes and epidemiologic data is integral to the system. Demographic change in this fast-growing county has driven shifts in resources and new center construction as patient populations follow jobs and affordable housing around the county. All Parkland COPC centers have standing community advisory boards that review service offerings and serve as liaisons to the community. These boards also include representatives from other stakeholders in the community, including health care providers, nonprofit organizations, schools, and civic groups. The Parkland COPC clinic system sees over 300,000 clinic visits per year, the majority of which are uninsured or on Medicaid.

Conclusion

COPC as a model of primary health care can provide primary care based on the needs of the community, whether that community consists of immigrants, specific ethnic groups, vulnerable populations, or a homogeneous group. The model focuses on including the community decision makers, providing prevention and health promotion as core competencies, and community and individual problem solving. Immigrants can benefit from a process that includes their contributions in designing services to suit their particular needs. COPC is designed to create a system of care that opens access and is designed to use the existing assets of a community. It should improve efficiency and effectiveness and as a worldwide model should be advantageous as a primary care model in any type of location, be it urban or rural, developing, or developed.

Related Topics

- ► Community
- ► Health care
- ► Vulnerable populations

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Suggested Resources

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Compadrazgo

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The practice of *compadrazgo* (godparenting, ritual kinship) goes back to the colonization of the Americas by Spain and Portugal. Historically, *compadrazgo* (godparenting) has been (and still is) a cultural practice connected to religious rituals through a person's life: baptism, confirmation, first communion, and marriage. Through each of these rituals, *padrinos* (godparents) enter into social relations of obligation and close friendship with members of another family. Historians suggest that the practice of *compadrazgo* shaped social and cultural life during and after the colonization and settlement processes in Latin, Central America, and the Caribbean. Visiting *comadres* (godmothers) was an important social activity for women because it cemented gendered and family bonds between women of the same social class. The practice of *compadrazgo* extended family bonds beyond those of blood-related family members. Although the practice has been attributed to the Spanish and Portuguese colonizing elites, there is evidence to suggest that complex sponsorship ceremonies also existed among Aztec and Mayan Indians prior to colonization. After colonization, descendants of indigenous people have also adopted this cultural practice. Historians also maintain that the tradition of *compadrazgo* was embraced by Africans and their descendants in the Americas as a way to create bonds of obligation between people.

The most popularly known form of *compadrazgo* is connected to a child's baptism. At the time of the baptism, surrogate parents (padrinos) are named and introduced to the community through the baptism ceremony. The selected madrina (godmother) and padrino (godfather) become compadres (godparents) of the child's parents. By accepting the role of padrinos, the couple promise to care for the child in the event that something happens to the biological parents. The most significant religious commitment is the promise to help raise the child according to Christian/religious values.

Today, *compadrazgo* is both a religious and cultural practice that characterizes Latino families across the hemisphere. Researchers have conducted numerous studies about the practice of compadrazgo in Mexico. They have documented how the cultural significance of this practice extends beyond the relationship of responsibility to a godchild, but more importantly in the relationship between *compadres,* which become social ties between two families. Therefore, Hispanic/Latino families tend to be large and each child is entitled to padrino and madrina, thereby increasing the number of people an individual considers kin. A clear advantage of compadrazgo is that it increases the social capital and resources of individuals and families.

Anthropologists argue that underlying *compadrazgo* relations lie a complex structure of relations, hierarchy, and behavior that needs to be studied more systematically. Research conducted in Oaxaca, Mexico, for example, confirms that *compadrazgo* rituals continue to be connected to the religious rituals of baptism, confirmation, and first communion, but that the most prestigious and onerous is the ritual connected to the baptism ceremony. In Oaxaca, godparents pay for the child's baptismal clothing and other needs. When the child marries, they pay for the wedding clothing, offer a large gift, and in some cases may sponsor a party for the newlyweds at their house. Confirmation godparents also incur some expenses in that they are also responsible for the child's clothing and provide a chest or cabinet for when the child marries. First communion godparents are expected to give a godchild a large wedding present. In Oaxaca, the responsibilities and expectations of godparenting bind community members in deep and complex ways, including most principally the organization of production and labor relations. Godparents with social class status (merchants) recruit godchildren and compadres as workers.

In US Hispanic/Latino communities, compadrazgo represents an important cultural institution. For some groups, migration entails the loss of supportive social relations as exemplified by compadrazgo ties. Among Puerto Ricans in the Northeast, for example, researchers have found that the loss of compadrazgo ties has led to poor evaluations of the quality of life and as a consequence poor health outcomes. In contrast, for Dominicans and Colombians, compadrazgo ties are used to facilitate migration. In many rural communities of the Dominican Republic and Colombia, everyone has a "compadre" in the USA. There is also evidence that among some Hispanic/Latino groups, small recreational clubs also offer immigrants an opportunity to facilitate compadrazgo bonds. There is evidence to suggest that compadrazgo ties play a major role in the settlement process as well. Compadres lend each other money, offer help in finding employment, may offer a place to stay in the process of migration, and/or secure business contacts. It is unclear, however, whether these compadrazgo ties function the same way for immigrant men and women.

There is some anecdotal evidence to suggest that second-generation Latinos in the USA continue to practice godparenting rituals. Maria Hinojosa's memoir of the birth of her son, Raul, includes an account of the baptism ritual they developed to maintain this family tradition. Although they felt strongly about the Catholic tradition of padrinos, they made a few adjustments. Raul had four sets of godparents, one for each element, fire, water, air, and earth. During the ceremony, the godparents formed a circle and each set of godparents stood on the four cardinal points. Each set of godparent gave the child a symbolic present for each element. There was drumming and singing and their friends were invited to say or give something to Raul. In the end, Maria Hinojosa writes that they "were creating a new kind of family for him. These people would be his familia now, his mentors and teachers and caretakers, the people who made up his days and nights, the people who may not have been tied by blood but instead by love, and to be frank, by the convenience of proximity."

Related Topics

- ► Family
- ► Hispanics
- ► Latinos
- ► Social capital

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Compliance

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The term compliance is generally used to refer to consumer/patient acceptance of recommended health behaviors, and is often assessed by the extent to which a person's behavior coincides with medical or health advice. It is frequently used in relation to the acceptance of specific required behaviors such as consistent and correct use of medicines or the following of dietary restrictions to correct or prevent a particular outcome or condition. Other terms for these phenomena are adherence, concordance, cooperation, and conformity. Since the term compliance can infer an asymmetric and hierarchical relationship between provider and patient, and the expectation implied is that a consumer/patient will accept provider instructions and will cooperate, there is a clear current preference for the term adherence. Adherence, in fact, implies a more informed and participatory decision by a consumer/patient to follow provider recommendations and/or protocols for medical treatment.

Problems with compliance are seen as manifested in missed appointments, failure to take medications, lost prescriptions or medications, and medication misuse. Also, discontinuation of protocols and medications are equated with noncompliance, even when discussed in the light of such obstacles as responses to unwanted collateral effects of the recommended behavior/procedure/medication.

Most research has focused on the factors influencing poor compliance and has examined patient characteristics, particular illnesses, or medications most associated with noncompliance. However predictive ability would seem to come from an understanding of psychosocial factors affecting compliance, especially health beliefs including perceptions of vulnerability, the meanings/implications of illness and disease, the perceived costs and benefits of complying, and the quality of the provider–patient relationship. Other factors which may influence compliance are *trialability* (ability to test out what is recommended), *comprehension* (how well the behavior/procedure or medication required is understood), and *cultural acceptability* (how consonant it is with cultural values and a sense of well-being).

The capacity of the consumer/patient to comply is another important consideration. Understanding the cultural acceptability of the required behaviors or health effects of a protocol or medication, while crucial to correct use and continuation, is not sufficient. Lifestyle issues, family influence and behavior, cost, convenience, risk of stigma, and accessibility are factors which may influence a patient's ability to comply. Addiction, or even the occasional use of illicit drugs or abuse of alcohol, is another factor which may interfere with an individual's ability to comply.

Noncompliance by immigrants is usually attributed to a lack of understanding of the instructions because of language or educational levels, or the willful refusal or misunderstanding on the part of the individual or family. If these assumptions determine the provider/patient interaction in a medical consult, they may limit communication and thus the resolution of erroneous assumptions, fears, and inadequate information which undermine recommended behaviors. This is especially true where self-administration and daily motivation are required. The effects of this type of consumer/patient–provider relationship exist despite the fact that in many cultures this dynamic is an expected one, especially between male physicians and female patients. But culturally appropriate or not, the role/status of the provider and the expectations inherent in the term "compliance" can serve as barriers to the correct use and continuation of a medicine or medical protocol. Compliance is affected not only by the provider/patient communication, but such salient issues as the perceived roles and expected behaviors of provider and patient, the characteristics of patients and providers, the type of protocol or program involved, the criteria for compliance, and many other aspects of the context and quality of the health care encounter.

Understanding compliance (and the behaviors, attitudes, knowledge, and motivation supporting it) must include identification of the social and cultural factors affecting behavioral decision making which vary with a complex array of factors in immigrant lives. An individual's or family's decision not to accept or to follow medical advice may be quite reasonable based upon their knowledge, experiences, or beliefs. Furthermore, continual exposure to controversies and contradictions, even in rural areas and traditional communities of sending countries, can foster fears and a lack of confidence in the alternatives being offered in a new country or community or type of provider. One of the problems in understanding "compliance" is that it is largely understood through outcomes. Except by the analysis of body fluids to determine the presence or absence or actual levels of a medication, for example, providers are usually unable to identify noncompliance until such outcomes as pregnancy, increased viral loads, or frank illness. Methods of assessment such as pill counts and self-report can only provide clues about compliance.

There are various steps which can be taken by programs and providers to enhance compliance: Some of those which involve a consideration of specific immigrant needs are:

1. Encouragement of questions in the initial consultation and in follow-up visits when new issues and concerns may have emerged; obviously, a lack of questions does not necessarily indicate satisfaction or compliance, especially in traditional cultures.
2. Understanding of the patient's level of comprehension of what is recommended.
3. Emphasis on the advantages and the attributes of what is recommended which are culturally acceptable; address the aspects of a medication or procedure which may have negative cultural interpretations.
4. Provision of information about health benefits and their meanings to the individual patient.
5. Direction of attention to media issues or local myths which may undermine required behaviors.
6. Assessment of patient characteristics which would act as barriers to their ability and desire to comply.
7. Assessment of the situational factors which might influence desire and ability to comply.
8. Satisfaction with patient–provider relationships and other aspects of the medical/family planning encounter can facilitate cooperation, understanding, and communication.
9. Referral to, or creation of, a culturally appropriate and accessible mechanism for patient support, especially for counseling and information regarding obstacles to compliance.

Clearly, these recommendations place greater responsibilities on the provider. Especially difficult in some cases may be the responsibility to recognize and have some understanding of immigrant needs and the cultural factors which may affect a patients' motivation and ability to comply. In multicultural settings, the challenge obviously includes a commitment to developing culturally informed and knowledgeable health care teams.

Related Topics

- ► Adherence
- ► Barriers to care
- ► Communication barriers
- ► Physician–patient communication

Suggested Readings

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Confianza

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In Spanish, *confianza* means "hope or firm belief in something or someone," and also "familiarity." Indeed, in the English language literature on Latinos, *confianza* is used for both "trust" and "familiarity," not one or the other but together.

Confianza is a necessity for any personal relationship that includes meaningful interactional behavior within the Latino culture. *Confianza* provides a comfortable, safe space, where the person can be himself or herself, with no need for false pretenses. A relationship with *confianza* is by definition personal, involves an informal way of relating that enables the formation of a special bond, and opens the possibility for sharing feelings and concerns at a deep level. Such a relationship also carries the understanding that the information being shared must be kept confidential and not disclosed to others who are not *en confianza.*

Like other cultural characteristics, *confianza* has to be learned through socialization. The importance of relationships within the extended family in Latino culture could be at the root for the perceived need for *confianza.* Such intra-family relationships are expected to involve *confianza* and, in turn, are held as the ideal for all other meaningful relationships. The presence of *confianza* within a relationship enhances the quality and value of the interaction. This quality, in turn, gives credibility to the relationship.

Confianza is closely related to two other integral characteristics of Latino culture: *personalismo* and *respeto. Personalismo* is the importance of personal relationships. *Respeto* is the use of appropriate deferential behavior toward others based on age, sex, social position, economic status, and authority. The exercise of *personalismo* and *respeto* in Latino culture engenders *confianza.* Interestingly, a Spanish version of the Therapeutic Collaboration Scale (TCS) is composed of 14 items that measure *personalismo*, *respeto*, and *confianza* because they are crucial constructs for Latinos' daily lives and for the development of a useful therapeutic relationship.

Confianza develops under certain conditions that relate to *personalismo* and *respeto*: a caring attitude, mutuality, informal communication styles, and repeated contact. A caring attitude shows that the person matters to the other and is demonstrated by asking questions, listening attentively to what the person has to say, or showing interest in the person's family. Mutuality refers to the sharing of information or experiences. It can also take other forms, from as simple as exchanging a few phrases in Spanish as a way of connecting, to talking about commonalities of food or family background. For example, many educators use their own youth experiences to communicate with students and foster *confianza.* The crucial aspect of these exchanges is the understanding that is established between the different parties, even if they have unequal power. The informal communication style, characteristic of *confianza*, helps in creating a connection. However, this informality should not be seen as a lack of *respeto*; a person could still maintain his or her position within the family/social hierarchy, while communicating informally with others who are older or younger or who hold more or less authority. Repeated contacts are also necessary, because a single contact can only demonstrate the potential for *confianza. Confianza* can only develop with time, and the investment of a valued resource, such as time, is a way of showing that one cares.

Latinos use *confianza* to evaluate all relationships, including professional ones (e.g., service providers). In fact, some researchers have argued that *confianza* is the cornerstone for any supportive relationship, especially those that involve giving and receiving information and suggestions. Latinos tend to rate highly physicians who inquire about the patient personally, take time to explain a diagnosis or procedure, and relate some personal information, however small, during the encounter. These same physicians could also expect higher compliance from their Latino patients. The benefits of *confianza* have been demonstrated in breast-feeding promotion, cancer screening, domestic violence and social work services, education, and psychotherapy. For example, *confianza* in the doctor coupled with a comfortable communication style has been shown to decrease the embarrassment associated with Pap tests, while the lack of *confianza* resulted in higher embarrassment levels and doubts about the service or the tests. In general, Latinos feel that doctor–patient relationships in health care settings in the United States are often rushed and impersonal, and make it difficult to foster *confianza*. The bureaucratic infrastructure and the lack of continuity of health care have also been shown to hinder the development of *confianza*.

Confianza can be purposively constructed and needs to be maintained. Cultivating *confianza* makes sense because it can help bring a great deal of cultural understanding into therapeutic or service relationships. Taking the time to develop *confianza* shows that the provider has the best interest of the patient, client, or student at heart.

The same principle that we apply to personal relationships can be applied to organizational settings. Developing relationships with Latino organizations could foster "indirect *confianza*" for the provider and enhance its credibility. As with personal relationships, organizational relationships require sincerity and trust to establish a bond that can exist over an extended period of time, and are based on proof of positive and contributing actions. This approach could also be used for recruiting research participants. Community members who trust a Latino agency are more likely to trust the research institution that has taken the time to develop a relationship of *confianza* with the agency.

Related Topics

- ► Hispanics
- ► Latinos
- ► Physician–patient communication
- ► Respeto

Suggested Readings

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Convention Against Torture

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The Convention Against Torture (CAT) is the common name for Article 3 of the United Nations Convention Against Torture and Other Forms of Cruel, Inhuman or Degrading Treatment or Punishment. The CAT as enacted in the United States provides that an individual will not be returned to a country where there are substantial grounds to believe that the individual will be tortured.

Torture is defined as any act by which severe pain or suffering, whether physical or mental is intentionally inflicted on a person. It does not include pain or suffering incidental to lawful sanctions, including the death penalty. However, the regulations state that lawful sanctions that "defeat the object and purpose" of the CAT can be considered torture. In other words, an individual can argue that some punishments for crime rise to the level of torture even if they are lawful punishments for crimes.

An individual can receive CAT relief based upon past torture and the possibility of future torture. Health care professionals trained in recognizing the mental and physical signs of torture are priceless when it comes to developing a successful CAT application. Although some individuals may have obvious physical scars, some individuals inflicting torture have become more sophisticated in developing techniques such as water-boarding, that do not leave a physical sign. Mental health professionals who can write an authoritative statement as to whether, in their opinion, a victim has suffered past torture, are extremely important to the preparation of a good case.

CAT relief differs considerably from asylum. In asylum, an individual must establish a well-founded fear of persecution based upon race, religion, nationality, political opinion, or social group. Well-founded fear is often described as a "reasonable person" standard – a reasonable person in that situation would be afraid. CAT relief requires establishing that it is "more likely than not" that an individual will be tortured – a higher standard than for asylum. In addition, CAT does not require showing that the torture is because of one of the five grounds for asylum.

Individuals granted refugee or asylee status are eligible to apply for permanent resident status after being in the United States for 1 year. Individuals granted CAT relief are not eligible for permanent resident status. CAT relief maintains the person under the jurisdiction of the Executive Office for Immigration Review (Immigration Court), in a status known as withholding of removal. Individuals in such status cannot leave the United States except in rare circumstances, although they are eligible for work authorization. These individuals are deemed still to be in removal proceedings. Normally, individuals granted withholding of removal are not imprisoned or otherwise detained by the government.

Individuals are ineligible for asylum if they are guilty of certain serious crimes, have themselves persecuted others, or are a security threat. However, such individuals remain eligible for deferral of removal pursuant to the CAT. Deferral of removal is more limited than withholding of removal discussed above. Under deferral of removal, the individual can be imprisoned in the United States. Most individuals who are ineligible for withholding of removal are subject to mandatory detention by the government. Such detained individuals are entitled only to have their detention reviewed at regular intervals to determine if the reason for detention remains. In effect, some applicants for CAT relief are accepting life imprisonment in the United States, rather than return to the country of citizenship.

At any time, the government can move the Immigration Court to reopen a deferral of removal case based upon new evidence that the individual will not be tortured, including diplomatic assurances from the individual's country of citizenship. The Immigration Judge is required to hold a de novo hearing, meaning a review of all of the underlying facts and the relevant law, on whether or not the individual still qualifies for relief. The individual in question also can move to have the deferral of removal order terminated – he or she would then be deported to the country of citizenship.

CAT relief is defensive in nature. The regulations provide that the Immigration Judge is the only person who can consider a claim for relief under CAT; unlike asylum, there is no administrative method to apply for CAT relief. Asylum applications generally must be filed within 1 year of an individual's entry into the United States; however, there is no time limit for applying for CAT relief.

Related Topics

- ► Asylum
- ► Detention
- ► Refugee
- ► Torture

Suggested Resources

United Nations website. http://untreaty.un.org/cod/avl/ha/catcidtp/catcidtp.html

Convention on the Prevention and Punishment of the Crime of Genocide

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The Convention on the Prevention and Punishment of the Crime of Genocide was the first human rights treaty that was adopted by the General Assembly of the United Nations on December 9, 1948. The key provision of this Convention is that genocide is declared to be a crime under international law and is punishable regardless of whether it is committed in a time of peace or in a time of war. This distinction is important as genocide is seen as different from "crimes against humanity," whose legal definition specifies wartime.

Genocide (from Greek: *genos*, people or race; and Latin: *caedere*, to kill) is the systematic attempt to destroy and/or eradicate an ethnic, national, racial, or religious group. The term was used for the first time by the Polish writer Raphael Lemkin in 1944, in his work about the Nazi occupation of Eastern Europe. Lemkin, who fled from Germany during World War II to the USA, drafted the International Convention on the Prevention and Punishment of the Crime of Genocide.

Yet, although the term “genocide” as such is new, the practice of extermination of entire groups or population is common throughout the entire history of mankind. It was the Holocaust, the systematic killing of Jews, Gypsies, Slavs, political opponents, and the so-called social deviants like homosexuals and the mentally disabled in the Nazi extermination camps that prompted the call for international legislation to prohibit and punish such deeds. The development of legal thinking and procedures after World War II, especially about war crimes and crimes against humanity, paved the way for the development and the adoption of the Genocide Convention. Even if the world was still in shock after the horrors of the Nazi regime, it took a while until the Convention was ratified by the necessary 20 States, and entered into force in January 1951.

As of today, 140 States have ratified the Genocide Convention, a treaty that is in line with the priorities set by the United Nations and the modern human rights movement, aiming to eradicate racism and xenophobia. More importantly, it stresses the role of criminal justice and accountability in the protection and promotion of human rights. The Convention is one of the important pillars of the framework of protection of national, racial, ethnic, and religious minorities from various threats to their very existence.

Unlike other human rights treaties, there is no specific monitoring body or expert committee but it contains the provision that any Contracting Party may call upon the competent organs of the United Nations to act under the United Nations Charter in any way that may be suitable to prevent and suppress acts of genocide.

The Convention is relatively brief, with just 19 short articles. The Preamble of the Convention affirms that genocide is contrary to the spirit and aims of the United Nations and is condemned by the civilized world, since genocide has inflicted great losses on humanity at all periods of history. It also stresses that international cooperation is necessary “to liberate mankind from such an odious scourge.”

The first Article provides the important clarification that genocide can be committed “in time of peace or in time of war” and that it is a distinct crime from crimes against humanity. The crime of genocide is defined in the second Article, as any of a number of acts which are committed with the intent to destroy, either as a whole or in part, a national, ethnic, racial, or religious group, killing members of the group; causing serious bodily or mental harm to members of the group; deliberately inflicting on the group conditions of life calculated to bring about its physical destruction in whole or in part; imposing measures intended to prevent births within the group; and forcibly transferring children of the group to another group.

According to the third Article, not only is genocide to be punished but also the conspiracy, the direct or indirect incitement, attempt or complicity to commit genocide. The fourth Article states that there should be no immunity since persons that commit genocide or any of the acts enumerated previously should be punished regardless, even if they are constitutionally responsible rulers, public officials, or private individuals.

The fifth Article contains provisions about the legislation that Contracting Parties have to adopt in order to provide effective penalties for persons guilty of genocide, or any of the other acts enumerated in the third Article.

The sixth Article of the Convention stipulates that any person charged with genocide shall be tried by a competent tribunal of the State in the territory in which the act was committed, or by an international penal tribunal that may have jurisdiction over the Contracting Parties. The next Article stipulates that genocide shall not be considered to be a political crime for the purpose of extradition and, in such cases, Contracting Parties pledge themselves to grant extradition.

Pursuant to the eighth Article, any Contracting Party may call upon the competent organs of the United Nations to take such action under the Charter of the United Nations as they consider appropriate for the prevention and suppression of acts of genocide or any of the other acts enumerated in the third Article.

The following Article stipulates that any disputes between the Contracting Parties relating to the interpretation, application, or fulfillment of the Convention, including those relating to the responsibility of a State for genocide or for any of the other acts described previously, shall be submitted to the International Court of Justice at the request of any of the parties to the dispute.

Although it is considered a pillar of the framework of international humanitarian rules, the Genocide Convention has been criticized for its limitations. Due to the vague and unclear definition of genocide, prevention and punishment of genocide is difficult. Moreover, Article XI requires that the members of the UN have to ratify the document, but there are many States which did not ratify it, for nearly 50 years. On the ground that the Convention violates sovereignty, the USA did not ratify the convention until 1988. At the time of its ratification, the US stipulated that the USA would not be subject to the jurisdiction of the International Court of Justice and that US laws would take precedence over the Convention. Nevertheless, in 1990, the US Congress passed the Immigration and Nationality Act (INA) (8 U.S.C.A. § 1182), that stipulates that aliens guilty of genocide are excluded from entry into the USA, or deported when discovered.

Another flaw is that there is no committee or monitoring body for this Convention to ensure implementation and compliance, like the Convention on the Elimination of All Forms of Discrimination Against Women, International Covenant on Civil and Political Rights, and United Nations Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment. After several requests for setting up a treaty body, by adopting an additional protocol to the Convention, or passing a resolution of the General Assembly, in 2004, the Secretary General of the United Nations established the high-level position of Special Adviser on the Prevention of Genocide.

The limitations of the Genocide Convention are obvious since, in spite of its provisions that State Parties should "prevent and punish genocide," millions of people still have died without intervention in Cambodia, the former Yugoslavia, the Democratic Republic of Congo, Sierra Leone, Rwanda, and Darfur.

Related Topics

- ► Ethnic cleansing
- ► European Court of Human Rights
- ► Holocaust
- ► Human rights
- ► Torture

Suggested Readings

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COPC

► Community-oriented primary care

Coping

► Resilience

Cortisol

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Cortisol is a hormone produced by the zona fasciculata of the adrenal cortex. There are two adrenal glands, each of which weighs about 4 g, located on top of the kidneys. Each gland is composed of two distinct parts: the adrenal medulla and the adrenal cortex.

The adrenal medulla secretes the hormones epinephrine and norepinephrine and the adrenal cortex secretes a group of hormones called the corticosteroids produced by three different layers of the medulla.

The zona glomerulosa secretes aldosterone, the zona reticularis secretes adrenal androgens, and the zona fasciculata secretes the glucocorticoids cortisol and corticosterone. These hormones are synthesized from cholesterol and have similar formulas but different functions.

Cortisol is referred as the “stress” hormone because it plays an important role in the stress response. Together with norepinephrine, cortisol is released during times of threat and is critical to survival. Cortisol aids in survival by redistributing energy when an individual is under attack. To do so it suppresses functions not needed for immediate survival, including reproduction, immune response, digestion, and pain. Cortisol promotes vital functions, including heart rate and blood pressure, while shunting energy to the brain and muscles to speed up thought processes and fight or flee.

However, chronic high levels of cortisol cause gastric ulcers, thinning of the bones, and possibly brain damage. In animals, stress has produced a reduction of neurotrophins which in turn decreases the growth of new neurons in the hippocampus. These actions may affect memory and mood leading to depression and feelings of fatigue. Stress also impairs the immune system which can lead to an increase in infections and possibly increase rates of cancer.

Stress also affects the cardiovascular system and patient suffering depression and heart disease have five times higher risk of sudden death than the patients without depression.

Persons suffering posttraumatic stress disorders are also predisposed to cardiac problems.

The disorder of hypercortisolism is called Cushing’s syndrome and the one causing hypocortisolism is known as Addisson’s disease. These are serious conditions that need immediate treatment. The main problems with Addisson’s disease are electrolyte imbalance, inability to regulate blood pressure, muscle weakness, inability to tolerate stress leading to cardiac problems, neurological problems, shock, and death.

The Cushing’s syndrome is characterized by mobilization of fat from the lower part of the body with extra deposition of fat in the thoracic and upper abdominal regions. Also there is an edematous appearance of the face with acne and hirsutism. Persons suffering Cushing’s syndrome are feeling weak and are susceptible to infections.

Increases in cortisol levels have been associated with the development of mental disorders, especially depression. The immigration process, legal or otherwise, is a stressful situation which will produce an increase in cortisol levels.

The development of mental disorders is the final outcome of a complex series of events in which cortisol is part of the process and methods of reducing the levels of cortisol may be beneficial in the management of these disorders.

Besides these disorders, there are different factors affecting cortisol levels. Among the ones increasing levels besides stress are ingestion of caffeine, sleep deprivation, anorexia nervosa, some oral contraceptives, and prolonged physical exercise. Factors reducing cortisol levels are music therapy, massage therapy, laughing and the experience of humor, and in general relaxation exercises. The ingestion of omega-3 fatty acids can also lower levels of cortisol.

Related Topics

► Job stress
► Posttraumatic stress disorder
► Social stress
► Somatic symptoms
► Stress

Suggested Readings

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Council for International Organizations of Medical Sciences

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The Council for International Organizations of Medical Sciences (CIOMS) was formed in 1949 by the World Health Organization (WHO) and the United Nations Scientific and Cultural Organization (UNESCO). CIOMS strives to facilitate and promote international activities in the biomedical sciences. In furtherance of this goal, CIOMS has issued *International Guidelines for Biomedical Research Involving Human Subjects* and *International Guidelines for Ethical Review of Epidemiological Studies*. Each of these documents addresses issues relating to informed consent, risks and benefits, vulnerable populations, and ethical review.

Several of the guidelines in each of these CIOMS' documents are relevant to the conduct of research with immigrant populations. For example, Guideline 13 of the *International Guidelines for Biomedical Research Involving Human Subjects* advises that special justification is required for inviting vulnerable individuals to participate in research and that their rights and welfare must be protected. Refugees and displaced persons are explicitly recognized as vulnerable in the context of conducting research in the commentary to this guideline. Individuals who are politically powerless are also identified as vulnerable; this could encompass individuals who are illegally present in a country and individuals who have recently immigrated to a country and are unfamiliar with its culture or systems. Similar provisions exist in the *International Guidelines for Ethical Review of Epidemiological Studies*.

Although other Guidelines in each of these documents do not refer specifically to immigrants, they are clearly relevant to the conduct of research with immigrants. These relevant provisions include the proscription against undue inducement to participate in research, the provision of information to prospective participants in language that is understandable, and the need to balance the risks and benefits of participation. Depending upon the focus of the study and the immigration status of an individual, the balance of risks and benefits for immigrants may be significantly different from that for native-born individuals. For example, a breach of confidentiality in the context of a US-based questionnaire study relating to drug use could potentially lead to jail or imprisonment for some participants, but to deportation for only noncitizen immigrant participants.

Related Topics

- ▶ Ethical issues in research with immigrants and refugees
- ▶ Helsinki Declaration
- ▶ Informed consent
- ▶ Nuremberg Code

Suggested Readings

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Suggested Resources

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Cross-Cultural Health

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Culture is defined by a group's distinct values, norms, and beliefs, including understanding of life and death.

It is shared among individuals who identify themselves similarly. Culture is passed down from generation to generation, and is a core part of every individual. Communication style, spirituality, familial roles, sense of autonomy versus collectivism, and behavioral and social norms are among the many factors that comprise one's identified culture. These factors help to shape one's understanding of health, what causes illness, what appropriate responses to illness are, and how illness should be treated. Thus, culture can profoundly impact how one approaches health care, from individual interactions with providers and staff to the larger exchange with health care systems and organizations.

What Is Cross-Cultural Health?

Cross-cultural health can be defined as an approach to health care that attempts to reconcile differing cultural values, behaviors, and practices about health. In this way, it strives to accomplish effective health care across different cultures. For its providers, cross-cultural health care involves both an awareness of one's own attitudes and beliefs, and an awareness of others' attitudes and beliefs, about health and illness. Cross-cultural health at an individual level entails everything from how a provider and patient interact; how they negotiate screening, diagnostic, and treatment interventions; how education is communicated; and how long-term relations are maintained between them.

At the systems level, cross-cultural health encompasses issues at the community, public health, and organizational level. Pertinent tasks include management of illness but also health promotion, and screening and education for illness prevention, including administering preventive medications to varied population groups. Examples include cultural attitudes toward blood pressure screenings and administration of the H1N1 (influenza) vaccine to those at risk. Also included in cross-cultural health at the systems level are the various strategies health organizations undertake to promote better relations with their culturally diverse patient populations. This includes education of providers and other care team members as well as outreach to patient groups. A necessary task in effective cross-cultural health care is the examination of those factors that pose barriers to care across cultures. Much of the literature to date focuses on the negative health impacts of cultural differences. Relatively less literature exists about how different cultural beliefs (which may deviate from biomedical models) may be protective in terms of health.

What Is the Relevance of Cross-Cultural Health?

In the USA, as well as in almost every country in the globe, the population is becoming increasingly diverse. For example, by the year 2030, the ethnic minority population in the USA (African Americans, Hispanics, Asian/Pacific Islanders, Native Americans, and Alaskan Natives) will grow from 28% to over 40% of the population. In the decade of 1990–2000, the number of people in the USA speaking a language other than English at home increased from 31.8 million to 47.0 million. Currently, 21 million Americans are limited in English proficiency. Linguistic differences, however, are just one facet of cross-cultural health care. Beliefs and attitudes, including religious, have been shown to have a large impact on an individual's health behaviors, according to studies on cross-cultural health care. In his formative anthropologic work on culture, illness, and care, Kleinman states that "70 to 90 percent of all self-recognized episodes of sickness are managed exclusively outside the perimeter of the formal health care system." This suggests that, with the steady increase in the minority populations in the USA in the past 30 years, many more individuals than ever before may seek out culturally based resources (family/friends, religious authorities, traditional healers, self-help groups, etc.) prior to seeking help from formal health care providers. In part, this may be due to a desire to avoid encounters that could potentially be costly, difficult, uncomfortable, or frustrating, and in the worst cases, offensive.

Where Do We See Cross-Cultural Health Care Today?

Cross-cultural health is carried out in a wide variety of settings today – outpatient community clinics, private health clinics, local hospitals (emergency room, inpatient units), offices of social work and other health care staff, disease prevention clinics (tuberculosis, sexually transmitted disease clinics), community health screenings, and specialized settings (substance abuse clinics, domestic violence shelters, homeless shelters, nursing homes, hospices, and rehabilitation clinics).

Cross-cultural health care also takes place in pharmacies, where patients are often educated by pharmacists just prior to receiving their medications.

Challenges of Cross-Cultural Health Care

Cross-cultural health care at its best will work towards decreasing the prejudices, misunderstandings, and assumptions between providers and their patients to enable care that is both meaningful and effective. Imagine the scenario of a newly immigrated young Chinese woman with reproductive difficulties presenting to a Los Angeles community clinic. One can imagine the possible frustration she and her family may be experiencing in the couple's futile attempts to conceive a child. Childbearing, across all cultures, is indeed a valued life task. However, this woman's distress may be more profound than we might imagine given her cultural context. Traditionally, in some Chinese subcultures, the ability to bear a male child is highly valued. It becomes clear that the initial interface between a provider and this patient and family will be critical in addressing their distress and concerns, and in clarifying their understanding of a possible physical problem. They may not accept, if in fact she is infertile, that she cannot have a child, much less a male child. Frustration, grief, understanding, and support will need to be skillfully managed in the context of what infertility means to the patient and family in their Chinese subculture.

How Do We Know We Are Achieving Cross-Cultural Health Care?

Cross-cultural health care, at its best, is a candid exploration and negotiation of culturally based beliefs about health and illness, which leads to a reconciliation of attitudes about how best to achieve good health outcome. It can thus be viewed as happening on a continuum. Reaching the goal would be defined by achieving optimal screening, detection, and management of a patient's illness and preventing future illness. It would also be defined by an enduring relationship built on trust, increased understanding of differences, and mutual respect. Differing views about health and illness will not be compromised but rather enhanced in an ongoing dialogue between health care provider and patient, or between a health care system and patient population. A critical component of cross-cultural health is cultural competence – defined as the ability of a provider or health care system to deliver care that is culturally appropriate, well informed, and tailored for the recipient of the care.

There are a variety of ways to conceptualize cross-cultural health. Structurally, it can be considered at both an individual level and at a systems level. As the individual level is discussed in detail in a separate chapter on cross-cultural medicine in this encyclopedia, it will be discussed only briefly here.

Cross-Cultural Health at an Individual Level

At the individual level, cross-cultural health is the approach to care in which a provider or other health care member engages with a patient in an exploratory, nonjudgmental way so as to elicit the patient's understanding of his/her health concern. This involves learning about the factors that affect the patient's presentation, including cultural and social factors. This is best accomplished by structured questions targeted at eliciting the patient's views about his/her illness, treatment options, and prognoses (the patient's explanatory model for illness) as well as the patient's fears and concerns. Economics, ethnicity and acculturation, spiritual beliefs/practices, family and personal dynamics (gender role, parental roles, individualism, collectivism), and academic or occupational demands all may impact health-seeking behaviors and attitudes toward health care. Culturally based gender roles in a family, for example, may be instrumental in defining how health discussions take place and how rapport is built with the provider. Cultural health beliefs ("folk beliefs") may also help or hinder one's health-related behaviors, including treatment adherence. Thus, providers of cross-cultural health care must listen and demonstrate self-awareness to open the door to a genuine discussion between himself/herself and a patient.

Cross-Cultural Health at a Systems Level

At a systems level, cross-cultural health care works at a larger scale and targets populations and communities. Whether in private or public health organizations, aims are to identify and negotiate potential barriers to care by examining trends among various groups in their health-related behaviors. Linguistic and cultural differences are bridged via written or oral communication aids, such as brochures, community screenings/education, and liaison persons such as translators or interpreters. Disparities in health care for US ethnic minority populations persist not only as increasing disease burden by minority populations but also in the level of satisfaction expressed by minority patients. The systems-based approach is particularly important because it is often the case that minority patients from immigrant populations are first seen in larger community or private hospitals rather than in smaller scale clinics. Because cultural factors impacting health care are multidimensional, cross-cultural health strategies at a systems level must aim to negotiate potential barriers in multiple ways.

Strategies for Systems-Based Approach to Cross-Cultural Health Care

Some of the ways that health care institutions and organizations can exercise cross-cultural health care involve application of tasks applied at the individual level. However, at a systems level, strategies can optimize ways to reach the masses by understanding group identity and shared thinking processes. By appealing to common characteristics among larger groups of people, important health information can be disseminated and health behaviors impacted. The strategies can target primary, secondary, and tertiary prevention and thus are a potential means to impact health care globally.

Examples of several strategies that can be employed at a systems level are:

- Mandated training of health care providers, employees, and trainees in cultural competence
- Specific outreach strategies for the prevention and treatment of illness, which include:
  - Peripheral strategies to educate and appeal to specific cultural groups
  - Evidential strategies to enhance a cultural group’s perception of the relevance of specific health issues
  - Constituent-involving strategies drawing on the experience of particular group members
- Linguistic strategies to make health care more accessible and effective
- Sociocultural strategies that address health issues in the context of larger social and cultural considerations

Strategies for a Systems-Based Approach: Mandated Training in Cultural Competence

Within larger health organizations, a tendency can develop for providers, staff, and management to generalize about behaviors of minorities. These tendencies are often reinforced through repeated experiences with similar presentations. For example, health employees might assume Hispanic or Asian patients manifest psychiatric complaints as physical ones, or that Asian male patients underreport pain symptoms. They may not fully appreciate expressed complaints if they perceive that some patients overreport symptoms. Understanding the meaning of an illness to the patient in his/her cultural context requires that providers and staff not make assumptions based on stereotypes. To achieve effective cross-cultural care, it is imperative to understand common cultural trends but also to approach each patient as a unique individual. Part of this task entails differentiating subculture from culture. An older African American man from a rural town in Georgia may hold different beliefs about health care than a young African American man living in Los Angeles, California. Also, an African American and a Vietnamese American may hold similar views about health issues by virtue of being longtime residents in the same community. Because it is not possible to know about every culture and subculture, the best strategy is to keep an open mind and explore belief systems by nonjudgmental inquiry.

The methods of such an inquiry and the appreciation for this kind of exploration can be taught early in professional training. Hiring minority faculty/teachers with firsthand knowledge and experience, implementing core requirements in cultural competency (didactics, clinical experiences), and evaluating standards for meeting requirements are some of the ways cross-cultural health practices can be taught. For large health care organizations, similarly structured employment training in cultural competence can be implemented. Hiring of multiethnic staff and experiential workshops with routine evaluation of effectiveness are additional ways to standardize competency in cross-cultural health care. Such training can be overseen by formal committees with clear competency guidelines and reassessments as necessary.

The focus of the training should be multidirectional and not unidirectional. There is an interaction of different cultural beliefs of the providers and the recipients of health care. The providers' culture includes the medical culture with its own belief system about the doctor–patient relationship, attitudes about other systems of care, and adherence to treatment.

In addition, providers bring to the table their own family cultural background. Cross-cultural health care at a systems level should strive toward a meeting of minds. It is a negotiation of the belief systems and explanatory models of patient/family and provider, but also of the health care system at large.

Specific Outreach Strategies: Peripheral, Evidential, and Constituent-Involving Strategies

Kreuter, Lukwago, Bucholtz, Clark, and Sanders-Thompson discuss specific strategies to promote health care in cross-cultural settings using culturally informed tactics. These strategies can be applied to many different cultures. As such, they are a compelling means to enable outreach to immigrant and other minority populations.

1. *Peripheral strategies* use design in a deliberate way to create and distribute materials and promote health programs that will appeal to specific groups. As an example, to communicate the importance of early detection of breast cancer to a Mexican immigrant population, the use of bright primary colors with bold messages and images may be more effective than utilizing the light pink signature ribbon symbol. Information delivered this way would likely appeal to the Mexican cultural aesthetic of colorful schemes and patterns. Bold, clear messages may be more consistent with cultures expressing higher emotive affect. For cultures whose family hierarchy is matriarchal, patients may respond best to brochures with images depicting older women educating younger family members. Peripheral strategies thus utilize specific images, themes, designs, lettering, and color schemes to appeal to cultural aesthetics as well as belief systems. In essence, it is the use of marketing to achieve a cross-cultural health goal.
2. *Evidential strategies* enhance a cultural group's understanding of the relevance of a particular health issue. These strategies work at a systems level by highlighting health epidemiology, that is, diseases specific to a given cultural group. By presenting information about the prevalence of high blood pressure in African Americans or the prevalence of strokes in Japanese Americans, the intent is that the statements will raise the level of concern and perception of individual vulnerability to the health problem. Kreuter references Weinstein's precaution adoption model – the notion that perceiving others like you have this problem can stimulate one's own decision to act to prevent the problem for oneself.
3. *Constituent-involving strategies* draw on the experiences or insights of specific members of a group being targeted for health education. These individuals serve as a liaison between other group members and the health care organization or system. They may be cultural leaders, folk healers, or trained paraprofessionals. As a member of the target group, they help to contextualize health care in culturally specific ways for both other group members and for the health care organization. By enhancing communication bidirectionally, these individuals can promote trust and understanding in health care discussions. They can offer insights into preferred strategies, communication styles, family dynamics, and other factors that may influence the patient's or target group's approach to health care. Finally, they may bridge overt language gaps.

Linguistic Strategies to Make Health Education More Accessible and Effective

Rogler et al. in 1987 appropriately called linguistic accessibility "the lowest common denominator of cultural sensitivity." Language-related strategies in cross-cultural health may seem obvious and fundamental but can be complex because they must be carefully integrated with sociocultural context. Also, current strategies are still contending with problems regarding consistency and standardization of quality.

In an overview of strategies to overcome barriers, Sherry Riddick discusses several important ways that health care organizations and systems can address language and cultural barriers. She describes the use of bilingual/bicultural providers, bilingual/bicultural health workers, employee language banks, professional interpreters, and written translation materials as key strategies. However, there are many subtle challenges entailed in the use of these resources.

Bilingual/bicultural providers: Riddick points out that even when providers and health care workers speak the patient's language, issues of credibility and trust arise.

Linguistic skills of the provider or health care worker do not equate to competency of communicating health information in a culturally appropriate manner. There is a need for standardized evaluation of linguistic skills, competency in health knowledge, and cultural appropriateness.

Bilingual/bicultural health workers: With bilingual workers, their utility is multifold – they have the potential to provide outreach, to promote community participation in the health care system, and to educate providers about cultural awareness. Their role in the system is limited however if they are not situated with primary providers or larger organizations. Often, they work in parallel with the system but in a different setting, that is, at an external case managing agency. This can lead to a breakdown in communication, which may negatively impact patient care and perception of care.

Employee language banks: Language banks are in-house employees used for interpreting or translating, in addition to their regular work duties. This strategy has potential economic and health benefits. However, such an arrangement is prone to abuse of employees, who may be pulled from their usual duties to provide interpreting services. These individuals may lack formal language training, which can lead to dangerous miscommunication about a health problem, diagnosis, or treatment. Successful use of language banks would require that systems formalize the use of such employees by providing the appropriate training, job descriptions, and compensation.

Professional interpreters: In his systematic review of the impact of medical interpreting on quality of health care, Flores concluded that the most rigorous studies on patient satisfaction have shown highest satisfaction with bilingual providers and trained telephone interpreters. Ad hoc interpreters (family, friends, nonmedical or untrained staff) resulted in significantly lower patient satisfaction. Patients who need but do not get interpreters have the lowest satisfaction. Thus, a key determinant in the success of cross-cultural health care will be improvements in linguistic accessibility.

Sociocultural Strategies, Considering Health Issues in a Social and Cultural Context

These strategies may best be described as culturally specific approaches to health care. Horky and Becker define cultural competence as possessing the set of values, beliefs, and practices that enables effective work across cultures. In this, they stress the importance of having the ability to honor the beliefs, language, interaction styles, and behaviors of patients but also the staff providing the care. Cross-cultural health care is therefore a process. It is a dynamic, ongoing relationship between patients, providers/staff, and the health care system at large.

Sociocultural strategies are categorically very broad. Social factors can include but are not limited to a patient's family and social supports, insurance status, occupational status, economic status (including access to resources such as transportation), health and nutritional status, and recreational life. Cultural factors include acculturation, spiritual beliefs, interpersonal dynamics, and beliefs about health, illness, and mortality. Sociocultural strategies would incorporate all of these factors into health care discussions to help bridge communication and understanding between the patients and the health care teams.

Example: Applying Sociocultural Strategies to a Minority Group

In order to conceptualize how these strategies can be effective, it may be useful to focus on a specific cultural group. The African American population is a diverse group. Every geographic region has unique subcultures with variability in practices and beliefs, particularly if religious affiliations influence beliefs. In applying sociocultural strategies at the systems level, however, the focus should be on identifying key similarities that may be generalizable across a majority of the African American population. Literature on the African American population has shown consistent findings about the larger culture among patient populations – strong emotional impacts of a history of slavery and the Tuskagee study, a history of racial disparity in health services and economic opportunities, poor health literacy, a tendency to advocate home remedies, and the strong role of religion and faith in beliefs about health and illness.

An understanding of the key influences in a cultural group's history and evolution in their country of residence allows providers and organizations to tailor approaches to care. For example, for the African American patient population, providers can be trained to inquire sensitively about nonbiological beliefs about illness (folk treatments) and attitudes rooted in spirituality and church affiliation. They can also explore for any negative health encounters in the past, which may impact the patient's approach to health care today. This would include but is not limited to past exposure to prejudicial treatment. At a systems level, health care organizations can formalize alliances with community churches to promote health screening and educational seminars. Clergy, for example, may be key members of the health care team for an African American patient admitted with end stage kidney disease. Clergy may be instrumental in the patient's and family's coping with decisions about dialysis and need for long-term care.

There are numerous ways in which organizations can practice and improve cross-cultural health care by taking the time to learn the history and belief systems of different cultural groups in their community. Ongoing epidemiologic research will continue to be a vital way for health care organizations, particularly managed care, to allocate resources so that quality health care is ensured to minority populations in ways that respect their culture and beliefs.

Conclusion

Cross-cultural health presents a rich arena for improvements in overall health care. Furthering the community's understanding of what it is and how much it can impact the well-being of all our populations is a key task for the future.

In many US health professional training programs, cross-cultural curriculums are already implemented and being evaluated for their efficacy. Providers and health care systems will face the challenge of keeping up with the diverse populations whom they serve, as minority populations increase exponentially in the next half century. No longer will it be enough to acquire biomedically based understandings about health and illness (medical competence). Cultural and nonbiomedical understanding about health and illness (cross-cultural competence) will play an increasing role in health care competency.

Related Topics

► Barriers to care
► Communication barriers
► Cross-cultural medicine
► Cultural competence
► Cultural humility
► Culture-specific diagnoses
► Explanatory model of illness
► Health beliefs
► Multiculturalism
► Physician–patient communication
► Public health

Suggested Readings

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Suggested Resources

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Cross-Cultural Medicine

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Culture is commonly defined as shared beliefs and attitudes of a group. In the diverse world we live in, currently, culture undoubtedly shapes ideas of disease causation and what is considered to be acceptable treatment in accordance with a person's worldviews and religious beliefs. Many patients find comfort in their worldviews which are internally consistent. The clinical encounter will vary depending upon cultural understanding of health and illness. The expectations of the roles physicians play in one's life also differ depending on what culture you are from. Lastly, culture and ethnicity affect the prescribing practices of physicians' and patients' acceptance of medications.

Culture and Concepts of Health and Illness

Each culture has beliefs about how bodies function normally and abnormally. Gaining insight into a patient's understanding of what constitutes disease and the illness process is the first step in appreciating the patient and developing a therapeutic alliance. For example, the traditional Han Chinese system conceives of human beings as being part of the universe that is regulated by the opposing forces of *yin* and *yang* (male/female, hot/cold, wet/dry, dark/light, earth/heaven) which are always changing. Good health and well-being are maintained by finding a balance between *yin* and *yang* and diseases are treated by restoring this balance. Asian cultures believe that foods have "hot" and "cold" properties and associate these with the nutritional qualities, medicinal value, and healing power of most foods. This concept of health exists in other Asian and Latino health belief systems as well.

Traditional Mexican beliefs of health include the importance of balancing hot/cold and wet/dry concepts that were probably influenced by traditional concepts of native peoples, such as the Mayans and Aztecs, and by the colonialist Spaniards whose New World concepts originated with Hippocrates' theory of disease and the four humors. The traditional holistic system of healing in India, *ayurveda* ("science of life"),was built on the ancient knowledge in the Atharaveda text about the three humors: *Vita, Pitta* and *Kapha* more than 3,000 years ago. Each person's prescribed lifestyle of diet, exercise, and meditation is designed to maintain his or her specific balance between the three humors. The focus is on establishing and maintaining balance of the life energies within the individual, rather than focusing on particular symptoms. Ayurvedic medicine recognizes that each individual has a unique constitution and thus, treatment and prevention is based on the individual, not on illness, disease, or symptomatology. This system of healing has influenced other Asian systems, such as the Thais.

Every healing system has beliefs about how the natural realm is connected to the social and supernatural aspects of life and how these beliefs relate to health, illness, and healing. The *natural realm* reflects the connections between people and the earth, such as soil, plants, water, air, and animals. The *social realm* refers to the connections between people of different ages, genders, lineages, and ethnic groups. The *supernatural realm* is characterized by the connections between the human world and the spiritual world and includes religious beliefs about birth, death, and the afterlife. Religion and spiritual beliefs are some of the strongest influences on health systems. For example, Chinese medicine is interwoven with and influenced by Taoism, Ayurvedic medicine by Hinduism, and Tibetan medicine by Buddhism. People's religious beliefs are intertwined with their interpretations and experiences of health and disease. Many African American women, for example, across all socioeconomic levels, believe in the power of prayer and God's healing power to treat and cope with breast cancer. This belief can often lead to a delay in seeking professional health care despite being an important source of emotional support for many African Americans.

In trying to understand how the patient views a particular illness, the physician should ask the patient what the illness means to him/her and what treatments the patient is currently undergoing. It is important to elicit pertinent history by inquiring about what alternative therapies the patient has already tried and what providers he/she has already seen. There is often a "hierarchy of care" in many cultures, where patients would first try home remedies, prior to seeking care from the folk sector (traditional healers or religious leaders), and lastly approaching the professional sector (such as a physician) only when all other therapies have failed.

In the popular or lay sector of healers, treatments are usually provided by family members or by the patient and may include practices such as massage, coining, cupping, burning, incantations, medicines, or wound dressings. The folk sector of healers usually consists of priests, shamans, herbalists, or bonesetters. Treatments are usually culturally integrated and congruent and require some sort of payment usually in the form of gifts which may be monetary, material items, or involve exchange.

The professional sector of healers includes conventionally trained allopathic medical personnel (physicians, nurses, dentists, pharmacists) and those trained in complementary and alternative medicine (acupuncturists, homeopaths, Ayurvedic and Chinese medicine specialists, etc.). Formal education and licensing are required and an apprenticeship may be involved. Monetary payment is standard, usually paid by third-party insurance or in the form of cash payments. Healers from each sector may refer, ignore, or compete with each other. In many countries, various folk healers exist in parallel providing specialized or generalized services.

Arthur Kleinman, a prominent American psychiatrist and one of the world's leading medical anthropologists, calls people's ideas about an illness their explanatory model. Explanatory models consist of five components: (1) timing and onset of symptoms, (2) pathophysiological processes, (3) the etiology of the condition, (4) natural history and severity of illness, and (5) appropriate treatments. The ill person, family members, medical providers, and social networks have their own explanatory models about the illness, which may be complementary or contradictory. The more the agreement that exists between explanatory models of all parties involved, the less likely there is conflict. Kleinman et al. designed eight questions to elicit patients' explanatory models: (1) What do you call the illness? (2) What do you think has caused the illness? (3) Why do you think the illness started when it did? (4) What problems do you think the illness causes? How does it work? (5) How severe is the illness? Will it have a long or short course? (6) What kind of treatment do you think is necessary? What are the most important results you hope to receive from this treatment? (7) What are the main problems the illness has caused you? (8) What do you fear most about the illness?

Cross-Cultural Care

Patient role is influenced by culture, especially in relating to the clinician and adhering to treatment recommendations. There might be unique feelings toward the clinician related to the perceived cultural orientation of the clinician based on racial and power differentials. Patient role and feelings, in turn, affect the beliefs and expectations about the therapeutic alliance and the treatments prescribed by the clinician. Clinicians may also be affected by their perceptions of a patient's illness based on racial or ethnic characteristics, which can influence their diagnosis of the illness and beliefs about likely treatment response. They might perceive patients from certain ethnic backgrounds as having more psychopathology, as being more likely to need medications, as needing more "potent" medications, and as having a worse prognosis for their illness. Clinicians have been found to overpathologize symptoms found in African Americans and Hispanics, and possibly to minimize symptoms in Caucasians.

Culhane-Pera and Borkan recommend six fundamentals to assist healthcare professionals in providing quality cross-cultural care. Health care providers must know themselves as cultural beings, know their patients as cultural beings, have attitudes that express respect and engender trust, develop communication skills that facilitate mutual understanding, apply a culturally appropriate interview model during the clinical encounter, and develop cross-cultural negotiation skills that build therapeutic relationships. The goal is to provide medically, linguistically, and culturally appropriate health care interactions irrespective of the cultural background of the patient and provider, in order to deliver excellent health care service with optimal outcomes.

Culture is something that all humans possess and being aware of one's own cultural beliefs, values, and assumptions is extremely important in providing quality health care that is culturally sensitive. Adverse effects on health care delivery can occur when interacting with people of different cultural beliefs, values, and ethics because of one's own biases and unchallenged assumptions. Thus, self-awareness and identification of sensitivities, reactions, biases, and centrisms are key to providing culturally competent care.

Health care professionals should strive to familiarize themselves with their predominant patient population's traditional lifestyles, religions, social structure, histories, and prior experiences with health care, ranging from lay and traditional healing systems to Western biomedicine. Identifying similarities and differences between the patient's traditional health care system and Western biomedicine can be helpful in delivering excellent health care. Expectations of the patient–provider relationship should also be explored in order to identify areas of congruence and incongruence.

Patients in general respond best to health care providers who can express respect and engender trust across cultural gaps in their behaviors with their patients, families, and communities. Respect is a cross-cultural concept that is demonstrated and experienced in different ways. As a health care provider, being culturally humble can facilitate the clinical encounter when dealing with patients of different cultural backgrounds. One needs to commit to self-evaluation and self-critique, to rectify the power imbalances in the patient–physician relationship and to develop nonpaternalistic clinical and advocacy partnerships with communities on behalf of individuals and defined populations.

Different cultural milieus dictate what a phrase, a word, or gesture may mean. When working with different groups, it is recommended that one be familiar with differences in nonverbal and verbal communication for these groups, including eye contact, personal space, gestures, greetings, touching, and body parts. Verbal communication differences must also be addressed. It is important to learn basic greetings and medical words and become proficient in working with interpreters. Generally, it is preferable to work with trained interpreters rather than children, adult family members, or untrained individuals who happen to know the language. It is important to choose interpreters that are acceptable to patients and their families in terms of their sex and ethnic group, and who can translate in the first-person singular style "word for word" rather than phrasing or summarizing. In addition to providing linguistic interpretation, it is helpful if the interpreter can also serve as a cultural broker.

There are several different cross-cultural communication models that can be applied to clinical encounters when interacting with a diverse patient population. The patient-centered model encourages health care providers to explore both the patient's disease perspective and illness experience. One should also strive to understand the whole person in the context of individual development, the family life cycle, and the larger socioeconomic and cultural context of people's lives. It is important to find common ground in the clinical encounter with good patient communication skills that lead to mutual decisions. One can incorporate prevention and health promotion, and enhance the patient–clinician relationships, while being realistic about the realities of clinical medicine.

Lastly, it is important for health care providers to develop cross-cultural negotiation skills. Difficulties may arise from different patient and provider health beliefs, expectations of life-cycle events, desires for treatment, moral values, or ethical principles. If providers have objections to requests from patients or their families for care or refusals of care, they have to decide if they are objecting based on challenges to their personal moral beliefs, personal preferences, or professional integrity. Health care professionals must negotiate treatment alternatives with the patient, family, and possibly community members as well. If negotiation is unsuccessful, the provider must either accommodate the patient or transfer the care to another provider. Challenges to personal integrity may be resolved by utilizing an ethics committee that has community input. To avoid harmful consequences of unintentional biases, physicians must (1) be aware that disparities exist in health care, (2) be aware of their own assumptions and preferences, and (3) take actions so that their biases do not negatively impact care.

The cross-cultural interview is one that requires time and patience. Cultural dynamics such as cultural norms, communication styles, and family dynamics all influence the clinical encounter. A person's concept of time and punctuality, facial expressions, body language, and personal space and touch issues are all relevant factors when interviewing a patient. For example, persons from Latino or African American culture may have a more relaxed sense of time, and schedules are considered less important than personal relationships. Non-Western cultures tend to view time as flexible as compared to Western cultures where time is equivalent to efficiency and considered an important entity. One can explain the importance of punctuality in the Western medical setting if a patient is late.

In the Latino culture, "small talk" can contribute to establishing trust (*confianza* in Spanish) between the patient and the clinician. Patients may frequently nod in agreement or say they understand something even if they do not comprehend. They may avoid asking questions due to embarrassment or respect. In such cases, it is helpful to have patients repeat the instructions in order to verify their understanding. Nodding vigorously may signify respectful attention but not necessarily agreement or understanding.

In Western cultures, eye contact signifies respect and attentiveness; however, in many non-Western cultures, direct eye contact may indicate disrespect of authority and/or sexual interest, and thus, patients may sometimes avoid eye contact with physicians out of respect, especially if they are of a different sex or social status. Clinicians should speak slowly and simply to the patient using concise sentences and a normal tone of voice. They should also address patients by their formal name if they are uncertain of how to address them. In many non-Western cultures, using one's first name as a greeting denotes disrespect, as compared to Western culture, where greeting on a first name basis helps to build rapport and denotes informality. If an interpreter is present, the clinician should speak directly to the patient.

Personal space and the degree of physical touch also differ among various cultures. Western cultures view personal distance as denoting professionalism and objectivity. Latinos may interpret Westerners as being distant while conversing because they prefer more personal space. Some cultures such as Orthodox Jews and people from Islamic sects do not allow opposite sex touching, not even hand shaking. It is helpful for clinicians to explain what they will be doing when working with low-touch societies (e.g., Asians). The physical examination should be conducted in a culturally sensitive manner, noting specific male–female dynamics particular to the patient's background. For example, in some cultures, a chaperone of the same sex must be in the room for a physical exam if the provider and patient are of opposite sex, while in some cultures only a clinician of the same sex as the patient is permitted to conduct a physical exam.

Physical gestures also differ among cultures. The "thumbs up" sign may be interpreted as a profane gesture in Iran. The "okay" sign in North America may be considered obscene in Latin America. Many Asian cultures consider patting a child on its head, exposing the sole of the foot, or pointing with the foot an insult. In many countries of Asia and South America, using the index finger to point or beckon someone is considered rude and disrespectful. Rather, beckoning is done with the palm faced down and all fingers are waved inward. Many cultures consider the left hand "unclean" because it is often used for personal hygiene. Thus, prescriptions and samples should not be given with this hand.

Culture and Medication Response

Ethnicity has been reported to affect medication response due to genetic differences among the different groups affecting drug metabolism and cellular differences in organs such as the brain. The focus discussed here will be on the effect of culture on medication response in nonbiological aspects of medication response such as in the degree of patient adherence, placebo effects of medications, and other behaviors affecting drug interactions including dietary habits and other alternative treatments such as herbal remedies. Variables involved with these nonbiological effects are related to the patient, the clinician, and their relationship; cultural beliefs about illness and medication; and the actual process of giving and receiving medications.

Culture influences personality and behavior patterns; perception of stress and coping style, including manner of utilization of social support; and interaction, including transference, with the clinicians. These variables influence the process and outcome of medical treatment, including medication response. It has been suggested that individuals from cultures that emphasize independence, struggle, and action (typically Western cultures) are likely to require more medication than patients whose personalities are shaped by cultures that emphasize interdependence and social adaptation (typically Asian cultures).

How one reacts to stress and utilizes social support are both thought to be important factors affecting medication response (needing different dosages and levels of medications) and prognosis of psychiatric illness. For example, in families of patients with schizophrenia with higher levels of "expressed emotion" (frequent criticism, hostility, and emotional overinvolvement), there is a poorer response to medications. There appears to be differing levels of expressed emotions in different cultural groups: Anglo-American families have been reported to have higher levels of expressed emotions than British families, who, in turn, have higher levels of expressed emotions than Hispanic families.

Culture also influences the role of the clinician in terms of one's prescribing habits and decision-making process in regards to the clinician's role and "healing power," the desire to please the patient, feelings about the patient including biases about race and ethnicity, and professional norms and values. Even when there is no indication for medications to be prescribed, the clinician may do so in order to comply with patient demands and thus placate the patient.

Certain cultures may objectify healing through medicines which serve to facilitate particular social and symbolic processes. This may be considered the "symbolic" effect of medication as compared with the pharmacological or "instrumental" effect. The symbolic effect includes characteristics such as "life" or "healing power" of a drug, and the attribution of value. Patients may experience and associate certain emotions with the use of certain medications. Some characteristics of medicines may have cultural meaning, including their form or consistency, the sensation experienced after taking the medicine, the source of the medicine, the packaging of the medicine, and the mode of administration of the medicine.

Form or consistency of medicine refers to the physical characteristics of the medicine: tablet, capsule, liquid, color, size, amount, and even the name of the medicine. The color of the capsule has been reported to affect placebo response differentially in different ethnic groups. For example, white capsules are often viewed by non-Hispanic Whites as analgesics whereas African Americans may view them as stimulants. On the other hand, black capsules are often viewed by non-Hispanic Whites as stimulants and by African Americans as analgesics. Yellow pills are often viewed as appropriate treatment for depression in Europe, and red capsules are perceived as suitable for strengthening the blood in Sierra Leone. Culture may also affect the amount of medicines purchased by patients. In El Salvador, patients buy medicines in multiples of four, since the number has ritual significance.

The sensation experienced after taking medicine refers to the reaction that occurs including the taste, such as bitter or sweet. Some cultures believe bitter medications to be more potent and effective. Certain types of aftertastes are considered to be indicative of the effect of the medication, either therapeutic or adverse, in some folk systems of medicine.

The source of the medicine (whether from plants, derived from animals, or is synthetic) can have a psychological impact on medication response. For example, many Muslims do not use alcohol-containing medications because of religious reasons, and they along with orthodox Jews may not use medications containing porcine products. Other concerns related to sources of medication include whether the manufacture is foreign or domestic, and the degree of difficulty in obtaining the medication. Western medicines may be viewed as more potent, faster, and superior for acute illnesses, whereas herbal medicines are seen as milder, slower, and better for chronic illnesses.

The presentation and packaging of the medication and location of distribution can influence the patient's perception of its value and perceived efficacy. The traditional belief in Eastern herbal medicines, which consist of several herbs, has accustomed Asians to polypharmacy. Many physicians in Japan, Korea, China, and Taiwan often use polypharmacy as standard practice and frequently do not disclose the contents of medicines to the patients. This contributes to the mystery of the contents which gives more therapeutic power to the treatment. Asian patients widely accept polypharmacy and view a good doctor as being skillful in combining different kinds of drugs.

The mode of administration of a medication has significant meaning to patients' perception of treatment efficacy. Injectable agents are frequently believed to be more potent than oral medications. The experience of pain from the injection may contribute to this perception.

After a clinical encounter, one should be aware that in many cultures, it is required to demonstrate one's gratitude with a gift and its refusal may cause offense. Gifts are frequently offered to ensure the best possible care for the patient (a "soft" bribe for the caregiver). Gifts may come in the form of food, animals, small trinkets, or money. If the gift is culturally inappropriate (e.g., money), one can suggest an alternative such as food that could be shared with the rest of the staff.

The conveyance of bad news or a negative prognosis also varies among cultures. In the United States, it is customary to only inform the patient in accordance to Health Insurance Portability and Accountability Act (HIPAA) regulations. However, in many other cultures, the family is informed first and then they decide if and when the patient should be informed. This violates HIPAA regulations if one is practicing in the United States. The patient or family may become angry at the health care provider if this custom is not followed because it is felt that giving someone a bad prognosis removes hope and becomes a self-fulfilling prophecy. Physicians should ask patients how they would like their family to be involved and then explain to the family that informing the patient first is the standard US medical practice.

Some benefits of possessing cross-cultural skills include better patient outcomes with greater patient adherence, improved access to care, reduction in health care disparities, and an awareness of the hazards and benefits facing the patient from traditional caregivers. One should be aware what aspects of traditional care can be adapted to a Western biomedical setting and know what aspects need to be rejected due to danger to either the patient's spiritual or physical health. It is imperative that health care providers learn about the ethnic populations they serve in order to provide efficient, effective, patient-centered, quality care. Providers should also know themselves and their patients as cultural beings, have attitudes that express respect and engender trust, develop communication skills that facilitate mutual understanding, be able to apply these knowledge, attitudes, and skills in clinical encounters, and develop cross-cultural negotiation skills.

Related Topics

- ► Assimilation
- ► Cross-cultural health
- ► Cultural competence
- ► Cultural humility
- ► Explanatory model of illness
- ► Health beliefs

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Ethnomed. www.ethnomed.org

National Center for Cultural Competence. http://nccc.georgetown.edu

National Council on Interpretation in Health Care. www.diversityrx.org

Cuba

► Hispanics
► Latinos

Cultural Adaptation Resources

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Many factors affect the well-being of immigrants as they enter a new society. Particularly significant is the mode of incorporation, that is, how they are received by the host community and the strategies they develop in response. This is often shaped by background factors such as language proficiency, socioeconomic status, race/ethnicity, and legal status. The mode of incorporation is key to an immigrant's access to crucial resources, including health care, education, and employment.

Host Community Integration/Incorporation

First of all, the way in which a government recognizes or refuses to recognize the status of immigrants is significant to adaptation. Immigrants' legal status can determine whether they have access to resources necessary for successful integration. For example, Iraqis fleeing war and sectarian violence by going to Jordan are granted only temporary protection by the Jordanian government, with the condition that they will be resettled in another country in 6 months. They are not allowed to work and receive only minimal aid through the United Nations High Commissioner for Refugees (UNHCR), forcing them to find support among other Iraqis and in the informal economy. Fortunately the official position does not restrict the movements of those given the status of "asylum seekers," and they are allowed to attend school and receive medical care at government hospitals. However, their marginal, transitory status provides little motivation to become part of Jordanian society.

It should be noted that cultural adaptation to a new society might begin before individuals arrive in their country of destination. A study of Sudanese refugees by Chrostowsky showed that those who had lived in Cairo before being resettled in the USA had an easier transition than those who had lived in Eritrea or Kenya. The reason is that many of the women worked as domestics during their transitional stay in Cairo where they had fewer language barriers (some Sudanese speak Arabic, albeit a different dialect), and gained familiarity with electricity and household appliances. Because they had an easier time finding work than Sudanese men, the women assumed more of the breadwinner role in family, anticipating the radically different constructions of gender roles to be encountered in the USA.

There are a number of assumptions about immigrant adaptation. The first is that immigrants naturally, for the better, assimilate or acculturate, that is, blend in with the host community, and the faster they do so the better for their own good. The second assumption is more recent and takes the opposite view, that immigrants are following a pattern of resistance to assimilation, refusing to learn the host country language and fit in with the dominant culture. Both assumptions are faulty and not supported by research.

In the USA, scholars of immigration such as Alejandro Portes and Ruben Rumbaut found that acculturation occurs along a continuum. Near one end is a more “selective” mode of acculturation, often involving conscious strategies by parents to socialize children into the culture of the ethnic community. Within this mode of adjustment parents and children in immigrant families tend to acculturate in similar directions and retain more traditional values and language. Parents and children tend to be highly involved in ethnic institutions (e.g., religious congregations), further keeping both generations acculturating in roughly similar directions. This pattern does not, as is often assumed, preclude the acquisition of English language ability and cultural competency in the wider American community. Studies of immigrant children reveal an ability to acquire bicultural/bilingual skills within constantly evolving frames of ethnic identity.

On the other side of the continuum is where children indeed acculturate rapidly, but parents lag behind, their lack of language skills making them dependent on their children to deal with the outside world. Thus, “generational dissonance” occurs as parents have difficulty guiding a highly acculturated second generation. This pattern is associated with such negative dynamics as the loss of parental authority and children’s rejection of the parents’ culture.

The mode of incorporation is shaped by many factors, including the type of community where immigrants live. Immigrants who settle in an urban enclave of co-ethnics, full of shops, churches, and people who speak the same language and share similar cultural norms, will experience a mode of incorporation different than those living in a more isolated suburban neighborhood.

It should be stressed that immigrants are proactive in the process of adaptation; it is not something that is done for them or to them. The rapidity by which immigrants establish networks, clubs, and organizations such as churches, is an example. Crane and Millard observed that the rapid creation of viable social institutions, such as religious congregations, demonstrated that new immigrant Latinos in the Midwest could create organizations that significantly benefit their constituencies and represent them in their new hometowns. Therefore, it should be acknowledged that cultural adaptation among immigrants is typically a process negotiated by immigrants themselves via the mechanism of entrepreneurial activity, education, mutual assistance organizations, and religious institutions as well as via other expressions of human agency.

This does not rule out the important role of individuals, organizations, and governmental institutions external to immigrant groups. Ultimately, success in American society requires resources beyond what private organizations can supply, particularly for language acquisition, education, health care, and financial capital.

Another factor that has led to new types of organizations involved in cultural adaptation is mutual group suspicion among new immigrants, various immigrant groups, and the host community. This leads to newcomer immigrants maintaining separate social networks. Their reasons are understandable – particularly if they have experienced suspicion and hostility from the host community. As Godziak and Melia observe, ethnic communities serve to “cushion the impact of cultural change and protect immigrants from outside prejudice...” The anthropologists Grey and Woodrick identified a “20-60-20” pattern in Iowa, where roughly 20% of the Anglo community sees the influx of Latino newcomers as basically positive, 20% react negatively, and 60% adopt a “wait and see” attitude. Because of mutual suspicion and the marginal status occupied by many new immigrants, public interaction between groups is more difficult, even if most individuals on both sides desire to get along. The fear that this engenders among immigrant populations produces additional barriers to finding an established place in a new community and to getting the necessary resources.

Fortunately, many concerned nonimmigrant citizens have proactively formed organizations to mitigate negative sentiment and constructively address the acceptance of new immigrants and bridge the gap between cultures. These organizations, an example being Heart and Hands, Inc., of Plymouth, Indiana, or TODEC in Perris, California, provide services to the new immigrant community, such as English language classes, job training, citizenship preparation, and translation and referral to other essential services, such as health care. In communities where immigrant communities are not well established, it is common that service organizations emerge that serve “all” immigrant newcomers.

As immigrant communities grow and become better established, they commonly create their own organizational structures to provide services to a specific language, nationality, or ethnic group. The advantage in this practice is that immigrant communities can mobilize mutual assistance resources faster in a more appropriate fashion to particular culturally defined needs, bypassing the more cumbersome mechanisms of public services. The risk associated with strong ethnic organizations is that they may further serve to isolate immigrants culturally and socially. This can present a further barrier to gaining English language proficiency.

Language Acquisition

In most cases, acquisition of the host country language is essential for overall success, to avoid exploitation, for upward mobility, and to retain control over and connection with children who are rapidly losing the mother tongue. Most immigrants to the USA enter an environment in which English is dominant, although some regions and communities may have significant bilingual populations. It is not unusual that immigrants will encounter expectations that “they need to learn English,” and “they need to adapt to our ways.” Local fears of immigrants “not integrating” into “our way of doing things” are common reactions. Fennely found that lack of English ability is interpreted by the host community as choosing not to “assimilate” and as rejecting American culture and “creating their own isolation.”

The 2000 census revealed that four out of five immigrant families spoke a language other than English at home. For people who see their place in American society as only temporary, there may not be an incentive to learn English. Even for those who intend to become citizens, the English language requirement is minimal. Furthermore, the demands of family and work schedules make it difficult to take advantage of classes. Nevertheless, as Gozdziak and Melia point out, most immigrants recognize the value of learning English and seek out ESL (English as a Second Language) programs. Their research also describes the many types of ESL or ENL (English as a New Language) programs created to accommodate the needs of immigrants. These include public and alternative schools with day and evening schedules, public library programs, and nonprofit organizations that offer low cost classes, often allowing the whole family to attend and providing childcare.

Often immigrants must draw on resources within their own community organizations for help in language barriers. The UNHCR reports that Albanian refugees from Kosovo resettled in Spain had to create their own Albanian-Spanish dictionary with key words and phrases that could be used by new arrivals and Spanish settlement workers.

Economic Self-Sufficiency

A crucial area of cultural adaption concerns economic self-sufficiency through employment or entrepreneurial initiative. With the exception of immigrants who are highly skilled professionals, new arrivals often find work in niche-markets and informal economies of ethnic communities. While this may work in the short term, it may not be a long-term, permanent option, and immigrants moving into the mainstream job market may face many barriers in the job market related to culture and language. Many countries have created specific programs to increase the changes of economic success for immigrants. For example, in Germany, refugees seeking help in finding employment work with a separate agency, the AWO, which works specifically with refugees to provide job assessment and placement support. In the Australian state of Victoria, refugees are provided with similar services within the same mainstream employment service, but through government workers who are provided special training to deal the immigrant populations.

Mentoring programs have also emerged, whereby immigrants who have achieved successful careers provide mentoring services to new arrivals. In the UK, a program developed by doctors who had been refugees now provides coaching, placements, and qualifying exams to qualified immigrants.

Many immigrants contribute greatly to host country economies through creation of new business. Family and ethnic networks may be sources of otherwise difficult to find start-up capital. The challenge of finding adequate start-up capital for entrepreneurial immigrants has led to an increasing number of microenterprise programs worldwide targeting immigrants and refugees. The UNHCR reports that refugees from Ireland to Burkina Faso have taken advantage of grants and easy term loans programs to assist small business.

Personnel and organizations working with immigrants also play a role in educating employers about the culture and religious needs of immigrant workers, for example, taking into consideration time for religious observance, prohibitions against handling certain food items, and gender role restrictions. The UNHCR advises that agency staff need to be careful not to inflate the skills or exaggerate the needs of refugees. Rather they should be seen as "normal people in extraordinary circumstances."

Accessing Culturally Appropriate Health Care

Immigrants worldwide often face significant obstacles to accessing health care that is culturally and linguistically appropriate and affordable. Even in places like New York City, which has a long history of dealing with diverse immigrant populations, barriers persist. The following description of these difficulties in New York and elsewhere in the USA has parallels in many other countries.

A recent report from the New York City Department of Health and Mental Hygiene noted that foreign-born adults are less likely than native-born adults to have a primary care provider; have Medicaid or health insurance; or receive regular preventive health measures such as colon cancer screenings, pap smears, or cholesterol screening. This difficulty accessing medical care is especially pronounced for recent arrivals and those who lack adequate proficiency in English (Low English Proficiency or LEP). Many undocumented immigrants actively avoid encounters with health care systems for fear of being turned over to immigration officials and deported. As a result, they may not have access to preventive care, routine screenings, or early treatment, seeking medical assistance only once potentially treatable conditions have progressed to the point of being severe.

Health care costs can be a significant barrier to accessing care for immigrants. Department of Homeland Security statistics indicate that one third of foreign-born individuals in the USA were uninsured in 2007, compared to less than 15% of those who were born in the USA. A Pew Hispanic Center report found that almost 60% of undocumented adults lacked health insurance coverage.

The Personal Responsibility and Work Reconciliation Act of 1996 (PWORA) barred states from using federal funds for Medicaid or the Children's Health Insurance Program (CHIP) for most undocumented immigrants and recent immigrants (within 5 years of arrival, regardless of immigration status), but allowed funds for some emergency Medicaid services. The result is a lack of preventive care. The 2009 CHIP reauthorization law, CHIPRA, changed regulations to allow states to use federal funds to provide Medicaid or CHIP to legal immigrant pregnant women and children, but not to other groups. Immigrants are also less likely than native-born citizens to have health care benefits provided by their employer.

Even immigrants who have insurance have less access to and lower use of medical care than do native-born individuals. Both linguistic and cultural barriers contribute significantly to making health care systems relatively inaccessible to many immigrants.

The U.S. Department of Health and Human Services Office of Minority Health issued National Standards for Culturally and Linguistically Appropriate Services in Health Care. Four of these standards mandate language access in health care in any medical facility that is a recipient of federal funds. These standards require facilities to offer competent language assistance services such as interpreters and bilingual staff to any patient who needs those services.

Despite these standards, often no qualified interpreter is available to the patient, leaving LEP patients to rely on family members, friends, other patients, or strangers to translate for them, resulting in a loss of privacy and accuracy. Reliance on children poses particular problems, as it causes role reversals in the family structure, and children often lack the vocabulary and understanding of complex issues to translate accurately. Additionally, children may wish to avoid sensitive topics, which can slant the information given.

Bureaucratic, large, and impersonal health care systems are often extremely difficult for immigrants to navigate, and cultural insensitivity can be enough to drive them away from seeking care or make receiving care a negative experience. Birth and death are particularly difficult times, with health regulations, safety rules, and hospital practices often interfering with the practice of cultural and religious rituals such as burying a newborn's placenta, touching the lips of a baby with honey or preparing the dying for passage into the next life. Physicians and patients may also have differing ideas about the causes and treatment of illness, which can cause misunderstandings and conflict. Patients may be using traditional, complementary, or alternative medicine in addition to the medical treatment offered by an MD, but unless both parties are able to communicate and know what to ask, this information may not be available to the physician. Patients may not volunteer information for fear ridicule or rejection if they reveal alternative treatments.

In general, immigrants' access to key resources can be facilitated or hindered by their mode of acculturation and by the availability of others in the community who can assist in making this transition. Community-based private organizations can provide an important bridge between immigrant families and participation in the wider society, connecting them to programs that provide resources for education and advocacy. Ultimately, nonimmigrants and a variety of immigrant groups need to cooperate together for a truly successful and diverse society to emerge.

Related Topics

- ► Acculturation
- ► Barriers to care
- ► Cultural competence
- ► Culture shock
- ► Culture-specific diagnoses
- ► English as a Second Language
- ► Ethnic enclave
- ► Immigration processes and health in the U.S.: A brief history
- ► Language acculturation
- ► Limited English proficiency
- ► Social integration

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Suggested Resources

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Cultural Appropriateness

- ► Cultural competence
- ► Cultural humility

Cultural Background

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The number of immigrants worldwide has almost doubled during the past 50 years. It is now estimated that there are 191 million immigrants worldwide, 115 million of whom live in developed countries. In fact, 75% of immigrants live in just 28 countries. One-third of all immigrants have made their new home in Europe, and another fifth have settled in the United States.

All of these immigrants carry with them their habits, beliefs, and lifestyle from the countries of their births to their new host countries. In short, they carry with them their cultures, which are the sum of all beliefs, attitudes, models, templates, living style, and any other characteristics that promote relationships among the group members. The concept of culture also includes codes of manners, dressing style, language, religion, rituals, and systems of beliefs. These elements often identify immigrants as a distinct group in the host country. The culture frames individuals' social lives and actions and differentiates the groups.

The differences between cultures may not be obvious unless individuals from different groups occupy the same space or contiguous spaces. It is critical that the host cultures adapt to the new incoming cultures, particularly in view of increasing globalization and increased diversity.

Host Culture Attitude

The entry of any culture into a different one will always generate reactions. Scholars have suggested that the level of hostility directed to the newcomers by individuals in the host country depends on the degree of similarity between the new host culture and the immigrants' original culture; it is hypothesized that the more similar the cultures, the less the level of hostility or antagonism.

A common way of understanding a culture and the extent to which cultures are similar or different is by reference to four elements: values, norms, institutions, and artifacts. Values refer to what is important for the society, what is important for the family, what is important in general in life. Norms consist of all behaviors that are judged by the culture to be appropriate in dealing with different situations. The institutions are those structures that are governed by the values and norms. The values and norms within a society derive from unwritten law (common sense) and written law (such as punishing all those that are breaching the norms and values). The artifacts are the products of a cultural history.

Attitudes toward cultural diversity as a result of immigration have been found by researchers to be associated with individuals' age, sex, and race. For example, some groups, such as Algerians and some other North African French persons, may continue to be stigmatized, marginalized, and discriminated based on racial reasons despite their legal status as citizens. Young educated females have been found to be more open to exposure to new cultures than older men.

Cultural Background and Health Care

In the health care context, five issues relating to individuals' cultural background are of primary importance: the style of communication, the existence and extent of mistrust and prejudice, decision making and family dynamics, traditions and spirituality, and sexual and gender-based issues.

Cultural background may affect doctor–patient communication and, accordingly, the doctor–patient relationship. For example, a medical team trying to provide medical treatment may find that the treatment conflicts with the patient's beliefs. Such dilemmas may be amplified when the patient's language differs from the provider's language. Differences in the cultural background between the provider and the patient may also bring different expectations. For example, the Western concept of health delivery stresses a collaborative model of communication between the health care provider and the patient. However, in many cultures, medical decision making requires the involvement of the family and not only the individual patient. In yet other cultures, individuals are accustomed to a more paternalistic model of relationship between the doctor and the patient. In many Eastern Europe cultures, for example, the doctor–patient relationship is one of trusting the doctor without asking too many questions about the treatment. The cross-cultural care model proposed by Betancourt and Cervantes requires consideration of the patients' cultural background. Successful cross-cultural medical education would assist health care providers to develop the skills necessary to provide care to individuals of diverse backgrounds.

Religious beliefs may also affect provider–patient communication and the patient's willingness to agree to particular treatments. For example, some immigrant groups may favor the use of prayer, meditation, or traditional preparations to treat an illness, rather than Western medicine. Provider sensitivity to and accommodation of these varying beliefs to the extent possible are critical to the development of a successful provider–patient relationship and open lines of communication.

Culture-based norms relating to sex and gender are also important in the health care context. Kopp, Réthy, and Chapuis reported on the case of a woman who presented to an emergency room for a gynecological problem. The patient and her husband initially rejected care from the male physician on duty based on their religious beliefs. However, they later agreed that the male physician could care for the woman after a religious authority explained that the religion did not prohibit the examination by a male physician because it was a medical emergency.

Accordingly, it is critical that health care providers consider in each particular case all of the factors that define an individual, including the person's attitudes, understandings of health and illness, language, and religious beliefs. A primary goal should be the development of a good relationship with the patient and smooth communication.

Related Topics

- ► Acculturation
- ► Communication barriers
- ► Cross-cultural health
- ► Cross-cultural medicine
- ► Culture shock
- ► Culture-specific diagnoses
- ► Cultural competence
- ► Cultural humility
- ► Health beliefs
- ► Physician–patient communication

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Cultural Competence

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Driven largely by immigration, the USA, like Europe and Canada, is becoming ever more diverse. For example, it is anticipated that the country will have a minority-majority population by the year 2042, largely the result of immigration from Latin America and the Caribbean, as well as both Africa and Asia. This underscores the importance of understanding different cultural experiences in the health care realm. These demographic shifts have exaggerated an already present cultural distance between the medical community, which is predominantly upper middle class and White, and the general population. As such, health care organizations are grappling with ways in which to both understand and meet the needs of diverse communities that are not always reflective of their employees and/or providers. Cultural competence has been proposed as a mechanism by which to bridge the cultural distance between patients and health care providers.

Cultural competence is a component of patient-centered care. In 2001, 7 years after being charged by Congress with improving the ability of health care providers to deliver culturally competent care, the United States Office of Minority Health published National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care. The overall aim of the CLAS standards is to address health care disparities through the delivery of culturally and linguistically competent care in health care services. As such, culturally competent health care organizations provide treatment services that effectively meet the needs of their patients, while considering the cultural, linguistic, and/or socio-environmental context of patients. Similarly, culturally competent providers bridge sociocultural divides, allowing them to recognize and understand the needs of diverse patient populations with varying cultural beliefs and behaviors.

Cultural Competence and Inequity in the Delivery of Care

The modern day health care system is founded on traditional beliefs of Western biomedicine, thereby forming its own unique culture built on a distinct cultural orientation and perspective, inclusive of distinct assumptions and beliefs about patients, providers, and the nature of health care. Cultural competence involves understanding the ways in which individual and community level practices and beliefs influence health, and the delivery of health care. Both patients and providers bring with them into the health care exchange a set of beliefs, experiences, and practices that shape their behavior and interactions. *Unequal Treatment*, a report commissioned by the Institute of Medicine, brought a new dimension to our understanding of cultural distance and the contributions of providers to health care inequality. The report found that systemic, provider, and patient level factors take away from the overall quality of care. More specifically, patient race and ethnicity are primary predictors of health care quality.

Culture also contributes to the divide between patients, providers, and the health care system. Culture, although often confounded with race and ethnicity, is more than race and/or it influences behavior, including health practices and interactions. Culture can be influenced by social constructs such as race and ethnicity, but additional factors such as religious beliefs, family structure, class, place, and time coupled with socio-environmental and sociopolitical context also contribute to cultural variation. Such variation can result in cultural distance as well as disconnects both between and within groups. For example, how patients describe their relationship to the biomedical system may vary dependent on the cultural context of the patient. The same can be said for providers describing their cultural distance from patients, and patients describing their cultural distance from providers.

Cultural distance contributes to poor quality care for racial and ethnic minorities including new immigrants. Cultural distance is a by-product of social, economic, political, and historical factors, which result in divergent health beliefs, communication barriers, mistrust, and bias. Socioeconomic and racial segregation – both associated with the social hierarchy in the USA – isolate individuals geographically, socially, and culturally. Isolation and unfamiliarity leave individuals vulnerable to the effects of bias and stereotypes. That which is unknown is more easily understood when grouped or categorized.

Social cognition is the unconscious process by which we categorize or group individuals – how our minds make the unfamiliar familiar. For example, providers, when interacting with patients of a background that is foreign to them, draw upon past experiences, perceptions, and stereotypes to make sense of that which is unknown, which can lead to health care disparities. Thus initiatives that promote cultural competence are important as they encourage providers to (1) meet patients where they are at, (2) avoid using mental shortcuts and stereotypes, and (3) broaden their worldview to assure understanding of patient cultural context, thereby engaging patients in treatment as opposed to maintaining cultural distance.

Cultural Competence as a Market Strategy

Beyond addressing health care inequity, cultural competence by some has been described as a market strategy in addition to a means by which to reduce racial and ethnic disparities in health care. Researchers have found that experts from managed care, academia, and government describe cultural competence as a mechanism by which to improve access to quality care for diverse, new immigrant communities. In addition, it has been described as a way for health care provider and payer organizations to increase their market share in a rapidly changing world demographic. This is significant; it represents a paradigm shift solely viewing cultural competence as the right thing to do in addressing disparities to a focus on good business practices in a shifting market. By providing culturally competent care, care that seeks to meet patients where they are at both culturally and linguistically, health care organizations can differentiate themselves from their competitors, increasing their market share.

Four interconnected financial reasons for organizations to provide culturally competent care have been outlined in the literature. The first being clear, *appeal to minority consumers. With the growing proportion of minority consumers in the market* many businesses, including the health care sector, seek to reach the minorities. Cultural competence in this sense would provide organizations the tools needed to differentiate their services in the market. The next two reasons are based on the same premise, to compete for purchaser business. Brach and Fraser report that providing culturally competent care allows health care organizations to compete for *private purchaser business* and to respond to *public purchaser demands*. They explain this in that cultural competence will increase performance quality scores, increasing their appeal to private purchasers, while at the same time facilitating compliance with public purchaser rules and regulations. Finally, it has been identified as a means to improve cost-effectiveness. As providers who confront barriers in communications are likely to order additional diagnostic tests and thus incurring greater costs, cultural competent organizations would have the linguistic capability to better capture medical history and reducing the need for unnecessary testing.

Conclusions

Cultural competence has the potential to reduce care health disparities, by increasing patient access to quality health care though a respectful patient provider relationship. In addition, culturally competent health care makes good business sense. The hope is that diverse populations plus cultural competence leads to better communication, increased trust, better assessment, more appropriate diagnostic services, improved outcomes, and over time the reduction of racial and ethnic disparities in health.

Related Topics

- ► Cross-cultural health
- ► Cross-cultural medicine
- ► Cultural humility
- ► Health barriers
- ► Health beliefs
- ► Interpreter services
- ► Transcultural psychiatry
- ► Vulnerable population

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http://minorityhealth.hhs.gov/assets/pdf/checked/finalreport.pdf
http://nccc.georgetown.edu/index.html

Cultural Humility

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In the context of health care, the term "cultural humility" denotes an attitude of appropriate respect by a health professional toward the culture of her clients or patients, where this differs from her own.

As an attitude, rather than knowledge of a body of facts about other cultures, or a set of acquired relevant cultural skills, cultural humility is a necessary condition of the combined task of gaining relevant knowledge of other cultures, developing a set of skills necessary to apply this knowledge in theoretical clinical situations, actually applying the knowledge in complex real life situations, and accurately monitoring the outcomes in terms of patient and client satisfaction, and other beneficial or detrimental effects.

The term therefore is used in contrast to other similar terms such as "cultural competence," "cultural safety," "cultural sensitivity," and "cultural proficiency," all of which emphasize appropriate cultural knowledge and skills brought to the clinical encounter.

In the modern health care discussion the term "cultural humility" was coined by Tervalon and Murray-Garcia, who describe it as incorporating "a life-long commitment to self evaluation and self critique, to redressing the power imbalances in the patient physician dynamic, and to developing mutually beneficial and non-paternalistic clinical and advocacy partnerships with communities on behalf of individuals and defined populations."

Hunt characterizes it as "not… an examination of the patient's belief system, but [a] careful consideration by healthcare providers of the assumptions and beliefs that are embedded in their own understandings and goals in the clinical encounter."

Described in this way, the concept of cultural humility is brought very close to the generic philosophical virtue of humility, and embraces the multidisciplinary nature of clinical work, emphasizing ethical commitment to continual professional improvement, and professional egalitarianism applied in the context of the multidisciplinary study of individuals in communities.

Tervalon and Garcia use the term in the context of medical education, emphasizing (1) patient-focused interviewing and care where, for example, patient-initiated questions and agendas are tolerated, as the physician relinquishes the role of expert in recognition of the fact that the patient is uniquely qualified to help the physician understand the complex intersection of the elements of a patient's cultural identity; (2) community based care and advocacy, where maintaining the client's cultural context as much as practicable is intended to be empowering; and (3) institutional consistency, where care is taken to ensure that polices are formulated and consistently applied so as to minimize the disadvantage, wherever practicable, to clients from minority cultures.

Subsequent literature has addressed areas as diverse as the assessment and diagnosis of illness and dysfunction, management of disability, and psycho-education in physical and mental health, including programs for families of children with special needs, psychiatry and psychotherapy, substance abuse, midwifery, gynecology and neonatal care, cancer care, public health, the measurement of quality for managed care organizations, the indigenous practitioner, and cultural practices with health consequences. Clearly there is scope for more research.

A strength of the concept of cultural humility is that as it emphasizes attitudes and habits of mind rather than specific domains of knowledge and skill, a clinician is readily able to bring cultural humility to unfamiliar situations, where knowledge and skill may be lacking, and seek to develop these as the relationship with her patients deepens.

A possible weakness of the concept is that it can be unclear what the scope and limits of cultural humility are, as unseemly haste to avoid "the hegemony of one culture over another" may lead to a de facto cultural relativism. However the practice of health care assumes that suffering and failure of function are what characterize an illness or disability, and in the extreme case a society or culture cannot tolerate or approve of these among its members and remain consistent with other values it embraces.

Practically speaking, a person dealing with a health professional of another culture, who was showing appropriate cultural humility, would expect to have her values respected, to experience receptiveness to her questions, and to receive questions asking for further information regarding her cultural values, roles, and expectations, all of which may enhance the value of the clinical encounter. Acknowledging that cultural humility (where present) may not always be fully expressed, a failure to experience this may indicate a lack of cultural humility on the part of a clinician. A remedy for this could then be found by a complaint or appeal to the authorities of the institution, the ethical base of which will express principles based on respect for autonomy, beneficence, non-maleficence, justice, and professional integrity, all of which also find expression in the notion of cultural humility.

The notion of cultural humility is fundamental to other cultural competencies, and is well supported from the perspectives of many related disciplines in health care. Increasing work on the concept of cultural humility in future academic and clinical discussion would be welcomed.

Related Topics

► Cultural competence

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Culture

► Cultural background

Culture Shock

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The term “culture shock” was introduced by Kalvero Oberg in 1954 to refer to an “abrupt loss of the familiar” or the “shock of the new.” Culture shock is caused by the anxiety that is associated with the loss of familiar signs and symbols that permeated one’s life before reaching the new environment.

Culture shock occurs in various stages or phases, which have been variously termed incubation, crisis, recovery, and full recovery; elation, depression, recovery, and acculturation; and contact, disintegration, reintegration, autonomy, and independence. The first phase of culture shock is often referred to as the “honeymoon phase” because the individual feels excitement about the many new things that he or she is experiencing. This phase may last for hours, days, weeks, or months.

The feeling of excitement that is experienced during the first phase of culture shock gradually diminishes as the individual begins to be aware of the differences that exist between his or her previous and current environments. This second phase is often characterized by the experience of many practical problems, an increase in misunderstandings, feelings of frustration, a sense of loneliness and uneasiness, and a decrease in self-confidence. This second stage often lasts about 6 months, but its exact length depends on the individual and his or her specific circumstances. Many people also experience physical symptoms of culture shock during these stages. These can include lethargy, headache, difficulties sleeping, a loss of appetite, and digestive irregularities.

During the third stage of culture shock, the individual will begin to adjust to the new environment or reject his or her new situation, blaming others and adopting negative coping mechanisms, such as substance use and self-isolation. During the final stage, the individual gradually adjusts and adapts to the new environment and experiences an increased sense of control and belonging.

Immigrant children may have a particularly difficult time adjusting to their new country and may experience severe culture shock. They may feel embarrassed because they do not speak the same language as their classmates or because they or their families look “different.” They may be unable to verbalize their feelings and may act out in frustration; accordingly, it is important that teachers have patience. They may also experience difficulties with their parents. The parents may want to continue the use of their primary language and the observation of their usual traditions, but the children may want to discard both their native language and their traditions in favor of those of their new country.

Immigrants may experience a greater degree of culture shock if specific practices classified as common social behaviors in their countries of origin are considered to be abusive and criminal acts in their new host countries. As an example, some countries might consider beating one’s wife to be an acceptable response to her challenge of her husband’s authority, but in the United States, this could be considered partner violence and could result in criminal prosecution.

The extent to which an immigrant experiences culture shock, and the rapidity with which he or she adjusts to the new environment is highly dependent on his or her personal experiences. Individuals who immigrate to a new country with their families are less likely to experience intense feelings of culture shock and/or may move through the various stages more quickly, because they have the support of their family members. Immigrants whose language is the same as that of their host country, and whose culture in their country of origin is similar to that of their new host country, may also be less likely to experience culture shock.

The extent to which an immigrant experiences culture shock also depends on individual factors. Individuals who are very resilient to change are less likely to experience difficulties in their new environments.

A variety of interventions have been suggested to help immigrants adjust to their new country and minimize their experience of culture shock. This includes the development of leisure activities that include physical exercise; enrolling for language classes to learn the language of the host country; and volunteering in the new community, which provides a mechanism for meeting new people and becoming integrated into the community. It is important that the immigrant try to keep an open mind about his or her experiences and not interpret everything through the cultural lens of his or her country of origin, since a behavior or saying may have a very different meaning in the new culture. A sense of humor may also help to alleviate the feelings of frustration, anxiety, and confusion that are part of culture shock.

Immigrants who return to their country of origin, for example, to visit family or friends, may find that they experience culture shock when they arrive in their country of origin. The immigrant may find that their family members and friends have changed during this time, and that their previous place of residence has also changed.

Related Topics

- ► Acculturation
- ► Acculturative stress
- ► Anxiety
- ► Assimilation
- ► Language acculturation
- ► Resilience
- ► Stress

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Culture-Bound Syndromes

► Culture-specific diagnoses

Cupping

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Origins of Cupping

Cupping therapy (*huoquan qi* in Chinese; and *al-hijamah* in Arabic) is a practice whereby glass or bamboo cups are applied to the surface of the skin and through suction and negative pressure, the skin and superficial muscle are gently drawn into and held in the cups. Based on the holistic principle that the body relies on a balance of energies to function properly, cupping is used to remove accumulated stress, tension, and cold channels from the body; promote blood flow and healing; and restore balance. Widely practiced in China, Taiwan, India, Pakistan, Iran, Saudi Arabia, the Gulf States and parts of Africa and the Middle East, cupping is commonly used in immigrant communities (e.g., Asian, Arab, Mediterranean) in the USA, Canada, Europe, Australia, and New Zealand.

The earliest recorded use of cupping is in the *Ebers Papyrus* of ancient Egypt (1550 BCE) where cupping was indicated for the removal of foreign matter from the body. Hippocrates (*ca.* 460–370 BCE) and Galen (*ca.* 129–200 CE) also described cupping as an effective remedy for numerous disorders and a means to evacuate toxins, reduce inflammation, arrest fevers, and restore humoral balance. One of the first records of cupping in China is by Taoist alchemist and herbalist Ge Hong (281–341 CE) who prescribed the use of cups in the form of cattle horns for the draining of pustules, boils, and carbuncles. During the Qing Dynasty, Zhao Xuemin (1719–1805) included an extensive chapter in his materia medica on *huoquan qi* or "fire cupping": the use of bamboo or pottery cups to treat headache, dizziness, abdominal pain, and snakebite.

In the 1950s, cupping was established as an official therapy throughout China; and today there are numerous Traditional Chinese Medicine (TCM) research institutes with ongoing clinical trials in cupping therapy (see below). In South Asia, cupping is a common therapeutic practice in Unani-tibb or Greco-Islamic medicine. Based on the principles of Hippocrates, Avicenna, al-Majusi and others, Unani-tibb advises the use of cupping (*al-hijamah*) to draw inflammation toward the surface of the body; divert inflammation from an important organ to a less important one; dispel humors from an affected organ; and alleviate pain. Unani physicians or *hakims*, like their TCM counterparts, use cupping to treat a number of muscular, circulatory, and neurological disorders.

Current Use of Cupping

In most parts of Asia and the Middle East, cupping is administered by medical practitioners, usually TCM doctors or Unani hakims. In the USA and other Western countries, cupping was historically introduced and practiced by immigrants from the Mediterranean and Asia in the 1800s and then spread to many parts of the USA flourishing as late as the 1930s in immigrant sections of large cities. On the Lower East Side of New York, cupping shifted from the domain of family doctors to barber shops, and one could see sign boards reading "cups for colds" on barber shop windows. Today, in rural parts of the Mediterranean, cupping is still practiced at home by families who put a set of cups in their first aid boxes or simply use a set of jam jars.

In the USA, Canada, Europe, Australia, and New Zealand, where there are sizable Asian communities (and hence an availability of trained practitioners) cupping is used alone or in tandem with other traditional therapies such as acupuncture, herbal medicine, massage, medicated steam, hydrotherapy, nutritional therapy, and in combination with biomedical treatments, such as pharmaceutical analgesics, nonsteroidal anti-inflammatory medications, orthopedic surgery, and physical and rehabilitative therapies.

For patients with arthritis, fibromyalgia, carpal tunnel syndrome, chronic back pain, chronic headache, and joint injuries, the appeal of cupping therapy is its use of low-tech equipment, its low cost, and its lack of side effects that might otherwise be experienced with analgesics. In the past decade, cupping has seen renewed popularity in the USA in the domain of complementary and alternative medicine (CAM) and health spas, with growing numbers of the general public using cupping, and more TCM and CAM practitioners training in the use of this therapy. New versions of "cellulite trimming" and "stress relief" cupping have cropped up on the menu of health spas in cities like New York and Los Angeles, creating an interesting contrast with the no-frills offerings found in Asian neighborhoods in Chicago, Los Angeles, New York, San Francisco, Toronto, Vancouver, and other cities, where cupping is still practiced in much the same way it has been for decades. Differences in technique and cultural milieu are reflected in cost: while a 30–40 min session with a holistic practitioner or spa technician can cost anywhere from $30 to $100, a session with a TCM practitioner in New York's Chinatown is closer to $10–$20. By contrast, in China the average cost of a session is 12 Yuan ($1.60) compared with an average 56 Yuan ($7.30) for herbal therapy.

The Procedure and Outcome

There are two primary types of cupping: dry and wet. In *dry cupping*, glasses are applied to the skin and either a gentle vacuum pump or flame heat is used to purge air from the cup. As the glass cup cools on the skin and a seal is formed, pressure within the cup declines, sucking the skin into the cup. Cupping glasses are typically applied for 10–15 min to the back, neck, hips, legs, knees, or arms. *Wet cupping* involves minor scarification of the skin so that a small amount of blood is drawn. Today, wet cupping serves as a modern substitute for venesection, in which larger quantities of blood were let out. Two other classifications exist in cupping as well: *stationary cupping*, where each glass cup is left in position on the skin and the cup is not moved; and *massage cupping*, where the glass cups are moved around the skin in a massage-like technique.

In regard to clinical evidence for the efficacy of cupping, a 2010 meta-review of the clinical literature conducted by Huisstede and colleagues found no evidence of long-term results of cupping in the treatment of carpal tunnel syndrome, but did find evidence for short-term benefit and relief of symptoms. The combination of acupuncture and cupping has been found to be of greater benefit in the reduction of pain and inflammation associated with acute arthritis and the reduction of pain associated with fibromyalgia, compared to the use of either cupping or pharmacotherapy alone. Cupping has also been found to be effective in the treatment of acute arthritis when combined with herbal medicine; in the treatment of fibrositis; and in the treatment of intractable migraine, when combined with acupuncture.

From a sociocultural standpoint, qualitative studies of cupping therapy and its rich historical and contemporary uses in immigrant communities are seriously needed. Such studies will enable public health and medical providers to understand the range of therapeutic applications of cupping in TCM, Unani, CAM, and biomedical contexts and the cultural meanings of cupping in widely diverse immigrant communities (e.g., African, Asian, Arab, Mediterranean). Importantly, as the number of individuals seeking cupping therapy increases in Western countries, providers should also be familiar with this practice so as to prevent any social and legal conflicts that may emerge from mistaken diagnosis, such as when cupping welts are misinterpreted as signs of violence or abuse as has been the case in Europe and in the USA.

Related Topics

- ► Acupuncture
- ► Alternative and complementary medicine
- ► Chinese
- ► Chronic pain
- ► Cross-cultural medicine
- ► Islam
- ► Muslim
- ► South Asians
- ► Traditional Chinese medicine

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Curandero

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Curandero is a Spanish term meaning “healer.” *Curanderos* (male healers) and *Curanderas* (female healers) are important community-based “folk” healers held in high regard within Latin American and Latino immigrant and transnational communities. Contemporary curanderos’ medical knowledge, beliefs, and practices are generally a mixture of pre-Hispanic medical cultures with Spanish and Catholic symbols and beliefs. The term *curandero* is a broad term that refers to a whole set of healers who utilize diverse methods in their practice. Each specialty has specific methods and a title that accompany it, and some *curanderos* specialize in more than one method. A *yerbero/a* is a herbalist who utilizes herbs to address health issues. A *Sobador/a* is a *healer* who utilizes massage to help alleviate pain or help a client recover from an illness or trauma. A *Huesero/a* is a bonesetter who manipulates injured bones, tendons, and muscles to alleviate pain and facilitate recovery from an injury. A *espiritisto/a* is a psychic medium who channels spirit beings and/or utilizes prayer to rid clients of physical, psychological, spiritual, and even social problems. A *partera* is a midwife who cares for pregnant women providing prenatal care as well as assistance with the birth of the child. Utilization of *parteras* in Latin America is widespread. For example, in some Mexican communities, *parteras* oversee a significant percentage, if not the majority, of births.

Curanderos often hear a “calling” to their profession and view this calling as a gift from God or other supernatural beings. Curanderos undergo an intense period of training during which their practical and spiritual knowledge is tested and affirmed. Generally, *curanderos* have a vast and specialized knowledge of the physical and supernatural worlds and employ this knowledge in their practice. Some *curanderos/as* are shamans who communicate directly with the supernatural through trance to heal. *Curanderos* attend to an individual’s physical, psychological, spiritual, and social well-being. This holistic approach to health is why many Latino immigrant communities seek out *curanderos/as* instead of, or in addition to, conventional medical care. Individuals and families seek out care from *curanderos* for diverse health issues that could range from cold relief to cancer. Certain *curanderos* can also address stresses associated with psychological or social states. For example, it is not out of the ordinary for an individual to approach a *curandero* for a *limpia* – cleansing with the goal of ridding themselves of a rash of bad luck that they are experiencing. A *curandero* is able to not only cleanse the person of the bad luck but provide for them an explanation of why they had the bad luck in the first place. *Curanderos* are the only source of care for common ethnospecific illnesses among Latino immigrant communities such as *susto* – fright, *mal de ojo* – the evil eye, or *coraje* – anger. *Curanderos* have the knowledge necessary to diagnose and treat these illnesses which historically have been dismissed by conventional medicine. There is, however, a growing set of research studies examining these types of ethnospecific illnesses and how they parallel the symptoms of conditions readily diagnosed in conventional medicine.

Utilization of *curanderos* among Mexican American and Latino immigrants has been a topic of research and inquiry among social scientists. Anthropologists in the 1960s argued that underutilization of conventional medical care by Mexican Americans and Latino Immigrants was a result of their continued use of *curanderos*. Most recent research, however, has revealed that socioeconomic issues and structural issues such as lack of health insurance, high cost of health care, undocumented status of many immigrants, and lack of culturally and linguistically appropriate health care services tend to play a larger role in limited utilization of conventional medical care for this community. Research has revealed that continued utilization and reliance on *curanderos* may actually be as a result to these larger socioeconomic and structural barriers. *Curanderos* provide easily accessible, affordable, and culturally and linguistically appropriate health care to Latino immigrant individuals and families. *Curanderos* share the same medical culture (world view, religion, views on the body, and beliefs about the causes of illness) as their clients, thereby facilitating communication, confidence in the provider, and adherence to treatment. Latino immigrant and transnational communities often have *curanderos* as members of their social networks who can be accessed either in the United States or in their community of origin. In the United States, *curanderos* are active members of Latino immigrant communities and are an important source of medical care. Curanderos are only a part of a complex system of community-based healing strategies and resources that also include home remedies and therapies, as well as "botanicas," which are small community stores that sell medicinal herbs, religious amulets, and products used in healing. Research shows that a large percentage of those patients who report complementing their medical care with these complementary and alternative medical practices often do not discuss them with their medical doctor. This withholding of information has the potential to impact patient-provider communication, as well as conflict with the treatment regimen prescribed by the medical doctor. Medical doctors should approach this issue in a culturally sensitive and competent manner as a way to gain the confidence of the patient to allow disclosure of information related to this topic.

Historically, there has been negative stigma attached to utilization of Latino complementary and alternative medicine (CAM) such as home remedies and *curanderos* among medical professionals. There has been, however, an increase of professionals who recognize the positive contribution of these community-based healers and resources. Health care professionals in some regions of Latin America and the United States have begun to collaborate and partner with *curanderos* in local communities as a way to meet the health care needs of residents in a more comprehensive and culturally sensitive way. Working in partnership with *curanderos* has also been successfully integrated into several health promotion interventions and awareness campaigns. Working in collaboration with CAM resources in the community as well as modifying the delivery of conventional medical care to mirror the way care is delivered in these community-based systems has been proposed by researchers as an effective way to reduce barriers to care, and improve the quality of health care delivered to Latino immigrants in the United States.

Related Topics

- ► Access to care
- ► Alternative and complementary medicine
- ► Communication barriers
- ► Cultural competence
- ► Culture-specific diagnoses
- ► Mal de ojo
- ► Transnational community

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Customary Marriage

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The term is usually applied to refer to various types of marriage or patterns of spouse selection, which in the widest sense can be classified as conforming to specific localized sociocultural traditions. “Tradition” in this respect can involve certain culturally or religiously established forms of performing the marriage ceremony or it can refer to the different types of normative marriage rules prevalent among various ethnic or religious groups. Generally, the term “customary marriage” is applied to denote marital relations which are considered to differ culturally from the US, Canadian, or West-European types of marriage, partly involving marriage patterns practiced among immigrant communities that many of the host societies declare as illegal, such as polygamy or first-cousin marriage. Customary marriages may be based on rules by which the circle of marriageable persons is limited to a large extent, as in the case of caste-like social systems, or other social communities whose marriage laws prescribe various forms of social, ethnic, or religious endogamy (the latter can apply likewise to Muslims, Christians, and other religious affiliations).

Among immigrant communities such types of customary marriage can differ from each other to a large extent, depending on the regional origin of the immigrants, and the respective marriage patterns may also combine several of the above mentioned features (i.e., Pakistani immigrants in the UK often upheld ethnic and religious endogamy and marry first cousins). Moreover, in immigrant communities customary marriages may take the form of arranged or forced marriages, often implemented by the elder generations who are concerned about the potential loss of their children’s “cultural identity” due to the influences exerted by the host society.

Customary marriages may entail several health problems, depending on the marital pattern. Polygamous marriages among immigrant communities, for instance, call forward the problem that in the Western host societies only the first wife is secured by her husband’s health insurance whereas his other wives are excluded since they have no legal status as spouses. Customary marriages may also be accompanied by mental health problems, particularly in case of forced marriages when pressure has been put on the couple by the parents and/or the wider social framework. Forced marriages may lead to the mental depression of one or both marriage partners, or to physical injuries in case of domestic violence. Mental depressions resulting from trans-generational conflicts may also occur among the generation of the parents if their children refuse to obey to the established patterns of traditional marriage rules, thereby challenging their parents’ authority and sometimes giving rise to irresolvable conflicts which may lead to the complete disruption of parent/child relations. Among various immigrant communities, particularly from the Middle East, nonconformance to customary marriage rules can entail several forms of honor-based violence or honor killing attempts, usually exerted upon women and frequently resulting in severe physical and mental health problems suffered by the victims.

Some societies or immigrant communities foster the idea that nonconformance to customary marriage rules is likely to entail physical or mental illness among the persons involved, particularly among the children who are supposed to suffer from disabilities or mental disorders inflicted by spiritual beings, the ancestors, or other cosmic forces.

Customary marriages based on marital relations between cousins have received the highest degree of attention in the Western host societies. Though cousin marriages are practiced by around 20% of the world’s population, they were largely tabooed in the USA where already in the nineteenth century many of the states decided to establish public laws in order to prohibit such types of marriage (Kansas 1858; 1860s: Nevada, North Dakota, South Dakota, Washington, New Hampshire, Ohio, and Wyoming). Cousin marriages during this period were often practiced among European immigrants and the respective laws were also intended to work against the migrants’ potential seclusion from their host society.

Recently, in some European countries (UK, Germany), there have been public debates as well whether to prohibit such types of marriages given the influx of migrants from the Middle East. Meanwhile, in France and Turkey, cousins have to present a medical health certificate before they are declared eligible to marry. Such laws are predicated on twentieth century Western biomedical assumptions according to which cousin marriages are supposed to entail a higher risk of hereditary diseases. Recent bio-genetic research, however, suggests that the risk of hereditary diseases resulting from such marital unions has been largely overestimated. According to a comprehensive survey undertaken by the National Society of Genetic Counsellors (NSGC), the risk of congenital defects resulting from first-cousin unions ranges from 1.7 to 2% above the background risk of 4.4% for pre-reproductive mortality, thus making any special preconception testing unnecessary. Other researchers, roughly averaging the statistics for birth defects and pre-reproductive mortality, noted that first-cousin marriage "only" increases the risk of adverse events by about 3%, which means that instead of 3–4% there can be a risk of genetic damage of up to 7%. Whereas some authors consider this increase of genetic risk as marginal, other commentators point to the fact that it nevertheless amounts to a doubling of potential genetic damage, thereby rendering the risk of first-cousin marriage highly significant. Furthermore, one has to differentiate whether a cousin marriage is conducted only once or repeatedly in every generation as practiced among various societies in the Middle East, Asia, Africa, Oceania, and South America. Whereas in the first case, the grandparents of the marriage partners are genetically unrelated, in the second case they are related due to preceding cousin marriages, thus increasing the risk of genetic disorders among the offspring. However, there exist hundreds of different recessive genetic disorders, many associated with severe disabilities and sometimes early death, and each caused by a different variant gene. One should thus bear in mind that not every society displays the same recessive genetic features, so that immigrant communities deriving from differing populations are subject to varying genetic risks.

Related Topics

- ► Eugenics
- ► Honor killing
- ► Marriage

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Suggested Resources

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Dementia

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Dementia is a disease process characterized by a progressive decline in cognition. The general criteria for diagnosing dementia include the development of multiple cognitive deficits manifested by memory impairment, aphasia (language disturbance), apraxia (impaired ability to carry out activities), agnosia (failure to recognize or identify objects), or a disturbance in executive function (problem solving or planning). These cognitive deficits cause major impairment in social or occupational functioning and represent a substantial decline from a previous level of functioning. Dementia is further defined according to the etiology including Alzheimer's disease, dementia with Lewy bodies, vascular dementia, frontotemporal dementia, mixed dementia, and dementias related to neurological disease, nutrition, endocrinology, infection, metabolism, and trauma.

The prevalence of dementia increases with age. The number of individuals with dementia, worldwide, is estimated to be over 35 million. Alzheimer's dementia is the most common type of dementia comprising 50–75% of dementia. Dementia with Lewy bodies (a type of abnormality seen in the brain cells of affected individuals) compromises 15–35% of dementia cases followed by vascular (blood vessel disease) dementia and mixed dementia (dementia of multiple causes) accounting for 5–20% of the dementia case respectively. The incidence of all dementias is expected to rise as the portion of the aging population increases. There are an estimated 5 million Alzheimer's disease patients in the United States and this is estimated to rise to 16 million in 40 years. Few studies have focused on the prevalence of dementia in the immigrant population. It has been hypothesized that immigrants have a higher rate of dementia but this has not been borne out in large, controlled studies.

Factors associated with the development of dementia include age, gender, genetic factors, comorbid illnesses, environment, and lifestyle. Age is the strongest risk factor for the development of all dementias. Gender is a risk factor for the development of Alzheimer's disease. The incidence of Alzheimer's disease in women is higher than that in men. Genetic studies in the field of dementia have demonstrated a significant relationship between the APOE genotype and the risk of Alzheimer's disease. Genetic variations in the APOE genotype are a major risk factor for the development in Alzheimer's disease. Genetic studies have also yielded a positive correlation between polymorphisms (gene variants) in one of the inflammatory genes and the pathogenesis (causes) of Alzheimer's disease. Dementia is associated with the following conditions: diabetes, infections such as HIV, traumatic brain injury, and cardiovascular disease. Diabetes, hypertension, and peripheral vascular disease are more commonly associated with vascular dementia but are also risk factors for the development of Alzheimer's disease. Environmental factors refer to nutritional status and exposure to toxic agents. The relationship between environmental factors and the development of dementia is unclear. It has been hypothesized that some metals such as aluminum, iron, copper, and zinc are related to dementia. In addition, several nutrients have been associated with the risk of dementia such as thiamine, vitamin B12, and niacin deficiencies. Sedentary lifestyles or the absence of significant recreational activity is a risk factor for dementia. Studies demonstrate that physical activity is associated with the preservation of cognition. The relationship between immigrant status and risk factors for dementia is not well studied. Immigrant groups with low socioeconomic status, often

Sana Loue & Martha Sajatovic (eds.), *Encyclopedia of Immigrant Health*, DOI 10.1007/978-1-4419-5659-0,

associated with less education, may be more vulnerable to dementia due to absence of the protective education factor. The young age of immigrants compared to natives may decrease the overall prevalence of dementia.

Protective factors against development of dementia include advanced education, moderate alcohol use, and diet. In studies which examined the relationship between educational level and dementia, individuals with less education had a higher risk of dementia. The association between education and dementia is not definitive as there is some speculation that individuals with lower educational level may have lower premorbid (pre-disease) cognitive function. Some studies have identified alcohol consumption as protective from dementia. However, other studies have shown that excessive alcohol consumption may be associated with an increased risk of dementia. Medications used to manage cardiovascular risk such as Statin medications, through an anti-inflammatory mechanism, have been shown to reduce the risk of dementia in some studies. However, additional studies are needed to confirm this relationship.

Causes of Dementia

The neurodegenerative causes of dementia are the most common. These include Alzheimer's disease, dementia with Lewy bodies, frontotemporal dementia, Parkinson's disease, and Huntington's disease. Alzheimer's disease, the most common of all the dementias, is a degenerative disease of the cholinergic system (neurotransmitter acetylcholine). Cellular and tissue abnormalities of Alzheimer's disease involve the development of amyloid plaques (deposits of protein) and neurofibrillary tangles (bundles of fibers) which interfere with the connection between neurons. Dementia with Lewy bodies is the second most common of the neurogenerative dementias. Its neurogenerative pathology is characterized by abnormal deposits of a protein, alpha-synuclein, referred to as Lewy bodies. Vascular dementia results from progressive changes in the blood vessels which result in ischemia or reduction in blood flow to the brain. Frontotemporal dementia results from the degeneration of the frontal and temporal anterior lobes of the brain. These affected areas cause disturbances in behavior and language. Parkinson's disease and Huntington's disease are neurodegenerative disorders of the basal ganglia, the nuclei which control movement.

Medical conditions such as endocrine abnormalities, infections, and metabolic disease can also cause dementia. Common endocrine disorders that can cause dementia are hypothyroidism, hypercalcemia (high calcium), hypoglycemia (low blood sugar), and vitamin deficiencies. Infectious causes of dementia include HIV, prion, or viral disease such as Creutzfeldt–Jakob disease and neurosyphilis. Liver or kidney insufficiencies result in metabolic derangements that can lead to dementia. Environmental causes of dementia include traumatic brain injury and external agents such as alcohol, heavy metals, or carbon monoxide.

Diagnosis and Symptoms

The diagnostic criteria for the diagnosis for dementia as outlined in the *Diagnostic and Statistical Manual of Mental Disorders, 4th edition, text revision (DSM-IV-TR)* includes the development of multiple cognitive deficits manifested by both (1) memory impairment and (2) one of more of the following cognitive disturbances (a) aphasia (language disturbance), (b) apraxia (impaired ability to carry out motor activities despite intact motor function), (c) agnosia (failure to recognize or identify objects despite intact sensory function), (d) disturbance in executive functioning (i.e., planning, organizing, sequencing, abstracting). These cognitive deficits each cause significant impairment in social or occupational functioning and represent a significant decline from a previous level of functioning. The diagnosis of dementia is based on a clinical evaluation, laboratory testing including structural tests, and neuropsychological testing. The clinical evaluation involves taking the patient's history, interviewing a caregiver or family member, physical examination, and brief cognitive tests (such as the mini-mental status examination). The history taking should include a thorough investigation of the onset of the patient's cognitive symptoms and duration. The level of functional impairment resulting from the cognitive symptoms should also be determined. A caregiver or family member may assist in the corroboration of history as well as providing additional information. Risk factors for dementia should be assessed. Dementia in immigrant populations is a poorly studied area. The majority of research of dementia in immigrant populations is from the United States which may not be generalizable to other immigrant populations.

A psychiatric examination including a psychiatric history and current psychiatric and behavioral symptoms should be elicited when assessing dementia. Certain psychiatric disorders may mimic dementia by causing cognitive problems. In addition, some dementing illnesses present with psychiatric or behavioral manifestations. The mental status examination and mini-mental status examination (MMSE) are brief examinations used to assess an individual's psychiatric presentation as well as cognitive abilities. The MMSE is the most widely used bedside evaluation for dementia. The MMSE is based on a score of 30. Patients with mild dementia score 18–26, those with moderate dementia score 10–18, and those with severe dementia score less than 10. The clock-drawing test (ask the patient to draw a clock at a certain time) is another frequently used examination to screen for dementia. The clock-drawing test evaluates executive functions and visuospatial abilities. Cross-cultural assessment of dementia is problematic related to language and literacy skills. The use of the mini-mental status examination and clock drawing, culturally biased screening instruments, may be invalid in immigrant populations. Immigrants may be unfamiliar with the information required to complete both tests. In order to reliably use these cognitive tests in immigrant populations, the tests need to be validated for examining cognition in different ethnic groups.

The physical examination should focus on medical conditions that cause dementia as well as signs of focal neurologic deficits. Laboratory and structural tests are used to rule out treatable and general medical causes of dementia. Neuroimaging with computed tomography (CT) or magnetic resonance imaging (MRI) provide an assessment of structural patterns of atrophy (cellular degeneration), ischemia (cell injury or death due to lack of oxygen), neurosurgical lesions such as tumors, subdural hematoma (bleeding under the skull), and hydrocephalous (excessive fluid accumulation in the brain). Functional neuroimaging (specialized forms of visualizing the brain) provides analysis of brain activity. These tests can help discriminate between types of dementia. Neuropsychological testing provides detailed information in various cognitive areas.

The hallmark of dementia is memory loss. Patients with dementia typically present with impairment in short-term memory followed by long-term memory. Additional symptoms of dementia include language impairment, such as word-finding difficulty, impaired ability to complete simple tasks such as using appliances or tools. Agnosia or difficulty recognizing objects may present with unfamiliarity to family members or friends. Disturbances in executive functioning include inability to solve problems, plan events, manage finances, or exercise good judgment. The neuropsychiatric manifestations of dementia include mood, psychotic, or behavioral symptoms.

Prognosis and Treatment

The prognosis and treatment of treatment varies according to the etiology. Most subtypes of dementia have a progressive and irreversible clinical course. The exceptions to this are the rare forms of reversible dementia such as dementia due to a nutritional deficiency, hypothyroidism, or a neurological condition called normal pressure hydrocephalus. The progressive decline in cognitive skills results in an eventual loss of an individual's ability to function, or care for themselves. Treatment modalities vary depending on the type of dementia. Some types of dementia can be treated by treating the medical illness that led to dementia. For most types of dementia, treatment is palliative and aimed at improving symptoms or delaying the progression of symptoms. There have been few immigration studies of dementia. As a result of the limitation of scientific data, little is known about the prognosis and treatment of immigrants with dementia. Future studies of ethnicity and migrant status in dementia are needed.

Related Topics

► Cognitive testing
► Depression

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Suggested Resources

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Dental Caries

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Caries

Globally, caries is the most prevalent and least addressed preventable infection. The World Health Organization (WHO) data indicates that tooth decay affects 60–90% of school children and the vast majority of adults. In all populations studied, it disproportionately affects poor and minority populations; its prevalence is increasing internationally; and untreated caries has long-lasting detrimental educational, medical, and social effects.

Untreated, this infection leads to tooth decay or cavities. Decay in children is particularly insidious. Tooth decay can lead to severe pain impairing both learning and achievement – children in pain are inattentive in school, have increased absenteeism, and do not keep up academically. Additionally, 10% of children with untreated decay have sepsis, leading to increased morbidity and/or mortality.

This oral health problem extends beyond children to adults. In developed countries, visibly decayed or missing teeth are the outward markers of a "caste" system, connoting low educational achievement, faulty intellectual development, and/or poor parenting. Conversely, good dentition is important for nutrition, systemic health, educational success, and normal social interactions.

Fortunately, caries is a preventable bacterial infection. Over the last 40 years, pioneered by Ronald J. Gibbons at the Forsyth Institute in Boston MA, USA, it became clear that specific bacterial pathogens cause caries. From these findings evolved a twenty-first century preventive care model to reduce or eliminate this infection. However, this new care model has yet to replace the nineteenth century model of "drilling and filling," that is currently in vogue globally. Fillings neither reduce the infection nor affect the disease process causing cavities. Further, WHO data indicates that dentists are largely unavailable to provide fillings in both developing and developed countries (e.g., dentist to population ratios are: 1:1.2 million in Ethiopia; 1:300,000 in India; 1:2,100 in the United Kingdom).

Childhood Caries in Immigrants

To identify the current best evidence for childhood caries in immigrants, we searched MEDLINE (Search strategy: (Dental Caries OR Dental Caries Susceptibility OR Root Caries OR Dental Caries Activity Tests OR Caries Detector OR Dental Decay OR Tooth Decay OR Dental Cavity OR Dental Cavities) AND (Immigrant OR Immigrants OR Emigrant OR Emigrants) AND Limits: All Child: 0–18 years). The search identified 28 primarily cross-sectional studies addressing immigrant caries. Thus, what we know about the oral health of immigrants is largely demographic association, not a cause-effect demonstration. Further, the outcome measures of the studies vary considerably, making comparative estimates uncertain. Given these significant caveats, the consensus finding is that, where studied, immigrants have a significantly greater (usually > 2X) prevalence of caries compared to natives of new country of residence.

To identify the hypothetical causes of these health disparities, we again searched MEDLINE (Search strategy: (Dental Caries OR Dental Caries Susceptibility OR Root Caries OR Dental Caries Activity Tests OR Caries Detector OR Dental Decay OR Tooth Decay OR Dental Cavity OR Dental Cavities) AND (((Developing Countries) AND (Developed Countries)) OR (Economic Development)) AND ((Health OR Health Status) AND Disparities)). This search identified a single comprehensive study by Eduardo Bernabé and Martin Hobdell at the University College, London, UK. The most common unifying hypothesis was social determinants of oral health – a concept most clearly articulated by Michael Marmot also at University College, London, UK.

Social Determinants of Oral Health

The World Health Organization defines social determinants of health as: "the conditions in which people are born, grow, live, work and age." These social determinants (including their health system) are ultimately influenced by policy choices at the local, national, and global levels.

Focusing on children's dental caries, Hobdell pioneered a detailed examination of social determinants of oral health. Together with Bernabé, they found that, globally, both absolute and relative poverty affect oral health. On a global basis, there is a direct relationship between oral health and gross national income: oral health *increases* as gross national income *increases*. However, in rich countries, there is in inverse relationship between oral health and income inequality: oral health *decreases* as income inequality *increases*. The same is true for general health.

From these perspectives, we hypothesize that immigrant oral health depends on three primary social determinants (with nine sub-determinants) and three biological determinants:

1. The country of origin: (a) Gross national income per capita, (b) Income disparity, and (c) Cultural norms
2. The immigrant: (a) Social and economic status in the country of origin and (b) Social and economic status in the new country of residence
3. New country of residence: (a) Gross national income per capita, (b) Income disparity, (c) Cultural norms, and (d) Acculturation

The three biological determinants are:

1. The genetic heritage of the family
2. The bacterial colonization of the oral environment
3. Epigenetic effects on the genetic heritage

Prospective cohort studies to identify which of the foregoing determinants of immigrant health are the "critical few" and which are the "important many" are now needed.

Immigrant Populations

At the extremes, one would predict that when individuals move from poor countries with large income disparities to wealthy countries with less income disparity, the immigrant's oral health would be significantly less than those of the new country of residence.

Examples of this phenomenon can be commonly found. Globally, Latin America and the Caribbean exhibit the greatest wealth disparity, based on the Gini index, when compared to five other global geographic regions. Looking more closely at Latin America, 11 of the world's 20 countries with the greatest wealth disparity are Latin American. Further, roughly half of the region's poor live in the two largest countries Brazil and Mexico.

Mexico and the United States are examples of adjacent countries with substantial differences in absolute and relative wealth and disparity. The United States accepts more legal immigrants as permanent residents than all other countries in the world combined (~850,000 people/year), and immigration from Mexico accounts for 23% of this immigration.

For Mexicans migrating to the United States, current data supports the association hypothesis that inequality and poverty negatively encumbers oral health. In the United States, on average, 20% of elementary school age children have untreated caries (~ten million children). For Mexican-Americans, on average, 41% of elementary school age children have untreated caries – twice the United States average.

Studies of acculturation and literacy suggest that both factors inversely correlate with caries prevalence – an increase in acculturation and literacy correlates with a decrease in caries prevalence. Thus, as income status and education of the immigrant increases, caries decreases. Significantly, however, when preventive oral health care is provided to immigrant populations, oral health disparities are quickly ameliorated.

Solving the Caries Problem: A New Model for Comprehensive Caries Prevention

For the last half century, we have known that caries is a preventable bacterial infection. Globally, with this knowledge, numerous prevention programs have been proposed, and employed, in impoverished, developing, and developed countries. The most notable – the basic package of oral health care – was developed and implemented by Jo Frencken and his colleagues at the WHO Collaborating Center, Radboud University of Nijmegen, Netherlands. The concept is simple.

Comprehensive prevention both prevents new caries and inhibits the progression of current cares. There are three central themes to these prevention programs: (1) harden the teeth with fluoride to make the less susceptible to decay; (2) reduce or eliminate the causative bacteria; and (3) increase access and decrease costs by using dental hygienists or paraprofessionals, not dentists, to deliver care. This model is being successfully implemented in Europe (Nigel Pitts and colleagues, University of Dundee, Dundee, Scotland) Africa and Asia (Jo Frencken and colleagues), North America and South America (Richard Niederman and colleagues, Forsyth Institute, Boston, USA). Comprehensive prevention significantly reduces prevalence and incidence of decay, costs a fraction of dental office care, can be delivered where people learn, work, play, and pray, and brings care to people. This is in marked contrast to the current model of care that requires people to travel to obtain care.

Systematic reviews of randomized controlled trials indicate that the following individual interventions can be cost-effectively delivered by paraprofessionals and significantly reduce caries. When used in combination, there appears to be an additive effect: (1) Silver diamine fluoride (>30% solution), to kill the pathogenic bacteria and harden the teeth (>90% decay reduction/year); (2) Fluoridated toothpaste (>1000 ppm), to facilitate tooth cleaning and harden teeth (>20% decay reduction/year); (3) Fluoride varnish to harden teeth (33% and 46%/year decay reduction in primary and permanent teeth, respectively); and (4) Glass ionomer sealants and atraumatic restorative treatment (e.g., no anesthesia, drilling, or rubber dam), to prevent decay occurrence (>80% decay reduction) and halt decay progression and (40–75% decay reduction/year), respectively. Initial work suggests that the natural sweetener xylitol, by inhibiting bacteria from attaching to teeth, and milk fluoridation to harden teeth, may each reduce caries. However the quantitative effect is not clear. Interestingly, both approaches also appear to reduce otitis media and school absence. Finally, salt fluoridation may be effective where water fluoridation is not feasible.

In sum, the benefits of caries prevention are fourfold. First, it can provide safe, effective, efficient, accessible, equitable care to a large patient population where people are located at a reduced cost. Second, if care is provided by local caregivers care will be culturally competent and relevant, and create new jobs. Third, the finding that oral infections have a multitude of negative medical and social consequences highlights the benefit of cost-effectively controlling this infection early in life. Fourth, twenty-first century caries prevention by non-dentists, offers the possibility of virtually eliminating the sequelae of this infection.

The Challenge

The challenge will be to overcome a century-old tradition of stakeholder infrastructure. The momentum of this tradition supports training, licensing, boarding, and compensation, all of which are secured by governments, professional schools, and regulatory agencies, who have a stake in the past. To overcome this barrier, at the extremes, care systems will need to implement either a “top-down” policy change, or a “bottom-up” disruptive innovation approach.

Given the momentum of tradition, the inertia infrastructure, and the difficulty of policy change, a top-down policy change seems unlikely. Alternatively, and much more likely, is a bottom-up, disruptive innovation approach articulated by Clayton Christensen and colleagues at the Harvard Business School in Cambridge, MA. This approach starts at the bottom of the social pyramid, and provides preventive care, with multiple demonstration programs in multiple countries. Independently, similar programs like this are being implemented by Frencken, Pitts, and Niederman and their colleagues. The challenge for innovators will be to quantitatively document increased care access, health improvement, and cost-effectiveness to support and secure long-term political, social, and financial sustainability.

Hopefully, were comprehensive caries prevention delivered by paraprofessionals, systematically disseminated and implemented, it could have an immediate cost-effective, beneficial impact in reducing caries and improving oral health among native, poor, and immigrant populations globally.

Related Topics

- ► Acculturation
- ► Child development
- ► Dhat

Suggested Readings

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Department of Homeland Security

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The Department of Homeland Security (DHS) came into existence in 2003. It was created in response to the terrorist attacks of September 11, 2001 in an attempt to bring under one roof the various agencies and departments concerned with protecting the USA and responding to disasters – natural or man-made. It combined 22 different agencies from the Departments of Justice, Energy, Agriculture and Treasury, including the Secret Service, the US Customs Service, the Immigration and Naturalization Service, the Federal Emergency Management Service, the National Domestic Preparedness Office, and the US Coast Guard.

Some agencies were split into components and realigned with other agencies. The Immigration and Naturalization Service was split into three new agencies and intermixed with various agencies including the Federal Protective Service, US Customs Service, and Animal and Plant Health Inspection Service. The Immigration and Naturalization Service became the Immigration and Customs Enforcement (ICE), Customs and Border Protection (CBP), and the United States Citizenship and Immigration Services (CIS).

The idea behind bringing these agencies into a new federal department was to improve the security of the USA by improving efficiency and communication. In addition, proponents felt that the new department would allow for faster response times and improve the effectiveness of a response by better coordination between agencies.

Critics felt that the combination of so many varied agencies with different agendas into one department would increase confusion and lead to more inefficiencies. Since 2003, three directorates originally created have been eliminated and one agency has been returned to the original department. Also, talks continue about the advisability of certain combinations. For example, there is talk about recombining ICE, CBP, and CIS into one organization again.

Some critics point to the slow response to Hurricane Katrina in 2005 as evidence that the DHS model does not work. Occasional calls continue to remove certain agencies, such as the Coast Guard from under the DHS umbrella. Others argue that certain agencies or departments such as the Federal Bureau of Investigation should be brought into DHS in order to truly have one organization that has access to all the law enforcement and emergency management tools available in the USA.

The Department of Homeland Security has limited involvement with health-related issues. The Federal Emergency Management Agency (FEMA) is responsible for responding to natural or man-made disasters, including organizing the provision of emergency health services, shelter, and food, all of which are of course important for the maintenance and management of the public health. Similarly, the immigration-related agencies are expected to enforce laws designed to keep out non-US citizen individuals with health issues deemed to pose a danger to the public health. The Transportation Security Agency (TSA) similarly has responsibilities to quarantine any individual (US citizen or otherwise) suspected of being a danger to the public health.

Related Topics

- ▶ Bureau of Immigration and Customs Enforcement
- ▶ Quarantine

Suggested Resources

Department of Homeland Security website. http://www.dhs.gov/index.shtm

Deportation

- ► Illegal immigration
- ► Immigration status
- ► Irregular immigration

Depression

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Depression: Overview

Depression is a medical condition that affects individuals of all racial, ethnic, and socioeconomic backgrounds. It is estimated that more than 15 million adults in the USA or about 6.7% of the population of age 18 and older suffer from depression in any given year. It is more prevalent in women than men and is the leading cause of disability.

Depression in Western Societies

The current understanding of phenomenology of depression is almost entirely based on studies of Western populations and has resulted in specific diagnostic criteria established in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) and International Classification of Diseases (ICD), commonly recognized by contemporary Euro-American psychiatry.

Based on those criteria, depression affects most aspects of life, interferes with daily functioning, participation in social activities, satisfaction with school and work, sleeping and eating habits and general health.

People suffering from depression exhibit a very low or irritable mood and inability to enjoy previously enjoyable activities. They are preoccupied with feelings of worthlessness, inappropriate guilt or anger, helplessness and hopelessness. They can exhibit difficulty with memory and concentration, and in severe cases they can have suicidal thoughts. Multiple physical symptoms, like disrupted sleep pattern, changes in appetite, reduced sex drive, fatigue, aches and pains, and digestive problems are common. The severity, frequency, and constellation of symptoms vary depending on the individual.

There are several forms of depressive disorders. The most common are major depressive disorder and dysthymic disorder. In major depressive disorder, also known as a major depression, a combination of symptoms disables and prevents a person from functioning. Dysthymic disorder is less severe and less disabling, but symptoms usually last for at least two years.

Other forms of depression have slightly different characteristics and may develop under unique circumstances. Postpartum depression is diagnosed within 1 month after a delivery. Depression as a part of seasonal affective disorder occurs during the winter months. Depression can also occur in the course of Bipolar illness.

There is no single known cause of depression. It results from a combination of biochemical, environmental, and psychological factors.

In addition to neurochemical changes in brain or genetic factors, any stressor, like trauma, loss of a loved one, or environmental factors can trigger a depressive episode.

Depression in Non-Western Cultures

Non-Western sufferers of depression make up approximately 90% of all depressed patients globally.

Based on research studies done across different cultural groups, depressive symptoms described in Western diagnostic systems are generally applicable and uniformly reported. However, a constellation of different indigenous experiences has been identified among various cultural groups. It accounts for a specific picture of depression among different ethnic groups.

The term “dysphoria” which is used to describe sadness, hopelessness, unhappiness, has dramatically different meanings and forms of expression in different societies. For Buddhists, for example, taking pleasure from things is the basis of suffering; therefore, a willful dysphoria is the first step for salvation. For some Muslims grief is a religious experience and the ability to fully experience dysphoria is the marker of person's depth.

There are differences described not only in the experience of depressive mood but also in symptomatology. In some of the African communities the first signs of illness are the dreams about witches attacking their vital essence. For some American Indians hearing voices of dead relatives is normal, not a sign of illness.

Dramatic differences were also found in the expression of bodily complaints associated with depressive illness not available for most of the members of Western society. Nigerians report "ants creeping in parts of the brain," and Chinese complain of exhaustion of their nerves and of their hearts being squeezed.

Depression in Immigrant Population: Risk Factors

Immigration is a process that includes the initial decision to migrate, the process of migration, and acclimatization to the new country.

Its path is filled with risks and stressors that are unique to immigrants both prior to and after their arrival. In general, immigrants are at higher risk for mental health problems, with depression and anxiety disorders being predominant.

Premigration and Migration Factors

Premigration and migration stressors include previous traumatic events in immigrants' homelands (war exposure, torture, terrorism), many of which prompt decision to migrate in the first place. These are often compounded by the loss of extended family, parental separation, and traumatic journeys to the USA (witnessing deaths, suffering physical or sexual assault, hunger, as well as continued rejection and suffering while seeking asylum) and survival as an immigrant.

Refugee populations arrive with memories of torture that intensify the shock of living in a new place. Those who survived the camps and other forms of brutality, must now navigate in the new culture which increases the sense of being traumatized and isolated.

Different immigrant groups have different degree of exposure to such trauma, with Central American, Cambodian, Tamil, Bosnian, and Cuban refugees being significantly affected.

Post-Migration Factors

For many immigrants it is not an extraordinary trauma, but the ordinary stress of everyday life, compounded by language and economic problems that causes their depression.

Changes in the living environment, difficulties navigating and negotiating social systems, financial concerns, discrimination, isolation, changing family structure and language barrier seem to be major factors in the emergence of depression in the immigrant population.

The majority of immigrants come to escape poverty in their countries and often have low education levels and little job skills. They inhabit inner city neighborhoods which have high prevalence of crime and live in overcrowded buildings in the atmosphere of impending danger. They suffer from feelings of loneliness, isolation, powerlessness, and dependency.

Change in living environment requires adaptation to new culture, people, and language. It often bears the burden of mismatched perceptions of living in the USA and the reality upon arrival. Immigrants' struggles are intensified by common lack of extended family and changing role status, like becoming primary bread winner or caretaker for the household.

Discrimination and prejudice are often the major stressors. They can originate not only from mainstream culture Americans but often from earlier-arriving immigrants who may feel threat to their job security and resources.

The process of cultural transition is as much of a psychological stress as a sociological one with significant implications for the immigrants. They may cope in different ways, like anxiously trying to meet the demands of both cultures, abandoning the culture of origin or trying to integrate the best of both. This is particularly challenging for older immigrants from China, Korea, Russia, and Eastern Europe. It makes them more vulnerable for depression because of an interaction of their traditionalism and cultural inflexibility, lack of family, language barriers, and physical limitations. The prevalence rates for depression among elderly immigrants have been described as high as 30%.

Another important factor is losing the social standing that people had prior to immigration. People who had a relatively high social status in their native countries because of their jobs, incomes, and education, may experience more frustration, uncertainty, and chronic stress which increase their risk of depression.

Treatment Options

Depression, even the most severe cases, is a highly treatable disorder. As with many illnesses, the earlier that treatment can begin, the more effective it is and the greater the likelihood that recurrence can be prevented. The most common treatments are medications and psychotherapy.

Antidepressant Medications

Depression is commonly treated with antidepressant medications that work to balance some of the natural chemicals in the brain called neurotransmitters. They include serotonin, norepinephrine, and dopamine and affect our mood and emotional responses.

The most popular antidepressant medications are selective serotonin reuptake inhibitors (SSRIs). These include fluoxetine (Prozac), Citalopram (Celexa), Sertraline (Zoloft), Paroxetine (Paxil), and Escitalopram (Lexapro).

Other types of antidepressants are serotonin and norepinephrine reuptake inhibitors (SNRIs). SNRIs are similar to SSRIs and include venlafaxine (Effexor) and duloxetine (Cymbalta). Another medication that is commonly used is bupropion (Wellbutrin) which works on the neurotransmitter dopamine.

SSRIs and SNRIs are popular because they do not cause as many side effects as older medications. Most common side effects associated with their use include headache, nausea, drowsiness, and increase in anxiety and sexual problems.

Older antidepressant medications include tricyclics, tetracyclics, and monoamine oxidase inhibitors (MAOIs). They can cause side effects like dry mouth, constipation, bladder problems, blurred vision, and drowsiness. People taking MAOIs need to be careful about the food and the other medications they take because of possibility of dangerous increase in blood pressure.

It can take 3 or 4 weeks until the medication takes effect. Some people take the medications for a short time but the ones with long-term or severe depression may need a long term treatment.

Psychotherapy

Psychotherapy has been shown to be effective in the treatment of depression and may be the best option for mild to moderate symptoms.

It is also known as talk therapy or counselling. During the sessions patients learn about causes of depression to better understand their illness. They learn how to identify and change unhealthy behaviors or thoughts, explore their relationships and find the better ways of coping with stress and setting realistic goals for life. Psychotherapy helps regain sense of happiness and control. It can ease sense of hopelessness and anger.

There are several types of psychotherapy. Cognitive behavioral therapy (CBT) is one of most commonly used for depression and it helps patients to identify negative beliefs and behaviors and replace them with healthy, positive ones. Other types include interpersonal psychodynamic therapy and supportive therapy.

Sometimes depression is so severe that patients require inpatient hospitalization in the psychiatric unit especially if they are in immediate danger of harming self or somebody else or are unable to take care of themselves properly.

Partial hospitalization or day treatment programs are also helpful.

The majority of outpatient psychiatric care occurs through community mental health centers.

Special Considerations for Treatment in Immigrant Populations

The use of community-based mental health services is extremely valuable in addressing the needs of immigrants and their families. However, several disparities have been identified between mental health of US-born citizens and minorities and immigrant populations. Some of them include diminished availability of mental health resources, lack of health insurance or transportation, cultural perceptions and societal stigma toward mental illness, racism, discrimination and barriers in communication.

Reluctance in help seeking is deeply influenced by cultural perceptions of symptom manifestation and culture-specific coping strategies. In many countries people do not talk about mental illness and in some languages there is no word for depression. Depression is a stigmatized condition and immigrants have much higher odds of reporting stigma related concerns, especially Latino and African women. The individuals who experience depression-like symptoms may not openly verbalize their concerns because of fear of being labeled "mad," or being worried about their family disapproval.

Symptom manifestation may vary and can be focused predominantly on somatic symptoms, such as body aches, tiredness, or headaches. This is distinct from Western-oriented terminology. It is the reason why about 50% of people from minority and immigrant populations never receive diagnosis or treatment for depression. It can also explain why most of the immigrants from rural areas seek help for their symptoms in the primary care clinics.

Addressing the issues of access to treatment and reducing the barriers should be dominated by development and delivery of culturally appropriate services. Service providers must be educated about the unique challenges that immigrants face that may reflect their ability and willingness to seek mental health services.

Psychotherapy and process groups should be organized and provided by culturally competent clinicians.

Another critical function placed upon community mental health services is help with housing and vocational training, allowing the beginning of integration and acculturation with a new community.

Patient education about mental health treatment, efforts to assure privacy and effective stigma-reducing educational campaigns are also helpful for immigrant populations.

Related Topics

- ▶ Discrimination
- ▶ Health care utilization
- ▶ Posttraumatic stress disorder
- ▶ Refugee
- ▶ Stigma
- ▶ Trauma
- ▶ Trauma exposure

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Detention

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Immigration detention refers to the policy of holding individuals suspected of visa violations, illegal entry, or other like circumstances. This policy is applied until the immigration authorities decide to grant a visa and release the individual into the community, or to repatriate him or her to the country from which he or she departed or in which they were born.

In the European law context, several provisions are relevant to immigration detention. The first one is a European Union directive adopted in 2003 that stipulates that asylum seekers within the European Union "may move freely" within the host member state territory. Another paragraph stipulates that "for legal reasons of public order, Member States may confine an applicant to a particular place in accordance with their national law." Also, another provision of the same directive relates to maintaining family unity: "Member States shall take appropriate measures to maintain as far as possible family unity as present within their territory, if applicants are provided with housing by the Member State concerned." Another important legislative act is the "Guidelines on All Stages of the Forced Return Process" adopted by the Council of Europe's Committee of Ministers in 2005, which stipulates that people in immigration detention in Europe pending their removal from territory "should not normally be held together with ordinary prisoners" and also that "that principle of the unity of the family should be respected and families should therefore be accommodated accordingly."

All of these provisions underscore the fact that the immigrant is a human being and also that the status of an individual seeking asylum is not to be equated with the status of a prisoner. Family values are to be recognized and protected. In order to have an overview of this issue and also to analyze the impact of detention on immigrants' health, the situation in different countries shall be compared.

In Germany, every person without legal authorization papers to be in the territory, including persons whose "asylum claim has been rejected and who are subject to . . . deportation" is subject to detention. The regulation in some of the detention centers provides that detainees are allowed to exercise for only "one hour in the yard" and that they have to ask for permission for every small gesture, like "to open a window. . .or fetch hot water for tea." It is obvious that such regulations may influence in a negative way the physical and mental status of the immigrants.

Until 2002, Australia had similar regulations in centers called "immigration reception and processing centers." The 2002 publication *Children out of Detention Report* showed that "detention itself is a damaging environment for children," that "detention itself is the cause of significant mental health problems in children, additional to the trauma and persecution already experienced by them in their home country and during their journey to 'freedom.'" Beginning in 2005, the development of alternatives to detention was proposed. Currently, all families with children under the age of 18 are integrated into a program based on "community detention."

Some Asian States like Indonesia and Malaysia are known to imprison immigrants for visa violations. In comparison, some immigrants in the UK are detained if they have been serving a prison sentence which has expired. (The 2002 UK Nationality, Immigration and Asylum Act in 2002 changed the name of "detention centers" to "removal centers.") In 2008, the UK Home Office published data that showed that 2305 people were detained in "removal centers" under Immigration Act powers. Of these individuals, 1980 immigration detainees were male and 35 were children under the age of 18 years. As of 2006, there have been approximately nine suicides in the UK detention centers.

In the United States, some reports indicate that between 2003 and 2008, approximately 104 mostly young individuals have died in detention of the United States Immigration and Customs Enforcement or shortly afterward; medical neglect may have contributed to 30 of those deaths. One of the most recent changes is the opening of centers specifically to house noncriminal families.

Summarizing, many reports have concluded that immigration detention may have negative consequences on the physical and mental health of detainees, especially those who are children. There have been reported deaths and suicides in detention centers. The environments created by internal regulations may adversely impact detainees' quality of life. The practice of detaining immigrants in ordinary prisons and detainees' lack of access to adequate health care raise critical human rights' issues.

Related Topics

- ► Human rights
- ► Immigration status
- ► Immigrant visa status

Suggested Readings

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Suggested Resources

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Dhat

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Dhat syndrome was first described by Norenda Wiq in 1960. However, Morris Carstairs, a British psychiatrist-anthropologist, had made note of the appearance of this syndrome in earlier clinical observations. Dhat is classified as both a neurotic disorder and a culture-bound syndrome by the *International Classification of Diseases, 10th edition* (ICD-10). Dhat syndrome is also classified as a culture-bound syndrome by the *Diagnostic and Statistical Manual of Mental Disorders, 4th edition, Text Revision (DSM-IV-TR).*

The word *dhat* is the English derivation of the Sanskrit word *dhatus*, indicating the seven essential elements of the human body: *rasa*, fluid from digested food; *rakta*, blood; *masma*, muscle; *meda*, fat; *ashti*, bone; *majja*, marrow; and *sukra*, semen. The imbalance of these elements is believed to injure one's health. Because semen is thought to be the source of physical and spiritual strength, its loss is perceived as both a loss of energy and the cause of physical and spiritual injury.

Both patients and some practitioners attribute the symptoms of dhat to a white discharge in the patient's urine; this is interpreted as the loss of semen in nocturnal emissions through urine and as the result of masturbation. Additional reported symptoms include fatigue, weakness, anxiety, loss of appetite, guilt, and sexual dysfunction. Other functional somatic syndromes present with similar symptoms.

It has been suggested by some researchers that individuals suffering from dhat may be predisposed to amplify somatic symptoms. They may be unable to discuss sexual issues openly because of cultural mores and, as a result, may have misconceptions about masturbation. When the individuals become stressed, they may focus their attention on symptoms of fatigue and changes in the turbidity of urine and misinterpret these symptoms as evidence of semen loss through their urine. This, in turn, may lead to increased anxiety and help seeking. Depression and anxiety have been noted in men presenting with dhat in both psychiatric clinics and in clinics for the diagnosis and treatment of sexually transmitted infections.

Dhat is now reported primarily from individuals between the ages of 20 and 38 who are from the Indian subcontinent. However, historical records suggest that the same syndrome once existed in Europe, the United States, and Australia. It is thought that the syndrome disappeared as the result of significant economic and social changes.

With increasing migration and globalization, more clinicians outside of the Indian subcontinent are likely to have patients who present with concerns about dhat. Accordingly, it is important that the clinician consider not only known biological and psychological factors, but also relevant sociocultural factors in diagnosing and treating a patient who presents with dhat.

Related Topics

- ▶ Culture-specific diagnoses
- ▶ Depression

Suggested Readings

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DHS

▶ Department of Homeland Security

Diabetes Mellitus

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Background

Diabetes mellitus is a metabolic condition characterized by elevated concentrations of blood glucose (sugar) derived from food sources, which may be due to lack of production or proper regulation of insulin. After a meal, blood glucose level raises and the pancreas releases insulin, a hormone, so that cells throughout the body take in the glucose and use it as an energy source. Unregulated blood sugar levels may lead to several physiological complications. There are three types of diabetes mellitus, defined by the cause of insulin deregulation:

1. Type 1 diabetes (T1D), formerly known as juvenile diabetes, is usually diagnosed in children or young adults, and is characterized by a lack of insulin production. Insulin is completely obstructed by autoimmune responses that destroy pancreatic β cells.
2. Type 2 diabetes (T2D) is the most common type of diabetes. People with the condition do not produce enough insulin, or body cells do not regulate it properly, a condition known as insulin resistance. In T2D, resistance to insulin occurs because muscle, fat, and liver cells do not respond well to insulin and cannot take up the glucose circulating in the blood. The result is elevated blood glucose and insulin, as the pancreas produces more insulin to help the accumulated glucose enter the cells.
3. Gestational diabetes occurs in some pregnant women – it affects about 4% of all pregnancies – without a previous diagnosis of diabetes, who develop elevated blood glucose during gestation due to insulin resistance caused by hormonal changes.

A person may also have prediabetes, a condition where blood glucose levels are higher than normal but not high enough to be classified as diabetes. This is known as impaired fasting glucose (IFG) or impaired glucose tolerance (IGT).

Prevalence

Over 285 million people worldwide have diabetes. As of 2007, 23.6 million children and adults in the USA had diabetes, accounting for 7.8% of the population. The number reflects both diagnosed (17.9 million) and undiagnosed cases (5.7 million). Additionally, 57 million people have prediabetes. Each year, 1.6 million new cases of diabetes are diagnosed in people aged 20 years and older. T2D represents the majority of diabetes cases; T1D accounts for only 5–10% of all cases. The prevalence and incidence of T2D increase with age. Almost one in four of people aged 60 years or older has diabetes. Diabetes rates are similar by sex; however there are striking differences by race. In adults, the prevalence of all types of diabetes is 6.6% for non-Hispanic Whites, 7.5% for Asian Americans, 11.8% for non-Hispanic Blacks, and 10.4% for Hispanics, with more variation among ethnic subgroups. Among the three major Hispanic subgroups, Cubans have the lowest prevalence (8.2%), followed by Mexican-Americans (11.9%), then Puerto Ricans (12.6%). There are geographical differences in prevalence of diabetes in the USA, with more diabetes cases reported in the southeast states.

High prevalence of diabetes has been reported among immigrants of several countries, compared to the native population, including the USA, Canada, Denmark, Belgium, Spain, India, and the UK. Region of birth among US immigrants is a factor for disparities in prevalence of diabetes; immigrants from the Indian subcontinent, from Mexico, Central America, or the Caribbean are more likely to have diabetes than European migrants. Moreover, diabetes increases with longer residence in the USA, stabilizing at 10 or more years of residence, with the largest effect among immigrants arriving to the USA at 25–44 years of age.

Similar disparities in mortality rates as those observed with prevalence are reported by race/ethnicity. Overall, diabetes was the seventh leading cause of death in the USA. As of 2006 close to 234,000 deaths were attributed to this disease and many more people die because of complications related to diabetes.

Risk Factors and Prevention of Diabetes

Genetic and environmental factors have been strongly tied to diabetes mellitus. Several genes have been pointed out as likely contributors to predisposition of T1D, most of them mapping to immune regulation pathways. Environmental factors that have been implicated with increased prevalence or risk of T1D include viral infections and other microbial stimuli, cold temperature, winter season, or lack of sun exposure. Some dietary behaviors, such as breastfeeding, may have a protective effect. Prevention of T1D has proven difficult so far. Prevention trials have been largely unsuccessful, and the focus is on lifetime management of the disease.

The genetics of T2D are more complex; several genetic variants have been implicated in predisposing to the disease at different combinations, with variations among racial/ethnic subgroups. Having a first-degree relative with T2D is one of the strongest risk factors for the disease; about 30–70% of the risk for T2D could be attributed to genetics. Some other non-modifiable risk factors for diabetes include older age and race/ethnicity (Black, Asian, Native American and Hispanic). Physiological risk factors include being overweight (Body Mass Index (BMI) $\geq$ 25 kg/m^2), hypertension, HDL-cholesterol level <35 mg/dL (0.90 mmol/L) and/or a triglyceride level >250 mg/dL (2.82 mmol/L), history of a cardiovascular condition, and being a women with polycystic ovary syndrome or who delivered a baby weighing >9 lb or was diagnosed with gestational diabetes.

There is strong evidence that the following lifestyle risk factors increase risk for diabetes, independently from obesity: physical inactivity (sedentary practices), smoking, and poor dietary habits including high intake of sugar-sweetened beverages and foods with high glycemic index or glycemic load (such as rice cakes/crackers, white bread or white rice). Additionally, moderate alcohol intake has been associated with decreased risk for diabetes. These lifestyle factors provide the main opportunities for prevention of T2D, particularly exercising at least 30 min a day, and maintaining a diet high in fiber and polyunsaturated fats, and low in saturated and trans fats and in refined sugars. Managing other biological risk factors, such as controlling blood pressure, losing and keeping off weight, and monitoring blood lipid levels, may also significantly prevent the disease. People with prediabetes may need drug therapy to further prevent development of diabetes.

Classification, Diagnosis, and Symptoms of Diabetes

The most common laboratory test used to diagnose diabetes is measuring fasting blood glucose. The American Diabetes Association (ADA) sets the diagnostic cut point at $\geq$126 mg/dL (7 mmol/L). An oral glucose tolerance test (OGTT) is another common diagnostic tool; 75 g of anhydrous glucose dissolved in water are given to the patient and blood sugar is measured at time intervals, over a period of 2 h (time span could vary from 1 to 3 h). Diabetes is diagnosed for those with values of $\geq$200 mg/dL (11.1 mmol/L) at 2 h. An OGTT is usually administered to pregnant woman during the 24–28th weeks of gestation to test for gestational diabetes. Measures of glycosylated hemoglobin, or HbA1c, are taken to confirm diagnosis of diabetes and/or monitor blood glucose control in diabetes patients. A value $\geq$6.5% is considered elevated. Any test resulting in values above the designated cut points should be repeated before a diagnosis of diabetes is confirmed, unless the patient shows classic symptoms of hyperglycemia (high blood glucose).

The classification for prediabetes, or individuals with high risk for future development of diabetes, is defined as having IFG (fasting plasma glucose between 100 mg/dL [5.6 mmol/L] and 125 mg/dL [6.9 mmol/L]) or IGT (OGTT values from 140 mg/dL [7.8 mmol/L] to 199 mg/dL [11 mmol/L]). Additionally, HbA1c values of 5.7–6.4% indicate high risk for diabetes.

Testing for T2D is recommended for adults 45 years or older, as well as those with risk factors or symptoms of diabetes. Testing for T1D in children is usually done after the child exhibits other signs and symptoms of diabetes. Although diabetes can manifest without symptoms, common ones include frequent urination, extreme thirst and hunger, and fatigue. People with T2D may also experience unexplained weight gain or loss, frequent infections, blurred vision, slow healing, and tingling/numbness in the extremities.

Complications of Diabetes

Health Complications

Diabetes mellitus is a serious metabolic disease that, if untreated, can lead to several complications. Because multiple organs are involved in the regulation of insulin and in glucose uptake, the range of complications is large and varied. The major concern is hyperglycemia, or extremely elevated blood glucose. Developing other risk factors, like gaining weight or having high blood pressure, is also commonly observed in diabetes patients. Having diabetes increases the risk of having a heart attack, stroke and other cardiovascular conditions, particularly at an earlier age. Skin infections and disorders, eye diseases (retinopathy, cataracts and glaucoma), and nerve damage (neuropathy) could arise, and tend to appear after several years of living with diabetes. Nerves from various systems may be affected, leading to further complications such as sweating, sexual dysfunction, gastric problems, loss of coordination, and loss of sensation in the feet. The latter is of great concern, as it increases the risk for foot sores and injuries that if untreated could culminate in amputation.

Ketoacidosis is another serious complication that can lead to diabetic coma or death. The condition is due to the production of ketones, a by-product of burning fat for energy (because glucose cannot be used). Ketones accumulate in the blood and are excreted in the urine; this is a warning sign of uncontrolled diabetes and possible diabetic ketoacidosis. Another complication of diabetes is that kidney function may be altered because blood albumin leaks into the urine. Kidney failure may occur with advanced stages of diabetes and kidney damage. This condition requires dialysis, a procedure where blood is filtered to remove metabolic wastes and extra water while adding new vital chemicals (artificially doing the function that the kidney can no longer perform), or a kidney transplant is needed. Imbalances in thyroid function are also observed, especially in those with T1D.

Psychosocial and Economic Effects

Managing diabetes may burden the mental health and well-being of the patient, as well as the caregiver. The stress and anxiety of monitoring and controlling a lifelong condition can bring mental distress and strong, negative feelings. Although having diabetes does not cause depression, people with the metabolic disease have higher risk for becoming depressed.

There is also a high economic burden for the individual as well as the healthcare system. For a patient, the cost of treatments for diabetes adds up through a lifetime of having the condition. This is particularly true for low-income racial and ethnic groups, and immigrant groups lacking proper health care or coverage, and who have diabetes disproportionately. For the US health care system, the total cost of diagnosed diabetes amounted to $174 billion in 2007, including $116 billion for direct medical costs and $58 billion for indirect costs (disability, work loss, premature mortality). The total cost increases to 218 billion when accounting for undiagnosed diabetes ($18 billion), prediabetes ($25 billion), and gestational diabetes ($623 million).

Treatment for Diabetes

Unfortunately, finding a definitive cure for diabetes has been elusive. Yet, significant strides have been made toward defining successful treatments for the disease. A person diagnosed with diabetes mellitus should be followed by a team of clinical experts, as multiple tests and treatments, across various medical disciplines, may be administered. Monitoring blood glucose is critical in managing the disease. Home blood glucose tests are available to ease the burden of constant testing. The ADA has established guidelines on self-monitoring of blood glucose as part of an effective therapy strategy to help prevent complications and adjust medications and physical activity appropriately.

For those with T1D, measuring sugar in the blood must be done several times a day; while for patients with T2D and with glucose control, tests can be done less frequently. HbA1c tests should be performed routinely in all patients with diabetes as it strongly predicts diabetes complications.

Patients of T1D depend on insulin injections or pumps (insulin cannot be ingested as a pill) as primary treatment to manage the condition and prevent further complications. Insulin analogues with rapid absorption and long-lasting effects are effective and convenient to use. Planned meals consisting of healthy foods should also be part of the treatment. Parental participation is critical as this condition is common in children and young adults who may not be willing or able to manage the disease alone.

Initial treatment of T2D involves lifestyle modification similar to those suggested for the prevention of diabetes. Recommendations include weight loss or maintenance of a healthy weight, a high quality diet low in saturated and trans fat and high in complex carbohydrates, smoking cessation, and a physical activity routine consisting of 150 min/week of moderate-intensity or 75 min/week of vigorous aerobic physical activity as well as muscle-strengthening activities involving all major muscle groups 2 or more days per week. Professional nutritional counseling and meal planning is often advised. These lifestyle therapies provide significant benefits even when drug treatment is given, particularly in controlling other co-morbidities that may exacerbate diabetes.

There are six different classes of drug therapies for T2D; each one works in a different way to lower blood glucose levels. The most commonly prescribed medication is metmorfin, which lowers the amount of glucose produced by the liver and helps muscle cells absorb glucose. Other common drug types include sulfonylureas, which help the pancreas make insulin, and thiazolidinediones, which helps insulin work better in muscle and fat cells and reduces glucose production in the liver. Rezulin, a thiazolidinedione, has been discontinued because of serious adverse effects on liver function, and other drugs in this class, such as Avandia, have been associated with an increased risk for heart failure but are still effective and commonly prescribed. Medications can be prescribed alone or in combination. As diabetes is often accompanied by comorbidities, possible drug interactions must be considered. Finally, unregulated blood glucose in T2D patients may require insulin injections.

Other clinical tests should be performed to monitor risk factors as well as potential complications. These may include laboratory tests for blood lipids, blood pressure measurements, liver and thyroid function tests, and urinary measures. Due to the possibility of complications, diabetes patients may be followed by specialists in eye and foot care and in renal and digestive diseases, a dentist, a registered dietician, mental health counselors, and other specialists.

Although the ADA recommends that a person with diabetes receive comprehensive evaluation, immigrants are less likely than US-born individuals with diabetes to adhere to any one of seven diabetes care recommendations, in general. Specifically, they are less likely to report having received an influenza vaccination. There are similar reports of poorer diabetes control among immigrants in other countries.

Besides clinical treatments for the patient, diabetes mellitus should be prevented and controlled through other approaches. These may include community programs and interventions (particularly those targeting modifiable risk factors), continued education for clinical staff, support for caregivers, research on the causes and best treatment and clinical practices, and policy, legislation and system changes to improve insurance coverage and quality of care, among other initiatives.

Special Considerations for Immigrant and Minority Populations

Immigrants and racial and ethnic groups have disproportional prevalence and mortality rates for diabetes. The fundamental causes for such are varied, from genetic variation, to nutrition transition (changing from traditional dietary patterns to a Western-type diet), to disparities in risk factors and socioeconomic barriers for prevention and treatment. For example, foreign-born individuals with diabetes tend to be younger, have lower education levels and income, and are more likely to have public or no insurance compared with US-born individuals with diabetes. The impact of rural to urban migration can also affect lifestyle behaviors and thus, diabetes risk. For immigrants, diabetes prevention and control strategies should start soon after arriving to the USA.

Cultural norms and values should be taken into account when working with immigrant and minority populations with respect to prevention and control of diabetes. For example, issues like cultural perceptions of body weight, dietary customs, medical beliefs, language barriers, and citizenship status, among others, should be considered.

Related Topics

- ► Cardiovascular disease
- ► Chronic disease
- ► Hypertension
- ► Nutrition
- ► Obesity
- ► Vision and eye care

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Diaspora

► Emigration
► Ethnic enclaves

Dietary Patterns

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Introduction

With the American population becoming more and more diverse, dietary patterns of minority groups, constantly reshaped by new waves of immigrants, are also becoming more "Americanized" and rapidly adopted by the general population.

Immigrants of multiethnic backgrounds are a common scenario in the United States. While the proportion of non-Hispanic Whites will decline in the period 2000–2050, other major ethnic groups, including African Americans, Hispanics, and Asian and Pacific Islanders, will all increase substantially. New immigrants from all over the world contribute to those changes in magnitude and diversity of the American population.

Americans from racial and ethnic minority groups account for more than one third of the total population, according to estimates from the US Census Bureau. Hispanics, the fastest growing group account for more than 15% of the total US population; non-Hispanic Blacks represent about 13.5%, while Asians, the second fastest growing group, account for about 5% of the total population. Each one of these groups has very distinct food patterns, modulated by their culture, traditions, and socio-ecological factors.

In this section, we present a succinct review of concepts and explanatory factors about dietary patterns and discuss some of the main characteristics of those patterns as associated with specific ethnic groups. We briefly discuss the interactions between dietary patterns, health and disease in US immigrant communities and describe some indicators commonly applied to assess food patterns quality in terms of their contribution to good nutrition and health.

Conceptualization of Dietary Patterns

We define *Dietary Patterns* as the set of norms, rules, and principles that population groups have established to provide nourishment, healing, and comfort to its members, through the provision and consumption of foods and beverages in a variety of combinations. Dietary Patterns include not only the eating of the food, but all those activities around the acquisition and preparation of the food, as well as the cooking practices and the norms that dictate how food is distributed and shared at the internal of family or social groups.

Food patterns are established under the influence of several factors. The physical environment, the direct observation of the effects of foods, single or in combination with other food ingredients, the association of foods with life cycles and with climate phenomena, all contribute to modulate and define eating behaviors of population groups.

Dietary patterns develop slowly and are deeply inculcated in the social and cultural traditions of people. Those patterns are highly affected by cultural influences, as people define their preferences, choices, perceptions, beliefs, and attitudes about foods on the basis of their ethnic traditions and values. The dynamic constructs that define dietary patterns facilitate the modification and redefinition of those patterns as result of the interaction of people from different cultures and ethnicities.

Dietary Patterns of Immigrant Communities

Traditional food-related practices and food ways are deeply ingrained in the lives of immigrant communities, as those food-related practices are integral part of the identities of immigrants to the United States. The preservation of the dietary patterns, cultural foods, and eating behaviors are important sources of comfort in an environment that is new and sometimes intimidating to them. Immigrants maintain their attachment to their food systems as mechanisms of cohesion.

Foods have multiple connotations for people from any ethnic origin, including Americans from the general population. In addition to be means of maintaining their cultural identity, foods satisfy several needs: biological, as providers of nutrients and food components essentials for life; health, as foods ensure health and wellness; social as foods contribute to maintaining social structures; and religious because foods are associated with religious activities and some foods are considered sacred for certain cultures. Nutrition and social researchers had studied the relation between food and social structures and had determined that foods contribute to the maintenance of traditions and serve multiple roles including expressions of hospitality, goodwill, prestige, and status.

There are several ways to classify foods. One commonly accepted identified five food classification systems developed by different cultures: (a) food versus no-food, or what is edible or not; (b) sacred vs. profane foods; (c) food as medicine; (d) social foods; and (e) foods of opposing categories, such as the hot-cold system developed by some Hispanic groups, or the yin (cold)-yang (hot) Chinese principles. Therefore, when working with immigrant communities, it is important to identify their main food patterns and the interpretations they assign to the various foods they are attached to if changes or modifications to those food patterns are considered as part of the actions to be recommended for those groups.

Dietary Patterns and Acculturation of Immigrant Groups

Economic, political, or educational factors are usually the motivators of the immigration process. Rarely are the immigration causes motivated by food- or nutrition-related factors. However, foodways are invariably affected by the insertion of immigrant groups into a new, host culture.

New immigrants into the United States confront the realities of adjusting their traditional lifestyles to the American culture. They need to adjust to differences in language, values, traditions, and food habits. They may also experience changes in their social status and their social and family networks. How profound those changes could be is influenced by the geographic region and place where immigrants choose to live. Those that join already established communities of their own ethnic groups will benefit from the resources and support from their own peers, which include a better chance to maintain their dietary patterns.

Independently of where immigrants establish their residence, they will soon become immersed in the host culture and will initiate the process of acculturation by adapting norms, traditions, and cultural elements of the host American culture, and, at the same time, will preserve cultural elements of their own culture. Resources and opportunities influence their acculturation process, which is multidimensional and dynamic. A dietary acculturation also occurs with the incorporation of new foods and eating practices. The immigrant culture also contributes to the host culture their ethnic foods, which enrich the multiethnic and multicultural characteristics of the American foodways. Classic examples include the “Americanization” of tacos, tortillas, enchiladas, pizza, spaghetti in tomato sauce, and many dishes from the Chinese cuisine.

Dietary patterns are impacted by the acculturation process. The access to new foods or the lack of access to traditional foods, along with the socioeconomic demands of their new lives, affect the food choices made by immigrants, although different ethnic groups adjust their foodways differently. For example, more acculturated Hispanic immigrants, particularly those from Mexico, tend to decrease the quality of their diets (e.g., more fat and less fruit and vegetable intakes) as compared to those less acculturated. However, in the case of mainland Puerto Ricans, more acculturation is associated with better diet quality.

Past experiences with foods also affect the foodways of immigrants and slow the acculturation process. Groups that experienced severe food deprivation, hunger, and famine in their homeland (e.g., Cambodians during the Khmer Rouge period) feel the need to stockpile and consume their traditional foods, those that they were deprived of, even though this overconsumption may be deleterious for their health. These groups tend to maintain their traditional food patterns longer that other groups with less traumatic past experiences.

The age of the new immigrants also influences the acculturation process and the preservation of their foodways. For example, older immigrants, compared to younger counterparts, require longer periods of time to acculturate and are more likely to maintain their traditional food choices. Older individuals have developed strong attachments to their traditional foods. They had long before their arrival into the US defined their core foods, with the assignation of social, religious, and health-related meanings and obtain high levels of comfort and social acceptance from their foods. Moreover, they are seen by their younger peers and family networks as the gatekeepers of the foodways and cultural practices, which reaffirms their identity and cultural values.

Dietary Patterns and Health of Immigrants

In addition to acculturation, dietary patterns of immigrants are affected by the interaction of biological, social, economic, and cultural factors, which, at the same time, could affect their patterns of health and disease.

The easy and cheaper access to food, a more diverse combination of foods, frequent snacking and larger portion sizes, along with decreases in their levels of physical activity and increases in the economic power of immigrants are factors that have been associated with changes in their eating patterns. These same factors are also associated with higher prevalence of obesity and chronic diseases like type 2 diabetes, cardiovascular disease, hypertension, some types of cancers, and others.

The linkages between dietary patterns and health need to be considered when assisting newcomers to the United States, in order to avoid disease and promote health. Therefore, it is important to study the health benefits and nutritional characteristics of those dietary patterns, as this type of information is needed to protect immigrant populations. To examine the contributions of dietary patterns to the maintenance and promotion of good health, there is a need to collect and interpret data about: (a) food patterns and food components of immigrant groups associated with good health; (b) foods that contribute key nutrients; (c) immigrant groups at risk for disease due to insufficient or excessive consumption of certain food groups; and (d) food patterns associated with extreme, deleterious eating practices.

Assessment of the Nutritional Quality of Dietary Patterns of Immigrants

The study of food patterns and their nutritional components (e.g., proteins, vitamins, and minerals) are needed for the identification of the interactions and synergistic effects of foods on health and for health promotion. Several approaches had been used to examine dietary patterns and to identify groups of people with dietary patterns that, in addition to identifying them as cultural or ethnic groups, also provide insight into the health benefits of such patterns. Using appropriate methodologies for the identification of food patterns permitted the description of healthy dietary patterns such as the dietary pattern of Mediterranean groups (“Mediterranean diet”) which is considered health protective because of its high content of fruits, vegetables, and whole grains. A food pattern named “Western pattern,” adopted by some groups of Americans, has been associated with the development of chronic diseases including cardiovascular disease, diabetes, cancer, and obesity. Assessment of dietary patterns of elderly Caribbean Hispanics (mainly Puerto Ricans and Dominicans) that migrated from their homelands to the US Northeast revealed that their “traditional food pattern,” characterized by high amounts of rice, root crops and fats, and low amounts of fruits and vegetables, was associated with higher risk for obesity and with low acculturation status.

Immigrants that come from countries and regions with easy access to a variety of traditional foods may be able to maintain good nutrition and health, as compared to those that immigrated from countries and regions where access to food was limited. Dietary patterns that include a large variety of foods tend to be healthier and more nutritious than those with a limited number of foods. This is because food variety is associated with positive health and nutrition outcomes, such as lower mortality and reduced risk for obesity and for chronic diseases like type 2 diabetes, coronary heart disease, and some types of cancer.

There are several approaches for estimating food variety. Simple counts of the number of foods consumed in a day are applied to estimate food variety scores, with the assumption that the larger the number of foods, the better the chances that the evaluated food patterns provide the nutritional components needed for good health and nutrition and for the prevention of diseases. This approach is too simple because some of the dietary patterns may include foods of low quality or with high amount of simple sugars and unhealthy fats. Therefore, when measuring food quality it is advisable to consider, in addition to the number of food items, the distribution and health value of the food included in those dietary patterns. The identification of the type and quality of the foods eaten by immigrant groups is needed when nutrition and health providers guide them in the maintenance of their health and nutrition in ethnically and culturally appropriate manners.

Final Considerations

Foodways are important aspects of the cultural heritage of immigrants, who bring with them unique cultural characteristics. Those immigrants do not come in a vacuum. On the contrary, they bring new and interesting dietary patterns that, through the acculturation process and the new food environment, get constantly reshaped and modified. Those changes are minimal during the first generation of immigrants, as they maintain a strong attachment to their food patterns and their cultural identity. Second and subsequent generations incorporate rapidly new dietary practices, in part due to their desire to be considered active members of their new culture.

Dietary patterns are not static. They change in a complex process and are influenced by various factors as discussed in this section. As immigrants acculturate into the new, host culture, and their socioeconomic status improves, they redefine their food patterns. Subsequent generations will become more "Americanized." Therefore it is important to guide those immigrant groups toward the maintenance of the health-protective traditional dietary patterns, and the incorporation of American food patterns that are also healthy and social and culturally acceptable. Getting the best of two cultures enriches the well-being and promotes health in the American population.

Related Topics

- ► Acculturation
- ► Chronic disease
- ► Food
- ► Health status
- ► Nutrition
- ► Nutrition programs
- ► Obesity

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Disability

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The definition of "disability" varies by the source and purpose of the definition. The US Census Bureau defines disability through a series of questions identifying long-lasting conditions (>6 months) that affect sensory, physical, mental, or emotional function. Impairment of function is defined as affecting basic life skills (learning, remembering, dressing, bathing, etc.), or engaging in activities outside the home (e.g., working). The statutory definition of "disability" developed for the Americans with Disabilities Act (ADA) is similar, although not identical. Both of these definitions may differ from other definitions of "disability," for example, the definition of "disability" within the US Department of Veterans Affairs (relevant to VA benefits) or as assigned by the US Social Security Administration (relevant to possible Social Security benefits and Medicare eligibility). As such, any consideration of "disability" among an immigrant population needs to be based on a clear understanding of how it is defined within a specific context.

New immigrants to the USA are less likely to report disability than either nonimmigrants or immigrants who have been resident for a longer period of time, even after accounting for demographic differences. This pattern is somewhat replicated in other countries, although data are only available for a few countries. Since one of the primary motivations for immigrating is to seek employment, recent immigrants are less likely to have been disabled prior to immigration. Interestingly, disabled immigrants are more likely to be employed and to report higher salaries than the nonimmigrant disabled in the USA. Nonetheless, similar factors are related to a higher risk for disability in both immigrant and nonimmigrant populations, including both lower incomes and lower educational levels.

The factors that affect adjustment to disability among immigrants are similar to those that affect adjustment to being in a new society. These include factors that help buffer an individual's transition to new circumstances, such as higher self-esteem and/or self-efficacy, younger age, and marriage and/or social support, as well as factors that impede an individual's ability to adjust, such as perceived societal discrimination. Immigrants with disabilities are thus at a substantially increased risk for poor assimilation into their new societies.

Disabled individuals, in general, use far more medical and support services than nondisabled individuals. This includes more physician visits, more frequent use of therapist or social work services, and a higher likelihood of having a personal attendant. Among the disabled population, immigrants are as likely to use medical and support services as nonimmigrants. Further, access to medical and support services for disabled individuals is affected by many of the same factors as for those who are not disabled, insurance coverage being a key example. As a result, differences in these factors between immigrants and nonimmigrants results in disabled immigrants being at a significantly higher risk for poor access to care.

Within the USA, immigrants generally have a lower rate of health insurance coverage than nonimmigrants, in part due to a lower rate of coverage through employer-based insurance. The eligibility of immigrants, both disabled and nondisabled, for Medicaid, the Childrens' Health Insurance Program (CHIP), and Supplemental Security Income (SSI), and by extension for Medicare, was significantly reduced by the Personal Responsibility and Work Opportunity Reconciliation Act in 1996. Eligibility for some immigrant groups, for example, "qualified aliens," is not restricted. This group includes immigrants with a variety of qualifying characteristics, such as lawful permanent residents, veterans, individuals who have contributed 40 quarters of Social Security coverage, and refugees and asylees. In addition, some immigrants cannot be eligible for coverage for 5 years from the date they enter the country as a qualified alien. Individuals who do not meet "qualified alien" status are generally barred from receiving any federal means-tested public benefit. This significantly limits health care access for disabled immigrants. For Medicare, this primarily affects immigrants who formerly might have been eligible through qualification for SSI benefits. Immigrants may still be eligible for Medicare if they are diagnosed with end-stage renal disease (ESRD; permanent kidney failure requiring dialysis or transplant), although immigrants who have not lived in the USA for 5 continuous years would need to contact the Social Security Administration to determine eligibility. Individuals eligible for Medicare due to ESRD can be less than 65 years old. It should be noted that laws and coverage for immigrants vary widely by state, with some states providing state or locally funded medical care to some or all immigrants. Health care coverage in other countries varies widely depending on the health insurance systems of those countries.

Related Topics

- ► Acculturation
- ► Barriers to care
- ► Health insurance
- ► Hispanic health paradox
- ► Social Security Disability Insurance

Suggested Readings

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Disasters

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The total number of humanitarian disasters has quadrupled in the last 2 decades. The number of people being affected by them is also increasing as a result of overall population growth, poverty, marginalization, conflict, and the movement of displaced populations to marginal areas.

It is currently recognized that while the most immediate causes of disasters are natural phenomena, their consequences are not. Rather, their impact is the result of human agency framed by structural social conditions (e.g., poverty, inequality, and environmentally unsound practices) and people's level of vulnerability (e.g., their capacity to anticipate, cope with, mitigate, and recover from the impact of a hazard). Illustrative of this approach are the *International Disaster Response Law Guidelines* established by the International Federation of Red Cross and Red Crescent Societies, which define a disaster as "a serious disruption of the functioning of society, which poses a significant, widespread threat to human life, health, property or the environment, whether arising from accident, nature or human activity, whether developing suddenly or as the result of long-term processes, but excluding armed conflict." Similarly, the Interagency Standing Committee's *Operational Guidelines on Human Rights and Natural Disasters* defines disasters as "the consequences of events triggered by natural hazards that overwhelm local response capacity and seriously affect the social and economic development of a region."

The negative impacts caused by disasters may include loss of home, community, and livelihood; sex- and gender-based violence; trafficking or recruitment of children into fighting forces; discrimination in the provision of aid; loss of documentation; forced relocation; and issues of property restitution, in addition to death, injury, and illness.

The health dimensions of disasters are twofold. On the one hand, serious health conditions often emerge, or are exacerbated, in the aftermath of a disaster. On the other hand, pandemics and other large-scale public health concerns can be understood as constituting a form of disaster in themselves.

Health Issues in Times of Disaster

Conditions of chronic disease are common features of the social and environmental vulnerability that frequently frames disasters. In addition to their immediate consequences, disasters may also have significant secondary public health repercussions resulting from relocation into overcrowded and unsanitary shelters and resettlement schemes, widespread flooding and exposure to stagnant waters, and the destruction of crops and other food sources.

Lapses in food security in the aftermath of a disaster are at the heart of nutrition and other public health problems. Although casualty rates may stabilize during the post-disaster phase, undernutrition is most likely to develop over the long term among affected populations. Generalized food shortages may be the result of crop losses and the destruction of agricultural land. And even when household supplies appear to be adequate, women, children, the elderly, and other marginalized groups may face an increased risk of food deficiencies or deprivation if practices of food distribution and consumption are discriminatory. Disenfranchised groups' access to other health care needs may also be compromised.

Women

In times of crisis, the already disadvantaged status that women occupy in many societies is likely to be exacerbated and become more conspicuous. Following a disaster, women may find themselves either alone or heading households with diminished resources. Efforts to meet the household's economic needs under difficult circumstances increase women's and girls' (and often boys') vulnerability to sexual exploitation. So does the risk that they will be pressured to participate in "survival sex" – a strategy in which people engage in sex in exchange for needed resources such as food or medicine.

Increases in domestic violence have also been reported in the aftermath of disasters. An extremely damaging form of female disempowerment, domestic violence may increase the risk of HIV infection, especially when it takes the form of sexual abuse. Furthermore, violence, or fear of violence, may act as a significant barrier to women negotiating condom use or requesting fidelity from their partners.

Reproductive health care needs – emergency birth control supplies, early contraception pills, birth control methods, condoms, and skilled health care providers to address obstetrical emergencies – must be made available in disaster relief operations. Culturally appropriate information regarding prevention of STDs, including HIV/AIDS is also important.

Children

Efforts to address the particular needs of children in disaster situations, especially those from mental health or psychological perspectives, have focused primarily on "traumatized victims" who exhibit problematic responses. Other approaches, however, have noted that many youngsters appear to cope well with stress, displaying outstanding resilience to disaster-induced changes.

Findings of young people's remarkable adaptive capacity notwithstanding, children and adolescents do have particular anatomical, physiological, and psychological characteristics associated with their stage of development that may make them more vulnerable to certain health risks than adults. Thus, their vulnerability to disaster-induced health hazards may also be higher. Cases of anemia and micronutrient deficiencies, for instance, are typically more severe in children, as are growth abnormalities associated with malnutrition, including low weight-for-height and low height-for-age. As was the case with women, separated children and those heading households are also more vulnerable to sexual exploitation and resorting to "survival sex."

The Elderly and Persons with Disabilities

While clearly not all senior citizens are frail, dependent, or in need of special assistance, steps must be taken to provide adequate support to those who are. Similarly, persons with disabilities may have particular requirements that must be considered in all disaster management interventions. For instance, it is necessary to ensure that warning systems are recognizable to them and that adequate rescue measures are in place. Additionally, provisions must be made to guarantee that assistive devices and required medication are available, and to ensure that temporary shelters and housing are accessible to those with restricted mobility. At the same time, special attention should be given to the prevention of contagious and infectious diseases among the affected population, particularly among those displaced by the disaster.

Pandemics as Disasters

Like classic "natural" disasters (those provoked by hurricanes, earthquakes, or tsunamis, for instance), pandemics originate in the conjuncture of a human population and a potentially destructive agent. Indeed, threats of pandemics – such as bovine spongiform encephalopathy or "mad cow disease" in 2000, severe acute respiratory syndrome (SARS) in 2005, and, most recently, H1NI or "swine flu" – have been categorized as humanitarian disasters by the international community. While recognizing that HIV/AIDS constitutes a pandemic of enormous proportions, discussions regarding whether it should be considered as a "natural disaster" have been characterized by bitter disagreement. The disastrous effects of this epidemic on the affected population and its clear links with many other dimensions of disasters are, however, undeniable.

Conclusions

The increasing incidence and intensity of humanitarian disasters around the world underscores the need to pay closer attention to the context-specific nature of public health in post-disaster situations. Heightened levels of food insecurity and malnutrition, unavailability of essential necessities such as food – including appropriate food for people based on religious/cultural restrictions – and clean water, lack of adequate sanitation facilities, and the diminished ability of overburdened health care systems to provide for or even reach the most vulnerable groups should be concerns of the highest priority.

There is a need to formulate strategies that address peoples' health needs both before and after catastrophes, prioritizing context-specific protection measures in all phases of disaster preparedness, response, and early recovery. These measures should be guided by a clear understanding of the factors that foster positive adaptation and resilience, facilitating the design of more effective disaster management programs.

Related Topics

- ► Displaced populations
- ► Food insecurity
- ► Health promotion
- ► Internally displaced persons
- ► Red Cross
- ► Risk perception

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Discrimination

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Discrimination and Immigrant Mental Health

Discrimination is a social behavior whereby one particular group of people is treated less favorably than others because of their race, color, nationality, or ethnic or national origin. Most countries recognize two kinds of racial discrimination: direct and indirect. Direct discrimination occurs when race, color, nationality or ethnic or national origin is used as an explicit reason for discriminating. Indirect discrimination occurs when rules, regulations, or procedures operating have the effect of discriminating against certain groups of people. Discrimination is not only common in the developed countries in North America and Europe but also in post-slavery and postcolonial countries where legacies of discrimination have been institutionalized.

The World Health Organization (WHO) defines health as "a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity." The Ottawa Charter for Health Promotion articulated a series of prerequisites for acceptable social practices. These include equal opportunity for all, social justice, sustainable resources, income, food, education, shelter, a stable economic system, and peace. Reports from many countries indicate persistent and entrenched inequality in the mental health provisions for women, the working class, old people, and immigrant populations. In the case of immigrant populations, they are frequently subject to racial discrimination. Racial discrimination exists in a variety of national contexts as well as in a variety of social settings. This form of discrimination is the one that is most frequently highlighted as the consequences seem to be the most long lasting and injurious to the long-term health and well-being particularly of immigrant populations of color in White societies. There is distinction that has been made by social scientists about direct or indirect discrimination. The former tends to result in intentional harm being done.

There are various forms of discrimination of which racial discrimination is the concept most frequently used to explain problems of ethnic inequality in Europe and Euro-America. Discrimination is not only visible, but it is also invisible and can take very subtle forms. There is need to clarify the concepts and the contexts in which it takes place. The concept can be applied at the individual, institutional, and structural levels. There is also still need to distinguish the theoretical and methodological differences between structural and institutional discrimination. Structural discrimination refers to institutional structures that discriminate against those who are ethnically and otherwise different from those who form the majority ethnic group in society. Institutional discrimination takes place through the development of policies routines and standards that permit those individuals who hold such power as to be gatekeepers in these institutions. These two kinds of discrimination are sometimes described as a single entity by some researchers while others view them as separate, especially as regards the question of intentionality and unintentionality.

The institutional character of most forms of discrimination is often found in markets and health and social care in which there are established rules and procedures. In addition, there are the cultural elements such as stereotypes. The Macpherson Commission defined institutional racism in England as "…collective failure of an organization to provide an appropriate and professional service to people because of their color, culture or ethnic origin…" It can be seen or detected in processes, attitudes, and behavior which amount to discrimination through unwitting prejudices, ignorance, thoughtlessness, and racist stereotyping, which disadvantages minority ethnic groups. Racism should not be conceived of as a unitary concept but one that has many elements – the institutional, the social, and the cognitive. Strategies to address racism must be conceived and implemented at several different levels.

The WHO links the inequalities on mental health, explaining that the chronic stress of struggling with material disadvantages is intensified to a considerable degree by doing so in an unequal society. Chronic stress affects individuals through the neuroendocrine, cardiovascular, and immune systems, which may be accompanied by health-damaging behaviors, violence, anger and despair related to occupational insecurity, poverty, debts, poor housing, exclusion, and other indicators of low status. All of these kinds of discrimination have a negative impact on the health and well-being of immigrant populations who experience considerable discrimination and disadvantage especially in accessing mental health care. There continue to be glaring inequalities in the provision of health care for these populations. Although there has been the collection of data on health inequalities, there continues to be methodological and conceptual problems that result in inadequate, or culturally inappropriate services developed. Considerable research has been done on Black and minority ethnic communities in Britain where Fernando in 2009 identified the following discriminant mental health ethnic issues. Black and ethnic minorities are more often:

- Diagnosed as schizophrenic
- Compulsorily detained under a Mental Health Act
- Admitted as "offender patients"
- Held by Police under Section 136 of Mental Health Act
- Transferred to locked wards
- Not referred for psychotherapy
- Given high doses of medication
- Sent to psychiatrists by Courts

In the Criminal Justice System, Black people are overrepresented in the UK prison population, where 17% of the male prisoners in England and Wales are from ethnic minority groups, constituting 6% of the general population. The rates of imprisonment for Blacks were eight times higher than for Whites. Of Blacks over the age of 21, 51% were serving sentences of over 4 years, as compared to 35% of Whites. In the Mental Health Services, Black and ethnic minorities (compared to the "White" majority communities) are more often diagnosed as schizophrenic, and compulsorily detained under the Mental Health Act. In addition, they are transferred to locked wards from open wards, are admitted to hospital as "offender patients," and held by police under Section 136 of the Mental Health Act (a section of the UK Mental Health Act that authorizes a police officer to remove a person from a public place).

They are not referred for psychotherapy, and they are given high doses of medication and sent to psychiatrists by the courts. In the education and schooling system, there were a large number of permanent exclusions of Black pupils of compulsory school age. African-Caribbean children were excluded four times more commonly than White children. These statistics show an overrepresentation of Black people in some of the major institutions such as prison and mental hospital; and underrepresentation in terms of scholastic and economic achievement. Between 1948 and 1973, approximately 555,000 persons of Caribbean birth migrated to Britain, the majority before the 1962 Immigration Act effectively cut off further migration.

Not only is there stigma against these immigrant populations but also there is stigma about the seeking of psychological and psychiatric care because of the history of oppressive and racist services provided and the role of psychiatry and psychiatrists. In fact, there have seen significant antistigma campaigns in many countries to address the problem.

There is also a problem about the pathways to care for the immigrant populations. Where the police are the pathway to mental health care for these populations, many problems exist. Quite often there have been public outcries to the manner in which mentally ill persons have been treated by the police or the mental health care system and these have resulted in commissions of enquiry. The issue of pathways to care is part of a much larger problem, which relates to the theories of social epidemiology. The discussions about inequalities in health care run more deeply into the structure of opportunity in the society, wealth, and poverty. What are the causes of health or well-being and why are some ethnic groups ill and poor? Matters of social and economic justice and relative power or powerlessness then enter the discourse that is fraught with difficulties.

Discrimination on the basis of ethnicity, religion, immigrant status, or gender represents considerable infringements of human rights in the entire European and Euro-American world. Many Europeans and Euro-Americans have considerable difficulty acknowledging this, and hence, efforts to address these issues have been more symbolic than real.

Related Topics

► Health disparities
► Racism

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Disease Prevention

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Although immigrants arrive in the USA with better-than-average health, this advantage wanes with increasing years of residence and succeeding generations. Screening services, routine health examinations, and adequate access to care are all essential prevention tools for newly arrived immigrants. Disease prevention occurs in three stages: primary prevention (keeping healthy people free from disease), secondary prevention (screening for early detection of disease), and tertiary prevention (preventing disability as a result of a disease). Although chronic disease prevention is the higher health priority for Americans or others from Western/industrialized countries, immigrants to these countries may suffer from both these and infectious diseases. This entry is divided into three main topics: infectious disease prevention, chronic disease prevention, and barriers to disease prevention. Subdivisions within infectious and chronic disease prevention categories are primary, secondary, and tertiary modes of prevention.

Infectious Disease: Primary Prevention

Keeping Americans free from preventable disease is a US public health objective. Disease prevention at the primary level keeps healthy people free from illness. "Vertical transmission" of disease occurs during childbirth when a mother passes an infection on to her newborn. "Horizontal transmission" occurs person to person as a result of close contact, sexual intercourse, sharing of infected needles, etc., or through water-, air-, or vector-borne infections. Primary prevention methods include vaccination and education on the modes of disease transmission and susceptibility of at-risk populations.

Immunizations are available for many infectious diseases including hepatitis B virus (HBV). Vaccination for HBV is completed after three separate doses ideally spaced out over 6 months. The Centers for Disease Control and Prevention (CDC) recommends routine testing for persons born where hepatitis B surface antigen (HBsAg) prevalence is greater than or equal to 2%.

Recent surveys with Chinese, Vietnamese, Korean, and Cambodian immigrants reveal a lack of basic knowledge regarding HBV transmission, susceptibility, and treatments. While most Asian immigrants know HBV is transmitted vertically, confusion regarding horizontal transmission exists. Many erroneously believe HBV acquisition occurs by sharing eating utensils and drinking glasses with infected individuals or by eating food prepared by someone with the virus. Even though these groups are at increased risk of acquiring HBV, they routinely fail to be vaccinated for the virus. Although awareness of an existing vaccine is high, many do not understand the complete vaccination process. Ensuring these immigrants receive HBV vaccinations and understand their risks of contracting the illness will limit the number of infected people.

There is an increasing prevalence of HBV among Latino immigrants due to sexual transmission compared to other routes of transmission more commonly seen in Asian immigrants. Latinos are undervaccinated because of the low HBsAg prevalence in most of Latin America. In a recent study assessing hepatitis B seroprevalence and risk behaviors among immigrant men, Latino immigrants were less likely to report prior vaccination for HBV compared to Asian immigrants.

Although infectious diseases such as tuberculosis (TB) and HIV/AIDS do not currently have vaccines, scientists continue to research effective immunization strategies for these diseases. A group of Chinese researchers are evaluating a recombinant strain of Bacille Calmette-Guérin (BCG) to vaccinate against TB, while Canadian researchers are investigating nontraditional biological pathways. Recently, clinical trials of a HIV vaccine were conducted in over 16,000 heterosexual men and women in Thailand. Vaccination did not affect $CD4^+$ counts or viral load, but the research suggests future possibilities for immunization. Until scientists develop effective vaccines, education regarding modes of transmission and susceptibility is essential for primary prevention of these diseases.

Immigrants who use illicit drugs are at greater risk of contracting HIV. Injection drug users from Puerto Rico were found to perform higher risk behaviors upon moving to the mainland USA, even though more services are available compared to those on the island. Risk behaviors included sharing needles and other injection equipment and having unprotected sex. While first-generation Latino immigrants have lower rates of illicit drug use compared to subsequent generations, determinants of drug use among immigrant Latino workers in New Orleans contest these data. Immigrants who arrived after Hurricane Katrina to assist in the rebuilding efforts were exposed to individuals and situations which facilitated the use of crack cocaine. Many immigrants reported both physical availability of the drug and affordable pricing. These immigrants used drugs to relieve stress from inconsistent work opportunities, social isolation, and workers' rights abuses. Oftentimes, drug use was associated with other risky behaviors such as solicitation of prostitutes. These behaviors can lead to increased prevalence of HIV among these groups. Primary prevention efforts to educate and inform immigrants about HIV transmission are necessary to curtail the increase in HIV prevalence among these groups.

Infectious Disease: Secondary Prevention

Medical examinations are required for every US-bound immigrant and refugee. Although refugees are not required to pay for this service, this waiver is not given to immigrants who are not sponsored by the US State Department. The CDC provides oversight and technical guidance for a panel of 400–800 local physicians who provide examinations in foreign countries. A member of the CDC-approved panel completes a form indicating overall health status and medical history, including the presence of TB, syphilis and other communicable diseases, drug abuse, and vaccinations. There is a referral portion for follow-up care.

Just as Asian immigrants are not routinely vaccinated against HBV, they are also not receiving routine HBV screening. Recent data indicate Cambodian and Vietnamese immigrants fail to discuss risk of HBV infection with a physician. Because many Asian countries have high endemic rates of HBV infection, screening immigrants from these areas should be a high priority for secondary prevention of HBV.

In much of the world, immigrants aged 15 and older are screened for TB via a standard posteroanterior chest radiograph. If the chest X-ray suggests possible active TB infection, sputum specimens are obtained over the course of 3 consecutive days. These specimens are stained for acid-fast *Mycobacterium tuberculosis* bacilli. Children younger than 15 years undergo screening for TB if there is a history of TB, signs or symptoms of TB exist, or there is close contact with someone diagnosed with TB. If a potential immigrant to the USA is diagnosed with active TB, therapy must be completed and sputum specimens must come back negative before travel is allowed. When immigrants arrive in the USA with a diagnosis of TB, follow-up evaluations are required. Limiting additional TB infection requires adherence to the CDC guidelines for follow-up care. State and local public health departments need to be responsible for ensuring all those diagnosed with TB receive appropriate treatments.

HIV/AIDS screening is no longer required for incoming immigrants. However, the CDC recommends that anyone who is sexually active participate in HIV screening. In the USA, oral fluid, blood, and urine can all be used for HIV testing, but using blood is most common. Using traditional diagnostic tests, results are usually available in a few days, with positive results requiring confirmatory testing. Rapid diagnostic testing yields results in about 20 min. Door-to-door rapid testing has been determined to be a feasible and accepted method of screening for HIV in Latinos. Since the Latino community is disproportionately affected by HIV infection, community outreach programs that limit barriers to testing should be practiced.

Infectious Disease: Tertiary Prevention

Immigrants are twice as likely as US-born Americans to be uninsured. Lack of insurance can lead to disruptions in care and medication adherence, possibly creating disease-resistant strains of illnesses. Patients lacking continuous care may not receive thorough medical support to achieve recovery and ensure others in close contact do not become infected. Additionally, viral infections can lead to increased risk for certain morbidities.

Carriers of HBV are at risk of developing chronic active hepatitis and cirrhosis as well as hepatocellular cancer (HCC). Asian immigrants have higher rates of chronic HBV infection compared to their American-born counterparts due to high endemic levels of HBV in their home countries. However, they do not report high susceptibility. While they understand HBV infection would change their lives, they are unsure about the consequences of HBV, including the possibility of acquiring liver cancer.

Effective strategies exist for decreasing the mortality from HCC. Patients who are at greatest risk should be selected for antiviral therapy, including those suffering with cirrhosis. Interferon-alpha (IFN-α) functions via antiviral and antiproliferative mechanisms. A newer treatment involves a class of oral nucleos(t)ide analogs. These drugs reduce viral load, but can also lead to development of drug resistance. Because HBV DNA is a marker of viral replication, monitoring is required to ensure effective treatment.

The CDC recommends treatment for active TB last a minimum of 6 months and up to 9 months depending on co-occurring conditions. Patients need to be monitored for side effects to medications, so follow-up treatment needs to occur monthly at minimum. Treatment for latent TB infection (LTBI) follows a similar protocol to that for active TB. Directly observed therapy (DOT) for TB infection has been determined to be the most effective treatment for curing TB. In a study comparing DOT treatment to non-DOT treatment in Vietnamese TB patients, those participating in DOT treatment had higher rates of completion and lower rates of relapse. Ensuring immigrant patients return to clinics and maintain treatment will limit drug-resistant strains of illnesses.

Opportunistic diseases that increase mortality from AIDS need to be prevented. Adherence to antiretroviral therapy (ART) is key to maintaining $CD4^+$ counts >200 cells/μL. If $CD4^+$ counts fall below 200 cells/μL, drug therapy against *Pneumocystis pneumonia* (PCP) must be initiated. If the patient responds to ART, drug therapy can be decreased. Patients with a history of PCP must maintain drug therapy for life. Once a patient is infected with HIV, tests should be performed to detect latent infection with *Toxoplasma gondii* and LTBI. Additionally, patients should be educated on ways to prevent *Cryptosporidium*, bacterial, and fungal infections.

Female HIV-positive African immigrants describe unfamiliarity with the US health care system as a barrier to maintaining medication adherence. Social workers indicate that male African immigrants often go untreated due to inability to come to the clinic because they work multiple jobs. Understanding cultural and economic issues relating to treatment can inform public health interventions and increase tertiary prevention among these populations.

Chronic Disease: Primary Prevention

Similar to native-born Americans, the three most common chronic diseases affecting immigrants are heart disease, diabetes, and cancer. Risk factors for heart disease include smoking, low levels of physical activity, obesity, hypertension, and hyperlipidemia. Ethnicity (Asian American, Hispanic/Latino, Pacific Islander, African American, Native American or Alaskan), history of gestational diabetes or cardiovascular disease, clinical conditions associated with insulin resistance, diagnosis with polycystic ovarian syndrome (women only), and advancing age are additional risk factors for diabetes. Along with the risk factors for heart disease, the risk of developing cancer increases with excessive exposure to UV rays and other radioactivity, certain carcinogenic chemicals (including those found in cigarettes), and hormones (estrogen and its derivatives), or from viral or bacterial infection such as HBV, HIV, human papilloma virus, or *Heliobacter pylori*. Excessive alcohol consumption is also a risk factor for many cancers.

Obesity, hypertension, and hyperlipidemia may be caused by high levels of dietary fat and low levels of vegetable and fruit consumption. The 2005 Dietary Guidelines for Americans (DGAs) recommend that people following a 2,000-calorie diet eat four servings of fruits and five servings of vegetables daily. Additionally, 30 min of daily moderate intensity physical activity is advised.

Although they know eating fruits and vegetables decrease the risk of heart disease, Chinese immigrants do not meet the 2005 DGAs. Additionally, they fail to meet physical activity guidelines. However, recent immigrants are more likely to be physically active compared to those who live in the USA for longer periods of time since immigration. Compared to women, men have lower fruit and vegetable intakes and are greater consumers of tobacco. Interestingly, Chinese immigrants do not identify tobacco use as a risk factor for heart disease. Failure to identify risks specific to immigrant groups can result in higher rates of chronic disease.

Female Vietnamese immigrants report greater physical activity with age, although the majority do not meet physical activity guidelines. Smoking prevalence increases with years of residence, while fruit and vegetable consumption decreases. Contrary to most data on acculturation, women who had less English proficiency consumed fewer fruits and vegetables than women who spoke English well. This could be the result of structural barriers such as reliable transportation or proximity to a grocer who supplies easily recognized fruits and vegetables.

Latino immigrants interviewed about diabetes acquisition do not know how diet affects etiology of the disease. It is understood that if one eats unhealthy foods, illnesses will develop, and diabetes is one of those illnesses. Traumatic incidents are also seen to result in great emotional imbalance, causing illnesses to surface. Similar to Latino beliefs regarding cancer, diabetes is deemed a naturally occurring illness that is within the human body, and certain factors can trigger that illness to surface.

American smoking rates are less than those of many foreign countries including China, the Philippines, and Korea. Tobacco companies' market research on Asian Americans indicates that brands popular in their home countries are not necessarily favored in the USA. Some of these reasons include feelings that a particular brand may represent exploitation in the homeland, or brands available in the USA are for higher status smokers. Tobacco companies aggressively market to immigrants regardless of their economic level, attempting to maintain their tobacco-use norms. For example, recent data show that the longer Chinese immigrants reside in the USA, the lower prevalence of cigarette smoking. Countering the industry by intervening with these and other new immigrants is necessary to reduce smoking prevalence.

Major tobacco companies make concerted efforts to understand emerging immigrant markets. They assess the rates of smoking in newly arrived immigrants, comparing rates in diverse areas and concentrated neighborhoods. Based upon this market research, and using assimilation as a proxy for smoking, Marlboro is the brand preferred by less-assimilated Hispanics. As Hispanics adapt and identify more with American culture, Camel is the favored brand. Many companies target border communities to increase smoking rates similar to those found in the home country.

Although Latino immigrants are less likely to use cigarettes, marijuana, or LSD compared to White European immigrants, they have higher rates of intermittent smoking. Furthermore, Latino immigrants who are characterized as light smokers tend to underreport the number of cigarettes consumed. Although Latino immigrants who prefer to answer questionnaires about illicit drug and tobacco use in Spanish are less likely to engage in these behaviors, accurate smoking rates may not be assessed. Because of this, it is important to address the risks of any level of tobacco consumption.

In general, Latino immigrants use alcohol less frequently than their US counterparts. However, alcohol use is associated with economic stress among Mexican migrant men in California. Stress related to finding and keeping steady employment, along with labor discrimination, resulted in increased alcohol use. Similar to findings among Mexican immigrants working in New Orleans, lack of supportive community services to constructively manage stressors can lead to alcohol and drug abuse.

Chronic Disease: Secondary Prevention

Secondary disease prevention begins with ascertaining disease status as early as possible. For many chronic conditions, early detection can result in reduced morbidity and mortality from complications of the illness. According to the American Heart Association, adults should receive blood pressure screenings every 1–2 years. The National Cholesterol Education Program guidelines include having a cholesterol check every 5 years upon reaching 20 years of age, with more frequent checks at 45 and beyond. According to the American Cancer Society, colorectal cancer screening (flexible sigmoidoscopy, double-contrast barium enema, or virtual colonoscopy) should be performed every 5 years beginning at 50 years of age. Colonoscopy can be performed every decade. If a patient is unable to have one of the previous exams, annual fecal occult blood tests (FOBT) or the equivalent should be performed. Women should receive mammograms with clinical breast exams annually upon reaching 40 years of age. Women aged 20–30 should receive a clinical breast exam every 3 years. Pap testing should be performed every 1–3 years if aged 21 years or older, or earlier if sexually active. The Agency for Healthcare Research and Quality states bone density scans should be performed upon reaching 65 years of age.

Screening practices for cardiovascular risks among Asian immigrants indicate areas of improvement. In a study assessing heart disease prevention practices, nearly all the Chinese participants received blood pressure screening, but many did not receive cholesterol screening. Although most Vietnamese participants received blood pressure screening in the past 2 years, many reported not having a cholesterol check in the past 5 years.

Recommended cancer screenings do not always occur. Demographic predictors of cancer screening among Filipina and Korean women indicate that screening adherence is higher with increased years of US residence and with having regular checkups when no symptoms are present. Filipina immigrants are not meeting screening guidelines for cervical, breast, and colon cancers. Compared to Filipinas, Korean women receive fewer mammograms, but more colorectal screenings. Among persons of Mexican origin, limited English proficiency (LEP) contributes to lack of colorectal screening because patients do not receive recommendations or do not know they need the exam. Without a regular physician, screening does not occur. Latino immigrants from Dominican Republic, Puerto Rico, and Columbia indicate colorectal cancer results from consequences of an unhealthy diet (including excess fat intake and constipation) and anal sex. If people feel like they are at lower risk because they do not participate in these behaviors or if there is perceived stigma related to certain behaviors, they may not seek out screening.

Chronic Disease: Tertiary Prevention

Upon diagnosis with a chronic illness, strategies exist to reduce the risk of suffering from comorbidities and hospitalization. Lifestyle changes can often improve health status and potentially decrease dependence on medication. Ensuring adequate follow-up care and maintaining scheduled appointments and communication with health care professionals can improve prognoses.

Diabetics are at increased risk of developing heart disease, stroke, kidney disease, and neuropathies. Smoking increases these risks. Diabetes progression can be slowed by making lifestyle changes such as weight loss, increasing exercise, consuming more fruits and vegetables, and smoking cessation. In order to prevent accompanying diseases, diabetics should follow various health recommendations including semiannual glycosylated hemoglobin (HbA1C) testing and dental exams. Annual eye examinations, urine creatinine screening, and foot examinations should also be performed. Diabetics should maintain HbA1c at 7% or lower, blood pressure below 130/80 mmHg, total cholesterol below 200 mg/dL with low-density lipoprotein cholesterol (LDL-C) below 100 mg/dL, and triglycerides below 150 mg/dL.

Immigrants who suffer from diabetes require additional information regarding comorbidities. Research examining diabetic Koreans' perceived risk of coronary heart disease indicates the same or less perceived risk compared to the general population. In a group of type 2 diabetic Koreans, more than half had uncontrolled blood pressure and higher than recommended LDL-C. In a similar study with diabetic Mexican immigrants along the Texas–Mexico border, the majority were hypertensive and nearly half had hyperlipidemia. Maintaining appropriate cholesterol and blood pressure levels can limit the development of heart disease, stroke, and neuropathies. Routine discussions about limiting these risks should be discussed with a health care provider at every doctor's visit.

Cancer sufferers can improve prognoses by adhering to chemotherapy and radiation treatments as prescribed by the doctor. Maintaining adjuvant treatment during remission can limit potential relapse. Female Mexican immigrants identified economic worries and the lack of money prevented the purchase of tamoxifen or other adjuvant treatment. This financial distress increases anxiety about not maintaining prescribed treatment, but without insurance coverage, many cannot afford medications and therapy. Improving access to care during remission will decrease relapse rates and limit stress resulting from fear of becoming sick again.

Sufferers from cardiovascular disease can limit disability and hospitalization by ensuring proper diet and exercise recommendations. Smoking cessation and stress reduction improve health outcomes. Medication adherence also limits complications. Four behavioral predictors that determine hypertensive medication nonadherence among Chinese immigrants include lower perceived susceptibility, greater perceived benefit of Chinese herbs, less perceived benefit of Western medical treatments, and longer residence in the USA. Ensuring adequate treatment among immigrant populations requires health care provider knowledge regarding cultural practices and barriers to medication adherence. Lack of insurance and the resulting inability to cover treatment costs lead many immigrants to discontinue treatment early.

Barriers to Disease Prevention

Financial, cultural, and language issues are a few barriers to disease prevention. Although immigrants arrive to the USA from different countries, many experience the same barriers. Cultural barriers to prevention may reinforce structural barriers such as shortage of health services and long travel distances to receive care. Additional structural barriers include lack of financial resources and unavailability of culturally competent care providers. Effective ways to reduce these barriers include increasing access to usual care while maintaining continuity of coverage. Additionally, cultural and linguistically appropriate preventive care provision can ensure ideal delivery of information and services.

Regardless of country of origin, many immigrants report similar barriers to cancer screening. Concerns regarding modesty and potential loss of virginity are salient among Filipino and Korean female immigrants. Immigration status and cost of screening prevent Latinas from receiving Pap smears and mammograms. Latinos are more likely to receive screening for colorectal cancer if a physician recommends the procedure. Length of residence in the USA, older age, and Medicaid coverage also affect screening rates. Korean and

Latino immigrants express fatalistic attitudes regarding cancer acquisition and prognoses. Cancer is considered to be a natural process resulting from imbalance in social, emotional, or dietary well-being. Prayer is a source of healing, as are traditional herbs. Latinos may seek out *Curanderos* (traditional healers) for treatment.

Limited English proficiency (LEP) patients may suffer from poorer quality of care due to physician-oriented behavior driven by communication difficulties. Fewer visits, fewer contacts, and visits of shorter duration can all lead to reduced quality. LEP patients have greater difficulty with filling prescriptions, asking their health care provider questions about health issues, and explaining symptoms. These patients also report less empathy from health care providers.

Lung cancer is a leading cause of cancer-related deaths among Filipinos. Predictors of smoking cessation among male Filipino immigrants include living with and socializing with nonsmokers. A key component could be the idea of *pakikisama*, a feeling of social acceptance and friendship among Filipinos. If one socializes with smokers and refuses a cigarette, this can disrupt *pakikisama*, and lead to confrontation. Recognizing this social dilemma and developing intervention materials to address it will ensure successful tobacco cessation programs.

Chinese immigrants identify several benefits and barriers to performing physical activity. Physical activity improves bodily processes such as digestion, circulation, and sleep. Missing from the description, however, is its effect on prevention of specific diseases. Barriers to performing physical activity include lack of time, weather and safety concerns, financial constraints, and lack of organized services for Chinese people. Specific cultural barriers are feelings that elders should not engage in vigorous physical activity. Identifying cultural norms and expectations for immigrants is essential to understanding and addressing perceived benefits and barriers.

Stigma regarding HIV infection affects many immigrant groups, preventing them from seeking screening or treatment for existing infection. In order to address barriers of treatment adherence in female African HIV-positive patients, clinic workers will provide medications in unlabeled bottles or give medications to another person for safekeeping. Workers also train the women to negotiate condom use with their partners without divulging their HIV status. In male Latino populations, men may have sex with other men (MSM) but self-identify as heterosexual. Failure to acknowledge this risky behavior may prevent HIV screening and delay treatment of HIV infection.

Inaccurate beliefs about causes of preventable illnesses, low priority for prevention, limited knowledge about preventive screening services, and delaying screening until initial symptoms occur rather than making it a part of routine care all contribute to limited use of prevention services among immigrants. To overcome barriers to preventive care, health care providers can hire bilingual staff, interpreters who speak patients' languages, translate materials into other languages, and document plans for providing LEP services in clinics and hospitals. Development of ESL (English as a Second Language) classes to educate these populations will reduce inaccurate knowledge regarding transmission, improve screening rates, and limit hospitalization.

Related Topics

- ► Access to care
- ► Cancer
- ► Cardiovascular risk factors
- ► Chronic disease
- ► Communicable disease of public health significance
- ► Diabetes mellitus
- ► Health barriers
- ► Health care utilization
- ► Health promotion
- ► Infectious diseases
- ► Panel physician
- ► Tobacco use
- ► Tuberculosis

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Suggested Resources

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Disordered Eating

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Eating disorders (ED) are generally defined in psychiatric terms as intense disturbances in the perception of body shape and poor body image, resulting in restrictive or binge eating/purging patterns. Two main disorders are anorexia nervosa, in which the individual has an intense fear of gaining weight and engages in near-starvation behaviors, and bulimia, in which the individual has recurrent episodes of excessive eating followed by compensatory behavior (e.g., vomiting, use of laxatives, excessive exercise). Severe forms of the disorder can result in death.

Idealized and normally unattainable body types of extreme thinness appear to be at the core of the syndrome. Although every culture has a normative body type related to attractiveness, associated eating disorders had been found predominantly in Western countries. Current literature had conceptualized ED as culture-bound syndromes with more than seven million Americans and 1.15 million English, predominantly women, suffering from these syndromes. High rates of disordered eating are also found in Canada and Australia with lower rates in Europe. Until recently, eating disorders rarely occurred in Asia, Latin America, and Africa. However, as cultures around the world have become exposed to the West and the thinness ideal, primarily through media (movies, television, magazines, Internet), eating disorders have begun to emerge, chiefly among young women. Hong Kong, for example, has seen an increase in disordered eating related to fat phobia, and women in Korea report similar risks for ED as do Americans. It has also been suggested that local variables, apart from Westernization, such as Confucian beliefs and the value placed on physical appearance, may account for the increase in ED in Asian countries. For example, filial piety, the Confucian principle in which the child unconditionally obeys the parent, results in less individuated children. Self-starvation may be one attempt to assert personal control and independence from the family. Parental pressure to be thin is weak as traditional Chinese belief holds that body fat is a sign of health and wealth.

As worldwide immigration has reached historical highs with movement patterns from Asian, African, and Latin American countries to Western ones, the question has been raised as to the effects of immigration on women's body image and risks for eating disorders. Immigration involves more than geographic transitions. Immigrants undergo a process of cultural and identity transitions in which their attitudes, beliefs, values, and behaviors change as they adapt to their new country. This process is known as acculturation, and it has been suggested that high levels of acculturation to a Western country may serve as a risk factor for poor body image and disordered eating. Further, researchers speculated that there may be cultural differences in susceptibility to these syndromes, with some cultures of origin providing buffers against the onslaught of thinness images in the Western settlement countries.

Immigration to the USA

The majority of the research on disordered eating in immigrants has examined immigrants to the USA and will be summarized here by country of origin. Asian-born (Hong Kong, Japan, Taiwan) immigrants formed a large category of study participants. However, studies examining levels of acculturation found mixed results. Some found that high acculturation to the USA was related to lower body satisfaction, but also lower levels of eating disorders. Other research found high acculturation was related to greater body perfectionism and higher ED. Yet other studies, with South Asian, Chinese, and Korean women, found that acculturation had no association with wanting to be thin, worrying about having fat on the body, or other negative attitudes.

Immigrants from Central and South America comprise the largest immigrant group in the USA, with Mexicans forming the majority. Research results again are inconsistent as to the link between body dissatisfaction and ED and regarding the role of acculturation. Several studies found no association between level of acculturation and risks for ED.

A clearer pattern has emerged among Russian and Eastern European immigrants. High acculturation following acculturative stress has been linked to both body dissatisfaction and higher ED attitudes and behaviors. A clear but opposite trend suggests that maintenance of ethnic neighborhoods are a buffer against ED for both Iranian and Caribbean immigrants. The latter, despite having a larger body ideal than the USA, report high body satisfaction and low levels of ED.

Immigration to the UK

Japanese-born and native-born women living in the UK reported similar relationships between emotional eating and bulimic attitudes, but this association was not found among Japanese women living in Japan. Similarly, in two studies, Pakistani-British women reported higher risks for ED and higher prevalence of bulimia than did women living in Pakistan. Examining the factor of acculturation, several studies among South Asian women found conflicts with parents over interpersonal relationships. Higher acculturation was associated with higher ED risk. Japanese immigrants had more risks for ED among women with traditional identity also suggesting that family conflict may contribute to ED. Similar to the study on Caribbean women in the USA, Kenyan immigrants positively perceived large body shapes.

Immigration to Canada

Among second-generation Italian and Greek immigrants, greater family conflicts, higher levels of perfectionism, and internalization of the thin ideal predicted risk for ED. A study of diverse immigrants found concerns with dieting increased with generation status suggesting that new immigrants were initially insulated from Western body norms.

Immigration to Australia and New Zealand

High levels of ED attitudes were found among Chinese female immigrants who either had high acculturation and high pressure to be thin from father or friends or had low acculturation and high levels of parental care. Among Chinese immigrants to New Zealand, positive appraisal of perfectionism served as a buffer between acculturation and ED.

In summary, there is a complex relationship between home culture, level of acculturation, family relationships, residential living patterns, and other demographic variables affecting clinical dissatisfaction with one's body and disordered eating among immigrant populations. Methodological problems plague this research area and the inconsistent use of scales and other assessments impede rigorous comparisons or the ability to integrate the literature. Clinicians should not assume that disordered eating is absent from immigrant communities but rather an array of variables influence the presence of the syndrome.

Related Topics

- ► Acculturation
- ► Acculturative stress
- ► Assimilation
- ► Body image
- ► Body shape
- ► Psychological acculturation

Suggested Readings

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Disordered Gambling

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Gambling consists of *any activity that involves risking something of value on the outcome of an event (e.g., lotteries, bingo, slot machines, sporting events, card games, and more), when the probability of that outcome is less than certain.* For most individuals, gambling is a form of recreation, but for some people it can lead to negative consequences, such as poor mental and physical health, financial difficulties, and degraded social relationships. Recent studies have estimated the rate of gambling-related problems (i.e., experiencing some negative gambling-related consequences) in the adult US population to be 2–3%, whereas the most recent US national studies suggest that less than 1% suffer from the most serious form of disordered gambling, pathological gambling (PG). Currently, one can make a diagnosis of PG using professional diagnostic instruments, such as the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*. The DSM criteria for PG include, but are not limited to: feeling restless, irritable, or anxious when trying to stop and/or cut down on gambling; trying to keep family or friends from knowing how much one gambled; and, having such financial trouble as a result of gambling that one had to get help with living expenses from family, friends, or welfare.

Although the available scientific literature is extremely limited, researchers and other key stakeholders are concerned that members of a number of special populations (e.g., elderly, youth, minorities, immigrants, casino employees) might be at increased risk for gambling-related problems. Researchers suspect that immigration and disordered gambling are related, possibly as a result of the stress of the immigration process on individuals, cultural differences in gambling acceptance and participation, and increased access to gambling opportunities postimmigration.

To date, most studies have considered the prevalence of gambling and gambling-related problems among immigrant populations. The research related to gambling participation has yielded mixed results. Some studies have found increased gambling prevalence among immigrants compared to nonimmigrants (i.e., immigrants from Hong Kong and South East Asia to Canada), although this association is not universal for all immigrant groups. Researchers have also found, in what echoes the findings of unpublished community-based surveys, that the longer the immigrants (i.e., Asian immigrants in Canada and Mexican immigrants in the United States) reported living in their new country, the greater the likelihood that they engaged in gambling activities.

Studies of gambling-related problems among immigrant populations suggest that immigrants should continue to be a population of interest. Studies of gamblers in Norway and Denmark show that, in general, immigrants were more likely to be at-risk for developing gambling problems than nonimmigrants. However, estimates of gambling-related problems and PG among specific immigrant groups vary widely. One study of South East Asian (i.e., Cambodian, Laotian, and Vietnamese) immigrants to the United States found that 12% had probable subclinical gambling-related problems (i.e., South Oaks Gambling Screen (SOGS) scores of 3–4) and 58% met criteria for probable PG (i.e., SOGS scores of 5 or more). A similar study of Cambodian immigrants to the United States found 3.5% had probable subclinical gambling-related problems and 10.4% met SOGS criteria for probable PG.

Despite the availability of some immigrant-focused disordered gambling research, there remain significant gaps in knowledge. The current literature related to immigrant populations is very small, and many studies rely on anecdotal evidence for community interventions and policy decisions. Additionally, most studies are cross-sectional in nature, and many rely on convenience sampling methods and have very small sample sizes. These methods lead to results that might not generalize to wider immigrant communities and cannot provide information on the temporal relationship between immigration and gambling behavior problems. Similarly, research is needed to assess the impact of cultural beliefs and traditions on disordered gambling among immigrants, as well as on treatment seeking and treatment success. Studies indicate that treatments that are culturally competent can aid the recovery of immigrants with gambling-related problems.

Looking to the future, the experiences of immigrants dealing with gambling problems will improve as research fills in the current gaps in understanding for these populations. Prevention and intervention efforts are needed that address the generally poor access that immigrant groups have to both mental and somatic health services, the cultural and language barriers that isolate immigrants and the stigma of seeking help in some cultural groups. Refinement of the knowledge and treatment of disordered gambling for immigrants has the potential to greatly improve the health of individuals and their communities.

Related Topics

- ► Acculturation
- ► Acculturative stress
- ► Addiction and substance abuse
- ► Cross-cultural health
- ► Drug abuse
- ► Substance use

Suggested Readings

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Suggested Resources

http:www.divisiononaddictions.org
http://www.basisonline.org

Displaced Populations

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Introduction

The displacement of a group of people can have many long-standing effects. Various forms of population displacement include voluntary forms, i.e., immigration, or involuntary forms, i.e., gentrification of neighborhoods or by the forces of mother nature or political unrest.

While immigrants may choose to leave their countries of origin under seemingly voluntary conditions, they are still leaving behind their homelands and families to move to another country. Thus, when they move and do not have any social support in the new country they have a harder time adjusting. They may suffer from depressive symptoms related to the change in their environment and their living situation, and lack of social support in the new country.

Gentrification of neighborhoods has been thought of a way to revitalize an impoverished area by bringing in a more affluent population. Housing costs increase thus bringing in a more affluent class that can afford these increased prices, and this forces out the lower economic individuals, effectively displacing them because they cannot pay the rent. As more affluent individuals move into the area, more services to cater to the affluent lifestyle move into the area, furthering the displacement of the lower economic individuals. Not all of these displacements are voluntary or friendly. Atkinson notes that 1 in 10 tenants are harassed each year to leave their homes, and 2% of the evicted reported that "other ways" of persuasion were used. These methods of persuasion can lead to emotional symptoms of anger, anxiety, or even posttraumatic stress disorder in severe cases; also there is the emotional component of leaving a home that may have been in a family for generations.

Refugees have similar stories in that they may be leaving behind a home country, city, or village that generations of their families have lived in. Refugees flee their countries to save their lives. They run from war and persecution, often losing beloved family members along the way. People who are displaced within their own country are called internally displaced persons. Not only are they experiencing the loss of their home, either through natural disaster or wars, but they have the added stress of the traumas they encounter before and during the displacement. Math and colleagues found that there was higher psychiatric morbidity in individuals displaced from their countries at 5.2% in comparison to the non-displaced individuals who had psychiatric morbidity of 2.8%. They found that in both the displaced and non-displaced individuals, there was an even distribution of depression and PTSD symptoms. However, interestingly they noted that in the displaced population there was more frequent panic disorder, anxiety disorder, and somatic disorders. Math et al. also found that women were more likely to experience problems with mental health problems after experiencing the tsunami. The World Health Organization noted that in times of war, women and children tend to become victims of exploitation.

It is important to consider the adjustment when dealing with a person who has been displaced from their country of origin. Assessing if that individual expresses feelings of being welcomed in the new culture will support these individuals acclimating with the dominant culture without problems. Individuals who feel isolated will have a harder time trusting people, feeling comfortable; all of these factors can lead to potential increase in emotional distress.

Related Topics

- ► Disasters
- ► Internally displaced persons
- ► Posttraumatic stress disorder
- ► Red Cross
- ► Refugees

Suggested Readings

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Divorce

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Divorce is the legal termination of a marriage through judicial proceedings. Although it has been said that the divorce rate is increasing, it has actually decreased or remained stable in many countries. For example, data indicate that in 1980, the US divorce rate was 7.9 per 1,000 persons aged 15–64 years, but the rate had decreased to 5.2 persons per 1,000 by 2008. The divorce rate has remained relatively stable in some countries, such as the UK and Denmark, but has increased in Japan, from 1.8 per 1,000 persons in 1980 to 3.1 persons per 1,000 in 2008. Ireland and Montenegro continue to have some of the lowest rates of divorce.

The legalization of divorce and the transition in some legal systems from a fault-based system of divorce (i.e., one partner asks for divorce because of the other's misconduct related to marriage) to one of no-fault divorce (i.e., divorce can be requested without claiming partner's misconduct during the marriage) and unilateral divorce (the ability of a partner to obtain divorce without the other partner's consent) may have led to an increased divorce rate. Although the introduction of these more lenient laws may have led to an immediate increase in the divorce rate, this increase has generally not been maintained over time.

The underlying reasons for divorce and the increased leniency of divorce laws reflect changes in societal attitudes. At one time, most people divorced due to their partner's specific/concrete negative behaviors such as alcohol consumption, or lack of support. Now, many divorces are premised on more abstract reasons, such as different or conflicting life styles or one or both of the partners' desire for increased freedom.

The reasons underlying divorce also vary by gender. Studies show that women often divorce because they feel unloved or underestimated, while men divorce more often because they feel neglected or because they believe their values and interests are incompatible with those of their partners.

Studies indicate that the primary risk factors for divorce in heterosexual couples include marriage at a younger age, low socioeconomic status, lower educational level, great age difference, and sociocultural differences between spouses. The importance of low education may decrease as the duration of marriage increases. Some of the inequalities that exist between spouses, such as a difference in income, may have a protective effect on marriage.

A study conducted in Norway and Sweden found that the risk of divorce is significantly higher in same-sex registered partnership than in heterosexual marriages. (A registered partnership is a legally recognized civil status that, in Norway and Sweden, functions essentially the same as a heterosexual marriage.) The investigators reported that the rate of divorce is about 50% higher in registered partnerships between men than in heterosexual marriages.

Among the same-sex partnerships, the risk of divorce is twice as high in partnerships between women compared to partnerships between men. The investigators hypothesized that the increased risk of divorce among same-sex registered partnerships may be due to lower exposure to normative social pressure for lifetime marriage and the lack of shared responsibilities for raising and educating children.

Studies indicate that international migration is associated with higher divorce rates than those prevailing in the migrants' countries of origin. The reasons and the moment for divorce vary and largely depend on the immigrants' cultural background, their level of acculturation, the new socioeconomic environment, and the social and legal attitudes toward divorce in host countries. Divorce may occur shortly after immigration as a consequence of several factors. These include the emigration of partners at different moments in time, involvement of the first migrating partner in a new relationship in the host country; one of the partners being a "tied migrant" (i.e., a person who immigrates depending on her/his partner), tensions caused by the wife's increasing income, more permissive divorce legislation in the host country. Immigrants may also divorce after a period of residence in the USA due to their assimilation of the more permissive attitudes of the new host society toward divorce, disagreements about returning to their country of origin, and the realization by the marital partners that they are no longer suitable for each other in the host country.

For example, a number of studies conducted with immigrants from Mexico and other Central American countries in the USA found that their divorce rate after migration was higher than the rate in their home countries. A qualitative study conducted with Puerto Rican immigrants in the USA showed that the longer a couple resided on the US mainland, the more likely the partners were to divorce, this association being stronger in informal partners than in married couples.

Research on divorce among Korean-Americans shows a much higher divorce rate than in their country of origin. One of the most frequent reasons for divorce among Korean-American women is the high rate of wife abuse, usually motivated by the patriarchal family structure, the emphasis placed on family harmony, and social discrimination of women in the country of origin. Another important reason is the extensive involvement of Korean-American women in the labor market (estimated at about 60%) and the women's increased economic role in the family, causing confusion and conflict due to disruption of traditional family roles, namely, the dominant role of men and their role as the financial supporter of the family. Given the women's involvement in the labor market they have a dual role: they must raise children and take care of the house but also fulfill their obligations at the workplace. This dual responsibility places a disproportionate burden on them, generating fatigue and marital conflicts. The ease of divorce and the ease of finding a job may have contributed greatly to women's decision to divorce.

A study involving a community of Hmong immigrants in the USA shows that the contact with American culture has induced some changes in their attitudes and opinions on marriage and divorce. They are confused when asked about the acceptability of divorce, as they come from a society and culture that are strongly opposed to divorce. They are, however, less inclined to believe that in case of divorce children belong to father, this being the case in their home country.

Related Topics

- ► Acculturation
- ► Assimilation
- ► Battered spouse
- ► Domestic violence
- ► Gender role
- ► Intimate partner violence
- ► Marriage

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Doctor–Patient Relationship

► Physician–patient communication

Doctors Without Borders

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Médecins Sans Frontières (MSF) – Doctors without Borders – is an international humanitarian aid organization that was founded in 1971 by a small group of French doctors and journalists, headed by Bernard Kouchner who had worked in Biafra during the 1967–1970 Nigerian Civil War. The founders were frustrated with the neutrality that characterized the attitude of the Red Cross during the Nigerian-Biafra conflict and felt the need to create an organization that would provide aid and emphasize and defend the victims' rights.

MSF's values are aligned with the principles of the Declaration of Human Rights of the United Nations, and its mission is to get involved and alleviate the suffering of people. A particular focus of intervention is when there are medical needs that result from violence, torture, warfare, persecution, oppression, natural disasters, epidemics, abandonment, exile, or exodus. MSF defends peoples' right to medical care regardless of race, religion, creed, or political affiliation, and in their view this right supersedes the sovereignty of the state. If necessary, MSF often enters conflict areas to help all victims without the government's permission. Consequently, human rights violations witnessed by its staff are exposed.

MSF believes that denouncing and speaking out about atrocities will raise awareness, educate the public and decision makers, evoke indignation, and eventually promote policy changes that will prevent humanitarian crises. To achieve this goal MSF documents its activities, has partnered with other organizations with a similar mission, and has a strong relationship with mass media (including renowned newspapers, Internet, listservs, speaker's bureau). Most of its publications (reports, documentaries, and videos) are freely available on the

Internet. MSF has also published more than 100 articles in academic peer-reviewed journals.

There are about 27,000 MSF-committed individuals (including doctors, nurses, logisticians, water and sanitation experts, pharmacists, administrators) operating in almost 70 countries and supported by 19 associate organizations distributed around the world (Australia, Austria, Belgium, Canada, Denmark, France, Germany, Greece, Holland, Hong Kong, Italy, Japan, Luxembourg, Norway, Spain, Sweden, Switzerland, United Kingdom, and United States). Each one of these organizations has its own board and a certain degree of independence. The vast majority of MSF aid workers are from the communities where the crisis is occurring, and because they tend to be in remote areas they often capture events that go unnoticed by the established media outlets. In December of each year, MSF publishes a report that describes the top ten humanitarian crises its staff has witnessed.

Eighty-nine percent of MSF's funding comes from private sources, which allows MSF to operate independently of any political, military, or religious agendas. In 2006, MSF had more than three million individual donors and private funders worldwide, and an annual budget over half a billion dollars.

More than half of MSF's programs include the provision of medical care to those affected by armed conflict or internal instability who reside in refugee camps and shelters.

Substantial programmatic effort is devoted to groups of people who experience difficulties accessing health care, even if they reside in stable and economically developed societies. The latter group includes street children, migrants, minorities, displaced people, prisoners, unemployed, drug users, sex workers, and people infected with tuberculosis or HIV/AIDs.

Between 1975 and 1979, millions of Cambodians migrated to Thailand to avoid the Khmer Rouge and MSF set up its first refugee camps in Thailand, and in 1979 they sailed to the China Sea to provide medical services to boat refugees. MSF has provided assistance to victims in many countries including Lebanon, Sudan, Ethiopia, El Salvador, Liberia, Somalia, Mozambique, Bosnia, Herzegovina, Kosovo, Rwanda, Chechnya, Colombia, Haiti, Chad, Democratic Republic of Congo, Ivory Coast, Zaire, Tanzania, Sierra Leone, and India (Kashmir).

For over 15 years MSF has been working with a network of countries (Belgium, France, Greece, Italy, Sweden, The Netherlands, Spain, Switzerland, Malta, and Morocco) on projects related to immigration in Europe, where many immigrants face detention, appalling living conditions and lack of access to health care. MSF has been urging policy makers in Europe to respect the life and dignity of migrants and asylum seekers and improve their access to basic services, including shelter and health care. A key support service has been providing medical and psychological care to those who have survived the journey. MSF also assists migrants in their countries of origin (Somalia, Afghanistan, Democratic Republic of Congo, and Nigeria) and at different stages of their journey. These journeys are often arduous and beleaguered with exposures to communicable and water-borne diseases, violence, and abuse. Unaccompanied minors and women are increasingly among those making the journey and are at increased risk of poor health outcomes.

MSF received the Seoul Peace Prize in 1996 and the Nobel Peace Prize in 1999. These awards recognize the crucial role of MSF in providing access to health care and protecting the human rights of immigrant populations.

Related Topics

- ► Asia
- ► Asylum
- ► Disasters
- ► Human rights
- ► Internally displaced persons
- ► Refugees
- ► Stress
- ► Torture
- ► Unaccompanied minors

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Domestic Violence

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On September 7, 1987, 28-year-old Jian Wan Chen was beaten to death with a claw hammer in her Brooklyn apartment. The man who delivered the eight blows was not a masked intruder, but her husband, Dong Lu Chen. Mr. Chen killed his wife after she admitted to having an extramarital affair. At trial, a defense expert testified that Chinese men commonly threatened to kill unfaithful spouses, out of a sense of inadequacy, but were prevented from doing so by family and friends, whom Chen did not have access to as an immigrant. As a result of this "cultural defense," Mr. Chen's charge was reduced to second degree manslaughter. The judge sentenced Chen to probation for 5 years, the minimum sentence for this offense.

While the last three decades have seen significant efforts to combat domestic violence, domestic violence in immigrants has largely been ignored until the past decade. Whether due to the many barriers they face in accessing services or, as in the Chen case, the dismissal of violence as culturally normal, immigrant women have not received the same protection from domestic violence that native born women are afforded. This entry will review some of the barriers that immigrant victims of domestic violence face in seeking protection and will offer an overview of some available legal remedies.

In deciding to seek help from the authorities in the USA, immigrant women often face disapproving family and friends, fears about the police, and the fear of legal sanction or even deportation. In some cultures, women are taught to play a submissive role, even in the face of abuse. These attitudes are almost always reinforced by the abuser and possibly by his family. The abuser may try to shame the victim's family by spreading rumors about her in close-knit, traditional cultures. Fears of causing the family to break up, of being an inadequate spouse, of being seen as an undesirable partner by other men, or of losing her children are also prominent. Prior traumatic experiences with authority figures in their country of origin also may play a role in preventing women from seeking assistance. Some women have been subject to rape, beatings, and other atrocities by authorities in their countries of origin which will make them fearful of police. For example, former Iraqi dictator Saddam Hussein built "rape rooms."

Once the woman has decided to seek the assistance of the authorities, she will likely encounter language and cultural barriers. In a study of 230 Latina victims of domestic violence, Orloff and colleagues found that only a third of women who called the police were interviewed by Spanish-speaking officers, though nearly all of the women spoke little or no English. Police officers did not interview the victim in one third of the cases, speaking instead with the alleged perpetrator or witnesses. Orloff and colleagues observed that police sometimes use the victim's children or the alleged perpetrator to translate. This can lead to inaccurate information being conveyed and may inflame an already volatile conflict. Police officers sometimes fail to act out of a belief that violence is part of the victim's culture. Therefore, these victims are, in effect, denied the protection that the law would normally afford because of cultural stereotypes.

Even after they are no longer involved in the abusive relationships, immigrant victims face additional barriers. In 1986, Congress passed the Immigration Marriage Fraud Amendment, which mandated that foreign nationals who came to the USA to join their spouses be married for at least 2 years. If the couple was married less than 2 years at the time of immigration, the immigrant spouse was granted conditional residency status until they had been married for 2 years or more. This was intended to combat "sham marriages," or marriages entered into in order to obtain citizenship or permanent residency status. However, it had the consequence of trapping battered immigrant women in abusive relationships for up to 2 years.

Congress attempted to alleviate this problem in 1990 with the passage of the Violence Against Women Act

(VAWA). VAWA included limited relief for battered immigrants. First, it included a Battered Spouse Waiver. Second, it allowed battered women to file a self-petition alleging battery. Third, it established a defense to removal based upon battery or extreme cruelty. A detailed review of the requirements for relief under VAWA is beyond the scope of this entry, but suffice it to say it allows for limited relief and establishes stringent standards for women seeking relief.

Personal protection orders are also available to immigrant victims of domestic violence. Orloff and colleagues recommended including provisions specific to the immigrant's situation in the order. For example, courts may order the batterer not to take the children outside the USA or may order him to surrender the documents the victim needs to complete immigration or social service applications. Thus, protection orders can serve the dual purpose of helping provided for the victim's physical safety while empowering her legally and economically.

Immigrant victims of domestic violence face unique barriers to protection including cultural stereotypes, language barriers, and legal barriers. While VAWA and personal protection orders provide some relief, more protections are needed. Future efforts should focus on bridging the barriers or culture, language, and law so that we can give these victims the same protection afforded other victims of domestic violence.

Related Topics

- ► Battered spouse
- ► Child abuse
- ► Family violence
- ► Gender-based violence
- ► Intimate partner violence
- ► Violence Against Women Act

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Dowry

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There are many customs in marriages across the world; one of them is the giving of a dowry. Europe, South Asia, and Africa have a strong history of giving dowries. Dowries can be cash, gold, goods, or estate. Dowries are given to the groom's family by the bride's family. Historically, this was to ensure that the daughter received some inheritance from her father's estate, as she was not entitled to it upon his death. Dowries are also seen as the wife's financial contribution to the marriage. In some societies a woman's dowry is given back to her if her husband dies, or is given to her children if she dies.

While giving of the dowry started as a well-intentioned tradition, to help the newly wedded bride have some contribution in her new home, over the years it has become a dangerous policy. In India the practice of bride burning has become more prevalent. The husband's family asks the bride's family for more money after their marriage, and when they do not get the extra demand goods they will pour kerosene on the bride and set her on fire. Burning the bride can more easily be passed off as a kitchen accident (compared with poisoning or strangling). Despite the Indian Government's passage of a dowry prohibition act in 1961, Pratap noted that police statistics showed a 15-fold increase in dowry-related deaths from 400 a year in the mid-1980s to more than 5,800 a year in 1995. This increase in the number of cases can be related to the fact that some women are speaking up and reporting this abuse. However, Pratap also notes that police and activists still feel that they are actually only seeing a third of the actual violence secondary to dowry extortions.

Other cultures receive dowries differently. In the Thai culture the prospective groom approaches the bride's family to give a sin sot aka bride's price, to her parents, either on the day of the engagement or wedding. Traditionally, this is a compensation to the parents for losing a set of working hands.

Giving of a dowry has become such a financial burden on families that there are many elective abortions once the sex of the fetus is determined to be female. India banned sex determining tests in the Pre-Natal Diagnostics Techniques (Regulation and Prevention of Misuse) Legislation in 1994. India's 2001 census showed there were only 933 women for every 1,000 men.

The giving of dowries is still practiced in rural, non-educated villages in India, despite government banning of this practice. Continued focus on the bridal abuse and education of the rural public to change this cultural norm will be the only way to eliminate this practice.

Related Topics

- ► Customary marriage
- ► Marriage
- ► Trafficking
- ► Women

Suggested Resources

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Drug Abuse

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In the American psychiatric manual, the *Diagnostic and Statistical Manual of Mental Disorders IV*, the term *drug abuse* was replaced with *substance abuse* and, for diagnosis purposes, it is necessary to identify as a maladaptive pattern of substance use resulting in a clinically significant damage or distress manifested by one or more of the following problems occurred over a period of 12 months: inability to fulfill major job tasks, school or home tasks (e.g., repeated absences or reduced work efficiency, absence or expulsion from school, child or home neglect caused by the consumption of a substance); repeated consumption of a substance, in situations where it is physically hazardous (e.g., car driving or machine operation); repeated legal problems arising from the substance consumption (e.g., arrests); and continuous consumption of a substance despite social or interpersonal problems caused or exacerbated by persistent or recurrent substance effects (e.g., domestic violence, physical aggression). In addition, the symptoms have never met the dependence criteria for a substance of the same category.

Drug abuse and addiction are complex phenomena, related to personality, drug, social, and cultural factors. Research conducted in groups of immigrants in the USA and Europe showed that drug abuse issues include: motivation, prevalence, consumption patterns, the significance of drug use, and addressability by specialized medical treatment.

Motivation of Drug Abuse Among Immigrants

The motivation for drug abuse among immigrants is a mix of past, present, and future situations, being often difficult to determine which of these prevails. By giving up their country of origin and by choosing to live in another country, an emigrant must identify the most appropriate coping strategies, drug abuse being often the consequence of choosing ineffective strategies.

Many immigrants are marked by negative experiences from their country of origin, such as armed conflicts, imprisonment, torture, loss of property, or death of close persons. Such experiences may induce posttraumatic stress syndrome, which is commonly associated with drug and alcohol abuse. These are supplemented by the stress caused by immigration, especially the hazards associated with illegal immigration or obligation to spend some time in refugee camps.

The difficult bureaucratic process at the arrival in the host country is a stressor because it induces fear and uncertainty by separation from the family and lack of power. Beside the mandatory bureaucratic procedures faced by the immigrants when entering the new country, they also meet a number of problems such as: stress caused by the new culture, language barriers, discrimination, and financial and social difficulties.

The phenomenon of acculturation, generated by the assimilation of a new culture, the adjustment to the life in a new country with different culture and customs from their homeland often leads to frustration of both first- and second-generation immigrants. Besides cultural differences between home and immigration country, immigrants have to face language barriers that impede their social integration and find a job appropriate to their training. In addition they may be forced to make compromises such as accepting jobs below their education to enable them to meet immediate financial needs especially at the beginning of their life in the host country. Immigrants' frustrations may originate both in society and the family of origin. For example, immigrating to a country with higher living standards and professional opportunities than in the country of origin, parents may have high expectations from children, which the latter cannot reach, thus inducing a strong emotional stress, which leads them to attempt to mitigate the psychological impact of personal failure by abuse of alcohol and drugs. Studies conducted in Sweden, France, and Germany showed that drug abuse among young immigrants is mainly the result of social integration difficulties.

Immigration places a variety of stressors on the individual, their impact on health being conditioned on the one hand by the magnitude of stress, and on the other by personal and social resources that the individual has to cope with stress. The cumulative exposure to major stressors increases the risk of drug abuse and depressive disorders or anxiety. If during the process of acculturation the stress experienced exceeds the individual's abilities to cope and if the individual considers that he/she cannot control the stress, this person may engage in acts of rebellion, delinquency, and drug abuse. Marginalized individuals feel the strongest stress and have the highest risk of drug abuse. It is possible that immigrants are not prepared for the challenges and stressors induced by immigration, these aspects being often underestimated.

Prevalence of Drug Abuse Among Immigrants

A paradoxical aspect when alcohol and drug abuse is recorded both among new and acculturated immigrants is that among the latter, drug and alcohol abuse prevalence is higher and increases as the length of stay in the host country increases. Among Asian immigrants in the USA and, in particular, the second-generation of immigrants (those born in the USA) there has been noticed a more frequent abuse of alcohol and drugs, often as an attempt to escape from family pressure and confrontations related to those parents who have a lower degree of acculturation, and who are largely confined to the culture of their country of origin, thus leading to conflicts between generations.

Studies show that acculturated US Hispanics reported much higher rates of illegal drug use than non-acculturated Hispanics. The greater the length of the Hispanic immigrants' residence in the USA, the more likely they are to engage in drug abuse, particularly tobacco and alcohol. In particular, among Mexican immigrants in the USA there is a higher prevalence of drug abuse and addiction in those born in the USA, compared to the new immigrants. This difference may be attributed to the fact that Hispanic culture has a protective effect against drug abuse, and the significant loss of cultural values by acculturation increases the prevalence of this phenomenon. Low acculturation and greater family support have a protective effect, acting as a buffer against the impact of social stress and/or limiting the exposure to social stressors.

Exposure to American culture increases opportunities for drug use in peer groups, in addition to familiarizing them with the rules or norms of drug abuse. As the young immigrants are acculturated, removing the language barrier, they may communicate more easily with those who have access to the drug environment.

Although the phenomenon of increasing prevalence of drug abuse in direct proportion to the degree of acculturation is supported by a series of research, there are few data indicating the time frame in which immigrants become acculturated and resort to drug abuse.

Patterns of Drug Abuse Among Immigrants

Cultural factors in home countries have a major influence on patterns of alcohol and drug abuse among immigrants, and the type of drug consumed. Abuse of alcohol and drugs is to immigrants a continuation of standards, values, and traditions of home countries, as demonstrated by a series of studies. In the Netherlands, opium trafficking networks, closed in the 1970s with market penetration of illegal heroin, have been reopened by Iranian immigrants who used to consume opium in the country of immigration, thus continuing the home country custom. Alcohol abuse is a problem among immigrants in Europe and usually addictive patterns of home are reflected in addictive disorders related to alcohol in the first generation of immigrants. The strongest predictor of current consumption of opium in South East Asian immigrants in the USA is the opium addiction in the home countries. The same pattern, represented by continuation of drug consumption in the immigration country, was identified among new immigrants arrived in the USA from Cuba, Ethiopia, and Palestine.

Significance of Drug Abuse

The significance of drug abuse in communities of immigrants depends on cultural and religious factors of the home countries, in turn causing the community's response to drug abuse and the degree of addressability to specialized treatment programs. For example, the members of South Asian communities are less involved in drug abuse due to their cultural and religious constraints, so that while alcohol consumption in these communities is quite high, opiate abuse is low. Asian addicts have a higher degree of adherence to their families compared with non-Hispanic White addicts, which facilitates recovery and achieving abstinence. Typically, the Asian immigrant communities use consumption denial techniques because either it is deemed harmless, or the consumption is considered negligible, because it is assumed that young Asians do not use drugs. Denial of the abuse of alcohol and illegal drugs in Asian communities is based on a number of cultural beliefs and the great diversity of ways in which abuse is perceived in different Asian countries. In general, it is considered that the abuse of alcohol and drugs places blame and shame on the individuals and their families, so that Asian families prefer to solve such problems from within the family. In some Asian countries it is considered that alcohol is harmless if it does not induce behaviors that bring shame on the family, and is therefore acceptable for solving personal problems. In other countries, to refuse a drink from a person in a higher position, such as an older relative, may be considered offensive. It is possible that Asians have a particular perception of alcoholism, in that they consider it a sequel of chronic alcohol consumption instead of loss of control over consumption, which may lead them to consider medical intervention useless.

Access to Specialized Medical Treatment

Immigrants use drug-addiction treatment services less than the native population. In the USA, for example, where Asians represent about 4% of the population, less than 1% of addicted enrolled in specialized treatment programs are Asians.

Low access to treatment programs is determined on the one hand by economic and sociopolitical barriers, represented by unfamiliarity with the system, ignorance of how to access these services, unawareness of the existence of such services, or erroneous belief that the treatment programs are intended solely for the native population, and on the other hand by cultural barriers represented mainly by the fact that drug abuse is not considered a problem in the culture from where the individual originates. In addition, community stigma and fear of deportation due to the illegal drug consumption may limit the access to treatment facilities. Therefore, low rate of use of specialized medical services is not due to low prevalence of drug abuse in immigrant communities but to low access to such services. However, studies showed that new immigrants are more receptive to health education and more worried about alcohol abuse, sexually transmitted diseases, and mental health problems than those who are already acculturated.

Drug abuse is largely linked to the transmission of HIV/AIDS worldwide. There are several risk factors for this association: the sharing of contaminated injection needles (UNODC reported that 13.2 million people use injectable drugs, and about 10% of HIV cases are caused by the use of injectable drugs), risky sexual behavior in individuals who were under the influence of drugs (drug abuse can lead to impaired reasoning and decision making), which increases the prevalence of sexually transmitted infections; acceptance of risky sexual behaviors by non-injectable drug users in order to obtain money for drug procurement; and HIV transmission to children born by drug-addicted and HIV-infected mothers. Research showed that retention in drug treatment programs is positively correlated with reduced risk behaviors for HIV transmission and it reduces the rates of HIV seroconversion. Therefore, treatment for drug abuse is an important and effective strategy to prevent HIV infection. As a consequence, the best way to increase access of immigrants to such services must be identified. A study on the use of services for drug-addiction treatment by Asian immigrants in the USA has shown that the key to Asian immigrants increased access and retention in the specialized medical programs is the provision of services in their native language and training of the medical staff for the purposes of sensitivity to their cultural traditions and the problems they face through immigration in a foreign country.

Related Topics

- ► Acculturation
- ► Acculturative stress
- ► Acquired immune deficiency syndrome
- ► Cultural humility
- ► Posttraumatic stress disorder
- ► Smoking
- ► Stress
- ► Substance use

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Suggested Resources

www.undcp.org/report
www.emcdda.europa.eu
www.samhsa.gov
www.drugabuse.gov

Drug Use

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Drug use represents a major problem in the world. The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) showed that in 2006, 65 million adults have consumed cannabis at least once (20% of the adult population), 10 million adults have consumed amphetamine at least once (3% of the adult population), and 8.5 million adults have consumed ecstasy at least once (2.6% from the adult population). In addition, in Europe there are approximately 7,000–8,000 drug-related deaths per year, comprising almost 3% of all adult population under-40 deaths. Since 2000, many European Union countries have reported a drop in drug-related deaths. However, during 2004–2005, this tendency has not been maintained and the number grew significantly. Alarmingly, the percentage of youth who died in relation to drug use has grown.

The incidence and prevalence of drug use in the United States is also growing. According to the National Institute in Drug Abuse's (NIDA) comparative statistics, in 2004, 7.9% of the population aged 12 and over was using drugs. The consequences of drug use are felt upon several levels. At the medical level, the prejudices are enormous upon both physical and psychological health, with short-term and long-term implications. At the social level, drug use often leads to job loss and loss of friends. It may also involve antisocial activities, including robbery and crimes of violence. At the educational level, drug use may foster a model for children, so that they may become the next drug users.

There are several categories of populations identified as more vulnerable to drug use. According to the EMCDDA 2003 Report, social exclusion, defined as "a combination of lack of economic resources, social isolation, and limited access to social and civil rights," is a key factor in drug use. This underscores the dual relationship between drug use and social exclusion. These elements interact in the following manner: drug use can lead to social exclusion and social exclusion can lead to drug use. Populations considered vulnerable for social exclusion and, so, for drug use are: immigrants, prisoners, the homeless, sex workers, and vulnerable young people.

Immigrants are particularly susceptible to drug use for a number of reasons. Some immigrants are undergoing a process of psychological distress regardless of the degree of self-motivation or self-preparation for the process of migration or of the circumstances. The migration process may involve experiences that could be traumatizing and could place the immigrant at risk for drug use/abuse. The phases of the migration process including premigration, departure, transition, and adaptation may foster experiences such as removal from friends, family, birth place, the feeling of being lost, anxiety, and the feeling of not belonging anywhere. Immigrants may cope with the stresses caused by the mismatch between their hopes and expectations and the realities of life in their new home by using drugs or alcohol. The background of immigrants such as traumatic experiences like war or torture may be related to subsequent drug use. Also the new country's social attitude toward them plays an important role in making immigrants vulnerable for drug use, such as marginalization and lack of social support. Immigrants' illegal status, their low income, and reduced access to healthcare system may foster not only drug use, but also it may assure the continuity of the process, without the possibility of treatment. The World Health Organization Report of 1996 points out that the consumption of drugs such as tranquilizers and antidepressants among young immigrants in Europe is growing.

To stress the importance of the phenomenon upon immigrants and also to examine the impact upon their health, immigrants' drug use has been compared in different countries to the native population's drug use. One study describes drug use in Russian immigrants in Israel. Before 1989, drug use in Israel was more common among people having origins in Morocco and Tunisia, their drug of choice being heroin. The drug user's typical profile was age between 18 and 30, low economic status, and low level of education. Since 1989, there has been an increase in immigrants from the former Soviet Union in Israel. With this phenomenon, the drug user's typical profile changed to be mainly Russian in origin. The drug administration pathway is now mainly intravenous injection, and in 20% of cases it involves women.

Drug use has an impact on immigrants' health. Intravenous injection brings HIV and hepatitis risk. Risk related to overdose death also grows.

Other findings are reported in Greece. In this country two "waves" of immigrants have been registered, the first one dominated by Albanians in the early 1990s, and the second one after 1995 from the Balkan region and Middle East, including Pakistan, Iran, Iraq, and the former Soviet Union. From 1993 to 2001 there was a significant growth in drug-related deaths in which foreign-born persons were involved. A study of drug use among immigrants in Greece describes some interesting findings. There was no difference between the natives and foreign-born population in preferred drug (heroin), but there was a significant difference regarding the administration pathway. Natives used the inhalant and the oral methods, while the immigrants used the intramuscular injection with more persons using the same needle and syringe. Immigrants were initiated into drug using at an older age than the native-born population, and those immigrants advanced faster than the native-born population in the intramuscular drug use. Compared to native-born citizens (13.7%), more immigrants had been registered without even having knowledge of the risks of taking and the consequences of AIDS infection (26.4%) through using the intravenous administration of drugs with the same syringe and needle. Another significant difference is lower use of the healthcare system among immigrant groups compared to natives.

A study of immigrants in the Netherlands showed that the preferred drug was a morphine type drug. Male and female immigrants from Turkey along with female immigrants from Morocco had a lower risk of first administration than male immigrants from the Dutch Antilles and Surinam and female immigrants from Germany.

Another study conducted by the Department Of Health And Human Services Substance Abuse and Mental Health Services Administration (SAMHSA) on immigrants and substance use (1999–2001) revealed that during the past month marijuana use was lower among foreign-born individuals living in the United States (1.7%) than among US-born persons aged 18 or older (5.1%). For adult immigrants, rates of substance use were generally higher among males than among females, and rates were higher among immigrants who had been in the United States for fewer than 5 years than among those who had been in the United States for 5 years or more. Prevalence rates also were generally higher among immigrants aged 18–25 compared with persons aged 26–49 or those aged 50 or older. Some differences have been observed on the different kinds of immigrants in the USA. For example, past month marijuana use rates were higher among immigrants from Mexico (0.9%), Puerto Rico (2.0%), El Salvador (1.4%), and Jamaica (5.5%) compared with immigrants from Cuba (0.2%). Foreign-born US residents from Mexico (2.3%), Puerto Rico (4.7%), and Jamaica (6.4%) had higher past year marijuana use rates than those from Cuba (0.8%) or El Salvador (1.8%). The prevalence rates for any illicit drug use for both the past month and past year were higher among persons immigrating from Puerto Rico (7.7% and 13.6%, respectively) when compared with past month and past year rates for persons from Mexico (2.2% and 5.5%), Cuba (0.5% and 2.6%), or Colombia (2.1% and 4.9%).

These studies draw attention to several facts regarding immigrants and drug use. First, the growing number of immigrants contributes to the proportion of drug users. Second, though most of the time, the drugs of preference are similar among native-born and immigrant populations, the administration pathways may differ, with consequences on immigrants' health in relation to their habit of sharing needles and multipersons syringe usage. If there is reduced access to information about diseases like AIDS or hepatitis and reduced access to healthcare, the potential for serious health consequences are encountered. Last, but not least, immigrants represent a vulnerable population on drug using for many reasons and special supports should be developed.

Related Topics

- ► Acquired immune deficiency syndrome
- ► Addiction and substance abuse
- ► Drug abuse
- ► Heroin
- ► Substance use
- ► Trauma exposure

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E

East Asians

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East Asian immigrants are among the fastest growing minorities in the USA. This is a heterogeneous population that includes people who have been represented in the USA for generations. The US census reports that between 1980 and 1990 the total number of East Asian immigrants living in the USA grew from 960,000 to 1,800,000. (For the purposes of this paper, East Asia includes China (with Hong Kong, Macao, and Taiwan), Japan, and Korea (north and south).) This was 10% of the total US immigrant population of 19.8 million in 1990. In 2000, the number had more than doubled to 4.3 million, representing 42% of the total Asian immigrant population and 1.5% of the total US population. The Chinese percentage of East Asian immigrants grew to 56%, followed by Koreans 25% and Japanese 19%.

In part because of data collected on average income and education, East Asian immigrants are stereotyped as socioeconomically successful. In reality, this is a diverse group that varies in terms of educational and economic status, and in degrees of assimilation. For example, although the average income of Asian immigrant families is higher than the US average, the poverty rate of all Asian immigrants in 1999 was 12.6% compared to the US average of 12.4%, and unemployment was higher. The largest group of East Asian immigrants – those from China – had a poverty rate of 13.5%. In comparison, the poverty rate of Japanese immigrants was 9.7%.

In moving to another country and part of the world, immigrants face logistical, social, employment, educational, and political challenges. Given the diverse gender and family role expectations in the USA, conflicts within marriages and families develop. This is exacerbated by loss of direct contact with family members and support networks in native countries. They also face higher unemployment and job discrimination, and often have to accept jobs that do not suit their experience and education. The reasons for emigrating from their countries vary and include political persecution. These stresses along with the stress of navigating a fractured and complicated system of health care can significantly impact health and well-being.

Health care workers should be familiar with health issues facing East Asian immigrants. The countries from which East Asians immigrate have different approaches to health care. Korea and Japan have universal health care though their systems reach that goal differently. Both have single systems, government funded and administered, but Japan has multiple insurance plans from which citizens can choose. Except for Taiwan, China does not have universal coverage. These differ from the US system in which employer-based insurance is common, multiple private insurance carriers exist, and a substantial percentage of the population lacks insurance.

Since 1945 East Asian health care has been influenced heavily by Western medicine; however, traditional practices continue to play a role. For example, most Chinese immigrants believe that herbal medicines are the most effective treatment for high blood pressure. A study done at Stanford Medical Center showed that 100% of Chinese immigrants use self-prescribed traditional Chinese medicine at least once during the year. Forty-three percent of those self-prescribe weekly and only 5% reported that their regular physicians asked about it. Affluent immigrants were more likely to have health insurance and use Western medicine instead of traditional practices.

Along with traditional practices, it is important for health care workers to know that within this population,

Sana Loue & Martha Sajatovic (eds.), *Encyclopedia of Immigrant Health*, DOI 10.1007/978-1-4419-5659-0,

medical decisions are often made in the context of social and family concerns. The focus is on family and social groups rather than the individual. For example, because native foods are often central in an immigrant population, symptoms of diabetes and its treatment strategies can challenge dynamics about nutritional practices and family role. Studies demonstrate that social support can be critical for successful health care visits and treatment adherence.

There are unique mental health, medical, and genetic problems in East Asian immigrant populations. Psychiatric symptoms are likely to manifest as physical complaints such as fatigue and upset stomach, and may be overlooked by primary health care practitioners. Depression is prevalent in older immigrants and is linked to numerous factors including the strength of family relationships and English proficiency. Degree of acculturation has been shown to be inversely associated with level of mental distress. For example, the more an individual is assimilated into US culture, the less impact a negative life event will have on his or her mental health.

East Asian immigrants are less likely than the general US population to seek psychiatric services for mild to moderate mental illness and overall, mental health services tend to be underutilized. Although they are just as likely to seek services for severe mental illness, their suicide rates are substantially higher than their US-born counterparts. Interestingly, children of East Asian immigrants are just as likely to seek psychiatric services as the general US population. Studies show that barriers to mental health access include language barriers, financial limitations, lack of knowledge, and perceived stigma.

Although East Asian immigrants have lower rates of smoking, drinking, obesity, and have healthier diets, Chinese and Japanese immigrants have a lower life expectancy than their US-born counterparts. Although there are little data to explain these findings, there are data about mortality rates from cancer. Japanese and Chinese immigrants have different mortality rates from cancer than their US counterparts. Mortality rates from lung, stomach, cervical, and liver cancers are higher whereas mortality rates from prostate and breast cancers are lower. In Japanese immigrants, the incidence of stomach and rectal cancer is higher than the general US population, and in Chinese immigrants the incidence of nasopharyngeal is higher. A study in Canada showed that Asian immigrants are less likely to get Pap smear screens in part because of lack of necessity and time.

There are infectious diseases that are more common in Asian populations than in the general US population. For example, hepatitis B, parasitism, and tuberculosis are all more common in Asian immigrants than in the USA.

The risks of disability and chronic disease increase with the amount of time East Asian immigrants are in the USA. With economic development, nutritional changes and a more sedentary lifestyle, diabetes and obesity rates have increased. This has put more at risk for heart and kidney problems and cancer. A recent study showed that Japanese immigrants with similar levels of obesity to their Japanese counterparts are 2–3 times more likely to develop diabetes. This suggests that mainstream US diet may contribute directly to diabetes and coronary artery disease in Japanese immigrants.

Some of the more prevalent genetic disorders are the blood disorders called beta and alpha-thalassemia, and hemoglobin E. These cause the formation of abnormal blood cells and are found in South Asian and Chinese immigrants. Other disorders include glucose-6-phosphate dehydrogenase deficiency (primarily male disorder that causes blood cell breakdown) and lactose intolerance. A study found that 76–92% of the adult Chinese population is lactose intolerant. In areas of the USA with a high concentration of Asian immigrants, the incidence of the diseases caused by these disorders is higher and it is important to counsel couples who are considering having children.

These are some of the important health issues facing East Asian immigrants. Health care workers in countries with East Asian immigrants should be aware of the cultural and social traditions and unique health care concerns of this population particularly if they are recent or older immigrants. Being familiar with this and the cultural barriers to accessing health care services will help ensure safe and effective care of a rapidly growing minority.

Related Topics

- ► Acculturation
- ► Alternative and complementary medicine
- ► Asia

- ► Assimilation
- ► Health barriers
- ► Somatic symptoms

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Eastern Europe

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History

The distinction between Eastern and Western Europe can be traced to the history of the Roman Republic. As the Roman Empire grew, a cultural and linguistic separation appeared between the mainly Greek-speaking eastern provinces and the Latin-speaking western territories. This cultural and linguistic division was reinforced by the political division of the Roman Empire and was buttressed by a number of events during Late Antiquity and the Middle Ages. In particular, the Great Schism that formally divided Eastern and Western Christianity enhanced the cultural and religious distinctiveness between Eastern and Western Europe.

Boundaries

Rarely are the boundaries of global regions defined by objective geographical criteria; more often the margins fluctuate with expert opinion and context. Currently, there are a variety of ways in which Eastern Europe is defined; most characterizations are aligned with a particular cultural or political position. Current descriptions lack precision, with growing debate even among political scientists. The United Nations Statistics Division records Eastern Europe as comprising the nations of Bulgaria, Czech Republic, Hungary, Poland, Romania, the Russian Federation, Slovakia, and the Slavic republics of Belarus, Moldova, and Ukraine. Frequently, the term "Eastern Europe" is used to refer to all European countries that were governed previously by communist regimes. This territory is known collectively as the Eastern Bloc, in reference to the concept of an "Iron Curtain" separating Western Europe and Soviet-controlled Eastern Europe throughout the period of the Cold War. Prior to German reunification, East Germany was usually included as an Eastern European country.

Geography

Eastern Europe features many steppe, forest, lake, and tundra regions, as well as a humid continental-type climate with cool summers. Generally, the region is considered to be bordered by the Baltic and Barents Sea on the north; the Adriatic, Black, and Caspian Seas and the Caucasus Mountains on the south; and the Ural Mountains on the east. The western area of the region is comprised mostly of glaciated plains. The west central section is dominated by mountains and highlands and with structural basins between the highlands. The eastern section of the region is characterized as a large, relatively flat, stable, geologic plateau. The northeastern portion of Eastern Europe features lakes and glacial ridges. The region is highlighted by a multitude of major rivers, including the Vistula, Danube, Volga, Dnepr, Don, Elbe, Rhône, and Ural.

Ecology

In the recent past, Eastern Europe has been plagued by ecological concerns. In the mid-1990s, the Polish Academy of Sciences described Eastern Europe as the most polluted region in the world. Throughout that decade, many countries in the region began to evaluate their ecological situations and discovered a lack of effective pollution control systems. In some cases, cities were without wastewater treatment systems, allowing raw sewage to flow into the rivers. In some areas, fruits and vegetables grown in the polluted soils were feared to be toxic to humans and portions of rivers no longer supported aquatic life. As a result, environmental rehabilitation was made a priority throughout the region.

Culture

While there is some continuity, the countries of Eastern Europe have their own unique traditions that continue to be observed today. Frequently, these customs originated thousands of years ago when nomads and farmers began to populate the region. The traditions that are practiced today combine ancient pagan rituals relating to the seasons and agricultural cycles with the holidays of Christianity (often Eastern Orthodoxy), and even the festival celebrations of the former Soviet Union.

Economy

Manufacturing is critical to Eastern Europe's economies. The Czech Republic is the leading industrial nation in the western section, while Ukraine, the Ural Mountains, and the land along the Volga River are the major urban-industrial regions in the east. However, many of the former Soviet-controlled nations are dealing with excessive pollution and significant environmental issues due to lax industrial controls that prevailed during the Soviet era. Eastern Europe boasts many commercial forests and agricultural areas, although the growing season in the north is short. The Danube Valley countries produce corn and wheat; by proportion of the total Danube basin area, these countries include Germany (7.5%), Austria (10.3%), Slovakia (5.8%), Hungary (11.7%), Croatia (4.5%), Serbia (10.3%), Bulgaria (5.2%), Moldova (1.6%), Ukraine (3.8%), and Romania (28.9%). Rye, potatoes, and livestock are important commodities as well. Known for years as the "Breadbasket of the Soviet Union," the Ukraine is one of the most important wheat producers in Europe. Eastern Europe's major mineral resources are coal, iron ore, petroleum, natural gas, and bauxite.

Migration

History

At the end of World War II, the Soviet Union occupied most of Eastern Europe and part of Central Europe. Longing for independence, more than 15 million citizens of Soviet-occupied Eastern European states emigrated to the West in the immediate 5 years following World War II. Until the early 1950s, the lines between German occupation zones could be crossed easily; the number of Eastern Europeans applying for political asylum in West Germany was 197,000 in 1950; 165,000 in 1951; 182,000 in 1952; and 331,000 in 1953. As a result of limited resources and space in West Germany, in 1952 the United States responded to a request by President Harry Truman and increased its resettlement admissions quotas under the United States Escapee Program (USEP).

The migration that occurred between 1945 and 1950 represents the largest movement of any European people in modern history. Considering ethnic Germans alone, at least 12 million fled or were expelled from Soviet-occupied territories that would become the Eastern Bloc. It is estimated that at least two million perished during the exodus, with roughly 25% dying from physical force. An additional four million ethnic Germans were prevented from leaving Soviet-occupied Eastern Europe or were deported to remote areas of the Soviet Union.

During the period 1950–1990, most east–west migration stopped as a result of a restrictive Soviet approach to controlling national movement. However, some migration persisted, both within and from the Eastern bloc states. For example, after the Hungarian Revolution of 1956; 171,000 Hungarian refugees crossed the border into Austria and an additional 20,000 refugees crossed into Yugoslavia. Most of the east–west flow that remained took place between East and West Germany, as the lines between

Soviet-occupied eastern Germany and the western-occupied zones could be crossed easily in most places until 1952. More than 3.5 million East Germans emigrated to West Germany before 1961; this flow comprised most of the total net emigration of 4.0 million emigrants from all of Central and Eastern Europe between 1950 and 1959.

On August 13, 1961, construction of the Berlin Wall began, a barrier erected by East Germany that separated East and West Berlin. Thereafter, only 5,000 persons crossed the Berlin Wall between 1961 and 1989, and the total net emigration from Central and Eastern Europe fell even further to 1.9 million between 1960 and 1969 and 1.1 million between 1970 and 1979. The numbers increased to 2.3 million between 1980 and 1989, owing to increased ethnic emigration. In fact, more than 75% of those emigrating from Eastern Bloc countries between 1950 and 1990 did so under agreements for ethnic and religious migration. Examples include emigrants from Bulgaria (ethnic Turks and other Muslims), Poland (ethnic Germans, ethnic Hungarians, and Jews), Romania (ethnic Germans, ethnic Hungarians, Jews), and Yugoslavia (ethnic Turks and other Muslims). The majority of Soviets permitted to emigrate during this period were ethnic Jews.

Recent Migration Trends

The Schengen Agreement, a treaty signed in June 1985, gives citizens of the European Union (EU) member states and their families the right to live and work anywhere within the EU. A large proportion of immigrants in western European states have emigrated from former Eastern bloc states. Geography, language, and culture have helped shape-specific migratory patterns. For example, there are large numbers of Polish expatriates living in the United Kingdom and Ireland, while many Romanians have chosen to settle in Spain and Italy.

Of particular concern in recent migration trends is a high level of human trafficking from some of the Eastern European countries. Central and South Eastern Europe (CEE) are reported frequently as an origin from which are taken victims of human trafficking. As compared globally, four countries rank very high as origin nations. These are, in alphabetical order, Albania, Bulgaria, Lithuania, and Romania. Among countries ranked high are the Czech Republic, Estonia, Hungary, Latvia, Poland, and Slovakia. According to the United Nations, trafficked victims from countries in Central and South Eastern Europe are reported to be trafficked mainly to Western Europe. Germany, Italy, the Netherlands, Greece, the United Kingdom, Belgium, Austria, France, and Spain are reported frequently to be destination countries for victims from the CEE. Poland, Bosnia and Herzegovina, and the Czech Republic are countries within the region that are reported to be destinations for those trafficked from countries in Central and South Eastern Europe.

Brain Drain

Switzerland's Federal Office for Migration reports that Eastern bloc countries are seriously affected by this ostensible brain drain – as over the past decade Bulgaria has lost to emigration approximately 20% of its educated residents. Even more staggering are figures from Armenia, from which it is estimated that 30–40% of the population emigrated over the same 10 year period.

Migration Policy

Free movement of EU nationals is an important aspect of regional migration policy and has resulted in significant political tensions between some EU countries. For instance, tensions have arisen between Italy and Romania, as Italy has expressed the intention of restricting free movement – contrary to treaty obligations and the jurisprudence of the European Court of Justice.

Related Topics

- ► Access to care
- ► Emigration
- ► European Union
- ► Health outcomes
- ► Immigration status
- ► Life expectancy

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For information on Eastern Europe from the United Nations. http://www.un.org/

For information on Eastern Europe from the World Health Organization. http://www.who.int/en/

Eating Disorder

► Disordered eating

Education

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Toward the end of the twentieth century, globalization has changed the face of cities and towns across the world. The racial and ethnic compositions of today's schools also reflect changing demographics. For example, in Europe, the largest immigrant student group is Turkish and in the United States, the largest immigrant group is students from Mexico. With the massive movement of people and resources across the globe, immigrant scholars are examining how receiving nations view the new immigrant students and in turn how they prepare them to be successful global citizens.

Here, we will discuss the major education issues facing school administrators and teachers who teach immigrant students. Because educational systems vary greatly across nations, we will not be able to do justice in explaining the intricacies of each country. Instead we will discuss the major educational issues shared by all receiving nations and then highlight those issues in the United States which has the highest immigration rate of all countries.

Major Education Issues

Schools around the world face common educational challenges related to language access, the achievement gap, teacher preparation, and curriculum development. In the past, publicly funded schools were seen as the mechanism by which immigrants could shed their native language and acculturate to the styles and habits of the receiving country. Issues of language proficiency, different cultural models of communication, and different parenting styles are a few of the issues that teachers and administrators struggle with daily. Research has also shown variable differences in educational outcomes between immigrant students and their middle-class native counterparts.

In addition despite their good intentions, many teachers are not equipped with the cultural sensitivity and background experience to effectively teach immigrant children. In fact, some research has found that teachers hold stereotypical beliefs of immigrant children and they have little understanding of how racism and discrimination impact them. Asian American children, for example, are seen as the "model minority." Children from this background may be assumed to be good in math and science and assumed to not have problems in school. Ignorance of student backgrounds can translate into a "color-blind" philosophy that, in essence, serves to deny a student's cultural heritage.

Another factor that may influence student outcomes is the family's migration experience. Children of immigrants have varying migration patterns. These demographic differences between past and present immigrants have several implications for schools and education. Today's immigrants are more likely to have global and transnational identities and lives. These immigrants tend to maintain an active connection to their country of origin. They frequently travel back and forth between the receiving country and their native country, and many send remittances back to their country of origin. Because of these patterns, children may miss long periods of school as they travel with their families. Some parents stay in their native country, but send their children to the United States and other developed countries to provide their children with better educational opportunities.

Because immigrants are part of a transnational workforce, families may move from town to town in search of better economic opportunities. Moving from town to town causes a disruption in their children's education. Under these circumstances, children can be transferred from school to school. Frequently, their records do not immediately follow them and these children are, in essence, getting an incomplete education for that year. This can also make it difficult for children to make lasting bonds with teachers and peers, relationships that have been shown to have a positive impact on educational outcomes.

Immigrant communities are extremely heterogeneous, though they share common characteristics. When working with immigrant children, it is important to understand their specific background and life circumstance especially since these diverse factors impact their academic careers. Immigrant populations span the range on different indicators of quality of life, economic, and educational achievement.

The receiving context in which immigrant children find themselves also has a significant relationship on their school experience. Immigrant children can find themselves in ethnic enclaves or in communities where they are one of few immigrant families. The schools, however, in either type of community may not be equipped to handle immigrant students. They may lack the linguistic and cultural resources to provide support and help.

Immigrant scholars have pointed to generational status as a strong indicator of academic achievement. Generational status is connected to age and education background prior to coming to the host country. Combined, these two indicators influence academic success. Many 1.5 generation children (i.e., children who immigrate at a young age) may have had schooling in their home country, but that education could have been disrupted by war and time spent in the refugee camps. Similarly, an immigrant child who arrives as a teenager may have had only an elementary school education from their native country. Oftentimes, the quality of education the immigrant students receive in their country of birth varies greatly from the quality of education of their host country.

For undocumented children, the challenges are many as well. They face all the challenges of other immigrant children and they have the added fear of deportation of themselves and their families. Though schools are not legally required to ask for status, this fear can permeate students' lives. These challenges are exacerbated by the fact that undocumented children cannot always access social services designated for the community without proper documentation.

The US Educational System

Public School Enrollment

Due to post-1965 immigration patterns, Latin Americans and Asian Americans are the two fastest growing ethnic groups in the United States. Between 1990 and 2000, the US Latino population grew by 58%, from 22 to 35 million. Since 1990, there has been a 72% increase in Asian American residents in the United States (US Census Bureau 2002). This increase in immigration from Latin America and Asia has affected public school enrollment. For example, in 2006, about 49 million students were enrolled in public elementary and secondary schools compared to the 30 million enrolled in 1990 (i.e., a 63% change). Of the 49 million students, 34 million were enrolled in prekindergarten (pre-K) through grade 8, and 15 million were enrolled in grades 9 through 12. Of this population, 56% of the students are White compared to the 15% Black, 21% Latino, 4% Asian and Pacific Islander, 1% Native American Indian, and 4% Multiracial.

Linguistic Access/Bilingual Education/ESL

Language access is one of the most important issues for immigrant children. According to the US Department of Education, there are 5.5 million English language learners (ELL) in the US public school system. The number one language spoken by English language learners is Spanish, followed by Vietnamese and Hmong. English language learners face many barriers to attaining educational success. Because many of their parents are not proficient in English, these children do not have assistance with homework, school projects, and communicating with school personnel. Because of this, immigrant children depend on their teachers, yet not all teachers are qualified to teach ELL students. Less than 3% of teachers instructing ELL learners have a degree in English as a Second Language or a degree in Bilingual Education. Oftentimes, ELL students find themselves misdiagnosed as special education students. Their limited English proficiency is categorized as a learning disability and they are placed in special education. Not only do ELL students face the rigor of learning the English language but they also face the challenge of learning the academic subject matter. Only 8% of ELL students receive extensive instruction designed to meet their learning needs. This translates into less than 10 hours per week of academic content. Research from the National Center of Educational Statistics shows that in order for ELL students to understand content they must have at least 25% of instructional time in their native language.

One policy challenge of teaching immigrant students is how to teach these students English and academic subject areas. While immigrant students are found across the United States, there is no one accepted way of teaching ELL students. There are a variety of methods including English as a Second Language, transitional bilingual education, two-way bilingual education, English immersion, and pull-out. How to teach ELL students is a contested battle. During the 1990s, residents of California, Arizona, and Massachusetts voted for state initiatives to end bilingual education.

Culturally Relevant Pedagogy

Many teachers are not prepared to teach a largely multicultural student population. The less teachers understand students' backgrounds, the lower the students' outcomes. Only 56% of teachers have taken a multicultural education course. Oftentimes, multicultural education takes the form of "heroes and holidays," which while important, can be a superficial way to address issues of diversity in the classroom. Instead of using "heroes and holidays," teachers can use interdisciplinary lesson planning and thematic learning in the curriculum. In other words, multicultural education is not taught in certain months but infused throughout the year-long curriculum. For example, a teacher using culturally relevant pedagogy for immigrant children must find examples from students' own culture and connect it to the content learning inside the classroom.

This strategy also helps immigrant children see school as a safe space for them to learn and grow. Too often, immigrant children feel a disconnect between their home culture and their school culture. For example, Lao children may grow up in a family where they are not expected to look teachers in the eye or question the teacher's authority. This cultural norm goes against the prevailing school practices that encourage students to speak out in class and seek help. Sometimes teachers misinterpret the silence as lack of comprehension of material. Teachers must learn about the culture that students come from in order to provide appropriate support.

Teachers who buy into the philosophy of "colorblind" deny the immigrant student's ethnic identity. In doing so, they are not capitalizing on the richness of culture that a student can bring into the classroom. They silence the child's voice when they do not connect their home life to their school life, sending a message that their home culture is not as important as what they are learning in school.

Gendered Experiences

Over the years, patterns of gender differences have been observed in educational outcomes and engagement of immigrant students in the US school system. Some immigrant children come from cultures that are patriarchal and where women have fewer opportunities than in the United States. While there are examples of strong women in their native country, many girls find increased opportunities through schooling in the United States and other developed countries. In the United States, most immigrant parents are hopeful and supportive of their daughters' academic pursuits. Coupled with the support of their parents, many females with higher aspirations and expectations have been able to achieve academically. These girls view school as a means to getting a better job and future.

In contrast, while girls may express their femininity through good behavior at school, boys sometimes prove their masculinity through defiance of authority and school culture. Boys are often characterized as "antagonistic" and "oppositional" by school personnel. With fewer opportunities to learning, boys see a lack of connection between school and work. Other factors such as gender role socialization and previous life experiences also predict education attainment. For example, early incarceration for boys and early childbearing for girls become negative turning points in their life trajectory.

Access to Higher Education

Immigrant young adults face challenges to accessing higher education. Many immigrant students from low-income backgrounds cannot afford higher education. Additionally, undocumented immigrants are not considered in-state residents and must pay out-of-state tuition. They are not eligible for any state or federal financial aid. In some states, though, the DREAM

(Development, Relief and Education for Alien Minors) Act has made higher education possible for countless immigrant children. The purpose of this legislation is to help immigrant children realize the American Dream by providing access to education. In states like California, Texas, and New York, undocumented immigrants became eligible to attend state-run higher education institutions and pay in-state tuition. They also received access to state and federal grants and loans, many private scholarships and work-study. Upon successful completion of college, these students are automatically eligible for citizenship.

Filling out the Free Application for Federal Student Aid (FAFSA) proves to be a huge deterrent to higher education for many immigrant students. Many do not know about the FAFSA or do not have family members who can help them fill out this form. Because they are unaware of financial aid, they may elect to go to a community college because it is more affordable.

Another problem facing immigrant students once they gain access to higher education is their academic readiness. Due to the inappropriate academic preparation, immigrant students do not find themselves competitive for universities. Many schools in low-income neighborhoods do not offer honors, advanced placement, or elective courses. Without taking these kinds of college preparatory classes, immigrant students sometimes find themselves at a competitive disadvantage when they apply for college.

The Achievement Gap

Contemporary discussions of the “achievement gap” in the United States are at the forefront of education debates, but it can be difficult to have, as there is not a universal way to talk about who is actually dropping out of school. The National Center for Education Statistics uses three definitions, that is, event rate (percentage of students who drop out in a single year), status rate (percentage of students in a given age range who drop out), and cohort rate (percentage of a single group of students who drop out over time). Given limitations in all these rates, the actual drop-out number may be even higher and are inconsistent across schools and states.

Early studies of immigrant children indicated that these children are performing as well, if not better, than their native-born counterparts. Immigrant children showed comparable rates of attending college as well as high school graduation. These perceptions, however, mask both inter-group differences and more recent trends in education. Dropout rates can differ within groups by gender, ethnicity, and nativity (see Table 1).

Education. Table 1 Number of status dropout rates of 16–24-year-olds by gender, nativity, and race/ethnicity

		Total	Native	Foreign born
Whites	Male	6.8	6.8	6.3
	Female	5.3	5.4	4.4
Blacks	Male	13.9	14.3	8.7
	Female	8.9	9.1	6.6
Hispanic	Male	23.7	13.3	38.9
	Female	15.7	9.6	28.0
Asian	Male	3.0	2.6	3.5
	Female	2.9	1.8	4.0
Pacific Islander	Male	9.5	8.0	13.5
	Female	5.6	2.5	10.8
American Indian/ Alaskan native	Male	16.2	16.3	[a]
	Female	14.3	14.4	[a]
Multiracial	Male	8.4	8.8	3.5
	Female	6.7	6.9	4.2

[a]No data is available

Source: National Center for Education Statistics, Institute for Education Science, 2007 Current Population Survey.

Standardized testing indicates that there is an achievement gap between White students and students of color. National statistics show that one-third of all high school students drop out of high school before their senior year. The actual number may be even higher, given that some students drop out in middle school. A higher percentage of boys than girls drop out of high school and this pattern is found across racial/ethnic groups.

Almost 24% of Hispanic students drop out of school. Of this group, there are large differences between native-born and foreign-born Hispanic students as well as males and females. Dropout rates for Hispanic female students born in the United States are approximately 10% whereas Hispanic male students born in the United States have a 13% dropout rates. These figures are larger for foreign-born Hispanic students (i.e., approximately 28% and 29%, respectively). These numbers still, however, may not capture the full picture because of various factors (e.g., lack of disaggregated data, inconsistent data collection, and time of dropout.)

These dropouts are disproportionately students of color, primarily from Black, Latino, and working-class immigrant backgrounds. Fifty-five percent of all Hispanics over the age of 25 have completed high school compared to the national average of 82%. Hispanic students typically find themselves concentrated in low-income, urban areas in schools without the proper resources to provide them with equal educational opportunity.

The Role of Parent and Family Engagement

Because family engagement is seen as a key strategy of school reform, it is important to understand the context for immigrant parent and family engagement in education. One in five children in the US public school system has at least one foreign-born parent. Because today's immigrants are increasingly from working-class backgrounds, the education experience of parents in their native country is often limited. Foreign-born parents may bring different cultural beliefs about schools than do native-born parents. Foreign-born parents may expect that the classroom teacher be the experts on their children's education. Parents repeatedly defer to teachers on academic decision-making and see their role as providing for their children's basic needs and helping to preserve the student's cultural heritage. As such, parents do not always challenge teachers or actively participate in parent–teacher meetings. At the same time, immigrant parents can have high expectations for their children. They want their children to achieve more than they have and achieve upward mobility in society. This expectation fuels their "immigrant optimism," a belief that they can come to this country, work hard, and achieve a better life than they had in their home country. This immigrant optimism is prevalent in the first-generation, but less so in the second- and third-generation immigrant students. As a result, we can see decreasing academic motivation in later generations of immigrant children.

While the first generation often has "immigrant optimism," with each successive generation, immigrant children become more aware of racism and discrimination in the school system. Some of these children of immigrants will actively resist assimilation and assume an oppositional stance toward schools and teachers.

Immigrant children find themselves acting as cultural brokers for their families. They may shoulder the burden and responsibility of being the family translators when parents are not fluent English speakers. Sometimes they have to miss school in order to go with their parents to a doctor's appointment or the utility company to provide the translation.

Because of different messages that they receive at home and at school, immigrant children face a disconnect between their home culture and the school culture. Immigrant children may adopt one identity at school and a different one at home. In essence, they are forced to "code-switch" between these different spheres. These students are navigating multiple systems and multiple cultures and they experience more pressure than their native-born counterparts. Schools should take this into account when teaching immigrant children.

Health and Education

Many low-income immigrant children come to school with basic health needs such as poor vision and poor dental care. Frequently, parents without health insurance are not able to get their children annual exams and some use the emergency room for primary care services. Students with poor vision often complain of headaches and cannot see the white board in the classroom.

Mental health issues are habitually overlooked in the immigrant population and not made a priority. Some immigrant children and/or their families have experienced trauma in the migration process and are in need of specialists who can address posttraumatic stress disorder (PTSD). Children coming to school with PTSD may appear silent and withdrawn in school and will not engage with teachers or their peers until they feel safe. Oftentimes, silence is interpreted as complacency by teachers and these children do not get the attention that they need. Parents and caretakers who struggle with PTSD are sometimes unwilling to come to the school because they fear and/or have anxieties interacting with authority figures.

Chronic health conditions such as asthma, diabetes, attention deficit hyperactivity disorder, and hepatitis B impact immigrant children in schools. For low-income families, they struggle to manage these diseases in the face of no health insurance. Unmanaged, these chronic diseases can lead to high absenteeism among immigrant children.

Conclusion

This is not a comprehensive or exhaustive list of the issues facing immigrant children in our schools. Immigrant communities are found all over the world and represent a spectrum of nationalities, languages, ethnicities, and religions. The reference list included goes into more detail about specific immigrant populations. Educators can also find resources in the local communities. Ethnic, faith-based, and service organizations can be a valuable resource as cultural brokers in helping to build bridges between schools and communities. Schools can also find resources from the immigrant community (e.g., service providers, college students) who can help with translation.

While providing broad strokes here to introduce issues of immigrant children in schools, educators and health providers must make an effort to get to know immigrant children and their families in order to understand their specific experience. In order to provide the appropriate services, they should develop relationships with service providers, religious figures, and community members who will help provide a better understanding of their student's unique learning needs and community context.

Related Topics

- ► Asians
- ► Assimilation
- ► Child development
- ► Cultural competence
- ► Cultural humility
- ► English as a Second Language
- ► First generation immigrants
- ► Latinos
- ► Race
- ► Resilience
- ► Transnational community
- ► Undocumented
- ► Youth

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El Salvador

- ► Central America
- ► Hispanics
- ► Latinos

Ellis Island

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From 1892 to 1954, over 12 million immigrants entered the United States through Ellis Island, a small island in the upper bay of New York Harbor. Lying within the shadow of the Statue of Liberty, the island is situated just off the New Jersey coast. Well before it was designated as the site of one of the first Federal immigration stations by President Benjamin Harrison in 1890, Ellis Island had acquired a rich and varied history. The local Indian tribes had called it “Kioshk” or Gull Island. Due to plentiful oyster beds and shad runs, it was known as Oyster Island for many years during the Dutch and English colonial periods. By the time Samuel Ellis became the island’s private owner in the 1770s, the island had been called Kioshk, Oyster, Dyre, Bucking, and Anderson’s Island. The Federal government purchased Ellis Island from New York State in 1808; it was approved for inclusion in the new harbor defense system, and fortification construction began – including a parapet for three tiers of circular guns. In honor of a brave officer killed during the War of 1812, the fort at Ellis Island was named Fort Gibson.

Prior to 1890, rather than the Federal government, the individual states oversaw immigration into the United States. From 1855 to 1890, Castle Garden in the Battery served as the New York State immigration station, where approximately 8 million immigrants, mostly from Northern and Western Europe, passed through it. In the latter half of the nineteenth century, it became apparent that Castle Garden was not equipped to handle the increasing numbers of immigrants arriving yearly. The federal government intervened, constructing a new federally operated immigration station on Ellis Island. On January 1, 1892, Annie Moore, a 15-year-old Irish girl, accompanied by her two brothers, was the very first immigrant to be processed at Ellis Island. However, after 5 years of operation, the station burned down, and the Treasury Department ordered the immigration facility be replaced quickly, stipulating that all future structures built on Ellis Island be made fireproof. On December 17, 1900, the new main building was opened and 2,251 immigrants were received that day.

Unless they were sick or had legal problems, those who sailed first or second class were not required to undergo the inspection process at Ellis Island. It was thought that if they could afford such a ticket, they were less likely, due to medical or legal reasons, to become a public charge in America. Passengers who traveled “steerage” or third class would arrive at the Hudson or East River Piers and were transported by ferry or barge to Ellis Island for medical and legal inspection. For those whose papers were in order and were in reasonably good health, the Ellis Island inspection process would last approximately 3–5 h. The inspections took place in the Registry Room (or Great Hall), where doctors would scan briefly every immigrant for obvious physical ailments. The two agencies responsible for processing immigrants at Ellis Island were the US Public Health Service (USPHS) and the Bureau of Immigration, later known as the Immigration and Naturalization Service (INS).

The island became known as a place of hope for many – and a place of tears for some. The two main reasons an immigrant would not be allowed entry into the United States were if a doctor diagnosed him or her with a contagious disease or if a legal inspector thought the immigrant was likely to become a public charge or an illegal contract laborer. Approximately 20% of immigrants stayed overnight in dormitory rooms until their cases were cleared. The hospital on Ellis Island opened in 1902, and grew to 22 medical buildings, sprawling onto two islands adjacent to Ellis Island. The hospital served as America’s first line of defense against contagious disease. Thousands of immigrant patients were separated from family, detained in the hospital, and healed from illness before becoming citizens. Three hundred and fifty babies were born in the hospital, many being named after the doctors and nurses who helped deliver them. Sadly, in an era before antibiotics, ten times that many immigrants died on Ellis Island – 3,500 were buried in pauper graves around New York City.

During World War I, immigration to the United States decreased, and numerous suspected enemy aliens were kept in custody at Ellis Island. Between 1918 and 1919, along with the Army Medical

Department, the US Navy commandeered the island complex for the duration of the war. Detained suspected enemy aliens were transferred from Ellis Island to other locations. During this time, inspection of arriving immigrants was conducted regularly on board ship or at the docks. At the end of World War I, as a big "Red Scare" took hold across America, thousands of suspected alien radicals were interned at Ellis Island, and hundreds were later deported – especially if they had any association with an organization that advocated revolution against the federal government. When Ellis Island reopened as an immigration receiving station in 1920, 225, 206 immigrants were processed that year.

With the passage of the Quota Laws in 1921, and the National Origins Act in 1924, Ellis Island was no longer primarily an inspection station but rather a detention facility, whereby many persons were brought and detained for various periods of time. Ellis Island served primarily as a detention center during World War II, when by 1946 approximately 7,000 aliens and citizens were detained there. In November 1954, the last detainee, a Norwegian merchant seaman named Arne Peterssen, was released and Ellis Island officially closed. Changes in immigration laws, new modes of transportation, and rising operating costs, all played a role in its closure.

Related Topics

- ▶ Immigration Act of 1924 (U.S.)
- ▶ Immigration and Naturalization Service
- ▶ Immigration and Nationality Act of 1952 (U.S.)
- ▶ Immigration processes and health in the U.S.: A brief history
- ▶ Inadmissibility on health grounds
- ▶ Infectious diseases
- ▶ Medical examination (for immigration)

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Emergency Services

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The core components of a country's or local community's emergency services include police, fire, and medical services. Extending from these are more specialized services including but not limited to military, coast guard, cave rescue, bomb disposal, poison control, animal control, public utilities, and chemical decontamination team. All emergency services deal with extraordinary and life-threatening situations in society. Because emergency service providers are confronted with situations that are outside of daily human living, they are directed by rigid codes to ensure effective teamwork and give a high level of expected performance. All emergency service providers share an ultimate goal to help and protect those that cannot protect themselves.

Police Service

The main function of the police is to enforce the law. This encompasses responding to emergency situations and to implementing injury prevention measures while upholding the human rights of all persons. Today, the majority of their tasks include maintaining patrols, responding to call-outs, directing traffic at emergency scenes, providing first aid at emergency scenes, investigating crimes, and arresting criminals. Policing first became a profession in 1829, London, England under Sir Robert Peel. Then and for the rest of the 1800s, it was a very political institution. During this time, the police in the USA were authorized and funded by local municipalities and were strongly connected to the local social and political scene. The organizational style was a very quasi-militant, or "do as your told" style. Their main tasks were to fight crime, riot control, and maintain order, mostly all on foot patrol. The organization was in the control of White politicians with little to no attention paid to communities of racial minorities and low socioeconomic status. The reform era, from the 1930s to 1970s came from a great desire for change in the organization toward professionalization. This occurred via a pioneer, August Vollmer, the first police chief of Berkeley, California, who emphasized education and training. During this time, women made advances in the profession. They began as matrons in the police organization with the primary focus of ensuring the proper care of children. In the early 1900s, they began to occupy positions as policewomen as well. Yet, there were still differences in their tasks, salaries, promotion requirements, and expectations. The demands on the local police departments to serve the community increased with no increase in budget. There was also a need for a stronger relationship between the community and the police. The community era from the 1980s to the present has been the best solution. The focus was on problems solving with the residents of the community. Outcomes are measured by quality of life in the neighborhoods, problem-solving solutions, citizen satisfaction, and crime rate. Today the citizen police relationship is improved with residents of a community taking more responsibility for the problems of their area.

Internationally, the police forces in less developed countries can be weak and ineffective. They still may be managed by a political administration that changes frequently with each election or militant change in power. Often, the "do as I say" style of command still prevails. In war-torn areas of the world, there is a shift in their responsibilities to more dangerous tasks. In Sri Lanka where there have been major natural disasters and a prolonged tribal war, the police force is pushed to manage disasters, fighting among citizens, sick and injured people, stranded children, criminal activities, ransom demands, and apprehending suspicious persons. In many circumstances, the force and control of other human beings is necessary to maintain order in a society. This fine line of control can and does lead to the abuse of privileges in some countries. Therefore, limitations are set on how to use force against citizens. While most police departments are set up regionally as local or municipal authorities, national or federal governments may also hire policemen. Additionally, trained police officers or military authority may be utilized to perform any of the duties listed above. Since they are constantly forced to handle potentially dangerous situations such as apprehending criminals, and emergency responses such as industrial fires, explosions, terrorist bombings, hostage-taking incidents, delicate rescue operations, it is clear why police officers have a higher injury and fatality rate than other occupations. In an emergency situation, the police are in the best positions to take control and coordinate the rescue as well as the safety of those at and around the scene including other emergency service providers.

Fire Service

Equally as dangerous of a service but in a different way is the fire service, also called the fire department, or fire brigade. This service is mainly responsible for extinguishing fires, and rescue work. Originally, the fire service began as private agency whose main focus was to minimize property damage from fires only for those who had insurance. It soon became clear that this was a valuable resource for all citizens. Most countries have developed a public fire response department. Like police, firefighters have many tasks such as, operating water pumps feeding high-pressure hoses, positioning ladders to deliver water, rescuing victims, administering first aid, ventilating smoke-filled areas, and minimizing property damage. Many firefighters are also trained as emergency medical technicians (EMTs) and paramedics. Their everyday line of work involves performing dangerous operations rapidly, and under intense pressure. For this venture, they must be physically fit and psychologically sound of mind. To coordinate all their activities and ensure teamwork, firefighters are directed by a superior officer. Similarly, different firefighting teams in any given area need to be coordinated, especially in disaster situations. Southern California had noted an increase in brush fires in dry hot weather. Because of the many agencies in the area, better coordination was needed to efficiently perform their duties. An oversight agency was formed that grew to coordinate more than just fire emergencies. FIRESCOPE (Firefighting RESources of California

Organized for Potential Emergencies) resolves issues of terminologies between agencies, coordinates modular expansion of services, multi-agency, multi-jurisdictional command conflict. With these other duties, and many agencies performing different duties, an oversight committee or superior officer is needed be most effective and efficient.

As with police officers, firefighter's duties change depending on the needs of the community. In Tokyo, firefighters provide emergency medical services more than cleanup of hazardous materials, rescue, and even firefighting. The trend in New Zealand, Ireland, and the United Kingdom is of increasing incidents attended by Fire Brigade but declining percentages of those cases as fire emergencies. They are spending more time in other duties unrelated to fires. Even in Berlin in 1994, the percentage of emergency medical services provided was close to 70% where firefighting incidents was only 5%. The fire brigade has many more tasks than is initially obvious by the name.

Medical Service

Emergency Medical Services (EMS) is the delivery of unscheduled care, usually in high patient census settings, for a wide variety of medical and surgical problems. It encompasses everything from emergency to primary care. Emergency medical services provide patient education, coordinating specialty care, resuscitation, management of critical care, toxicology, trauma, injury care, and prehospital and disaster response. It also covers preventive efforts for injury and violence. Commonly, however, EMS refers to the prehospital care of patients with traumatic injuries or serious illness. EMS is the conglomeration of autonomous and highly interdependent agencies.

The use of an ambulance dates back as early as the Larrey. This was a horse drawn, "flying ambulance" that was used to carry surgeons and medical supplies into the field of battle to help the wounded in the Napoleonic Wars. The Rucker Wagon was used in the American Civil Wars. This remained the standard until 1869 when Bellevue Hospital in New York began the first city-based ambulance service. In 1965, a commercial hospital in Cincinnati, Ohio was the first to develop a hospital-based ambulance service.

Since emergencies occur outside a hospital setting, a complex system of prehospital services requires coordinated resources. Providers have to be notified that an accident has occurred, before the necessary resources are brought to the scene where rapid evaluation and initial care is given. The patient then is safely and rapidly transported to a hospital for definitive care.

World Medical Service

Globally, there are two types of very different EMS systems. The Anglo-American system is made of skilled emergency departments and prehospital emergency medical services utilizing paramedics. The Franco-German system is a highly developed prehospital emergency physician service.

The type and quality of services are most influenced by a country's economic development and the funding that the government has committed to health care. Most countries provide most services in urban areas where the density of the population is located and almost all the tertiary hospitals. Many countries have a private fee-for-service health care system with any combination of private physicians, private hospitals, and private ambulance services. Although this is unavailable to the socioeconomically disadvantaged, they may provide advanced surgeries and better technology. Clearly, they are better funded, despite only serving a smaller portion of the population.

The World Bank designates four levels of national development based on a country's economic and health care development. Among the high economic tier regions, such as the USA, Japan, Europe, and Australia, there is a complex medical system. However, the health care even in Japan has a very limited EMS system where providers have minimal to no training. The middle level is divided into an upper and lower middle economic development. Under this umbrella are South and Central Americas, the Middle East, and Asia. In many of these areas where there is urbanization but unsophisticated EMS system, injuries are often the cause of premature death. For example, in some areas of Egypt, mortality rate is as high as 25% of road traffic injuries and is only expected to rise. Among the least developed areas including Sub-Saharan Africa, South Asia, part of Central America, there are high infectious rates and infant mortality. Developing countries often rely on primary health care workers to provide a needed cost-effective service.

The role of the Emergency Care Physician also varies based on the country's development and therefore health care need. In developed countries, emergency physicians coordinate emergency care, resuscitate, and provide toxicology expertise, trauma care, and much more. In middle spectrum developed countries, emergency physicians are limited to providing an advanced level of care including critical care and resuscitation, as well as injury care and prevention. Undeveloped countries have a lot of task shifting. It is vital for general practitioners to learn some emergency skills as well as to manage large volumes when and where an Emergency Department or prehospital service is not financially sustainable.

As is evident, developing countries do not have the finances for expensive prehospital equipment and training. Their goals are still delegated to improving the Primary Health Care system. Generally, they have urban centers with large population hubs and rural hard-to-reach communities. Transport in these rural areas would be inefficient and expensive. A long transport time will decrease survival. In this situation, the benefit would not be worth the expense that would be better served improving other areas of the health care system.

Underdeveloped countries may have a more informal system with no planned response, care, or transport. There may be no prehospital system in which a victim may rely on family and friends or a complete stranger to bring them to medical care. A rudimentary system may be provided by other services such as fire, police, or even taxi drivers. Here, the emphasis is on transport, not on care. Some countries offer basic first aid training to these transporters. Although rudimentary, this may be adequate and even more efficient in some countries. Multiple studies have shown that basic first aid training to these "first responders" improves patient morbidity and mortality. The level of hospital-based emergency care also affects the prehospital system. If there is no nearby emergency facility to transport the patient, then a prehospital system would be futile.

A more formal system has services of designated responders to care for and transport sick and injured patients. The system is incomplete if it does not provide access to all patients all the time. There may not be enough resources for 24 h/day coverage. Some areas of a nation may not have the resources while a wealthier area may. A system is universal when the services are accessible to any person at any time, regardless of the ability to pay. Many formal systems incorporate a dial-in-number, or access number that provides a dispatcher and emergency instructions to caller until help arrives.

The level of training of the transporter varies. These nonphysician caregivers treat patients based on preestablished protocols and direct telecommunication with a physician. The transporter may be a physician, nurse, or just the driver. In the Franco-German model, specially trained physicians in emergency or anesthesia ride in the ambulance and provide stabilizing care. Some of the patients cared for in this model may not need a hospital-based Emergency Department because they may be admitted to a ward directly from the scene.

The prehospital providers' ability to care for a patient is also dependent on the equipment they are able to carry. In Chennai, India vehicles only carry O_2 tanks. In the USA a basic transport vehicle will always be stocked with a backboard, cervical collar, splints, and bandages. Most places have a mix of providers, supplies, and funded agencies or within an agency.

United States Medical Service

In the USA, the level of prehospital care is optimized at a more complex level. Coordination and cooperation is key to running a functional system. EMS in the USA is fairly new. The Emergency Medical System took flight almost 100 years after the first city-based system, when a report was published on Accidental Death and Disabilities, describing the hazardous conditions of EMS care. In response, public and private organizations poured funds into improving the systems for prehospital care.

There are many designs to the EMS systems. The local community it serves decides the type of design. The regional system is assisted more than directed by a state administration. EMS agencies are relatively autonomous organizations but have a high degree of interdependency. In a crowded urban area, there may be multiple agencies of different types and levels. There are many challenges to coordinate multiple agencies of different types. Agencies in a region can be of different types, private, public, hospital based, or typically, a combination of these forms. This combination impacts whether the funding is federally provided, fee-for-service, locally provided, or from multiple sources. It also affects who is dispatched to notify the agency and medical director directed to medically support the providers. Coordination is best achieved at a local/regional level.

Once the call is received, either a Basic Life Support (BLS) or ALS (Advanced Life Support) squad must respond. BLS squads are not able to perform complex interventions. They have the ability to provide an oral or nasal airway, bag mask ventilation, cardiopulmonary resuscitation (CPR) including the use of AEDs (automated external defibrillators), hemorrhage control, and fracture and spine immobilization. Many squads can also facilitate childbirth. The ALS squad is more comprehensive. The responder's training is more advanced. They can provide advanced airways, intravenous line, and certain medications including anaphylactic dose epinephrine, cardiac monitoring, and manual defibrillation. First Responders are typically the first to respond to the scene of an accident because of their proximity. They are fire, police, and/or volunteers who will assess a scene, provide any life-saving interventions as well as CPR, basic airways, c-spine immobilizations, control of hemorrhage and cardiac defibrillation until EMTs arrive. These responders do not have the ability to transport the patient. Use of these providers and squads is locally determined based on a multitude of factors.

Conclusion

From police, to fire, and medical, the three core high-risk emergency services, though independent with unique tasks, have much overlap and interdependence that requires much coordination. With the safety of the people that they serve as their primary concern, the different disciplines and agencies within a discipline come together to work effectively as one team. Immigrants, often lacking access to health care, delaying needed care, and living in hazardous and threatening conditions are likely users of emergency services. Emergency service providers need to be aware of the life circumstances of this vulnerable population as they deliver services to protect the health and safety of the entire population.

Related Topics

- ► Injuries
- ► Public health
- ► Vulnerable populations

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Emic

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The term *emic* originates in linguistics, and is used regularly within the fields of anthropology and other social and behavioral sciences. The word emic can be used to describe perspectives, constructs, data, or methodology, and in all uses serves a descriptor of positionality. Sometimes referred to as the insider's view, emic perspectives strive to recognize and understand the meaning of a concept from within the cultural framework in which it is being observed. An emic approach attempts to assess and convey conceptual schemes, categories, and/or culture in terms of members' own indigenous and meaningful criteria. Intensive longitudinal, qualitative, and ethnographic methods are touted generally as the most effective means of gleaning an emic perspective of cultural phenomena.

Emic is often discussed in opposition to *etic*, a term that denotes assessment and/or evaluation of schemes, categories, and/or culture from the perspective of an observer, or outsider. An etic perspective strives to be neutral or culturally objective, whereas emic views attempt to represent subjective experience and cultural understanding. In addition to the insider/outsider contrast, the emic/etic comparison has been described further as focal/global, particular/universal, and first-order versus second-order conceptualization.

The terms *emic* and *etic* were coined by the linguistic anthropologist Kenneth Pike, and were derived from an analogy with the terms *phonemic* and *phonetic*. Pike suggests that, just as there are two perspectives that can be used in the study of a language's sound system, there are two perspectives that can be used in the study of a society's cultural system. In both cases, it is possible to take the point of view of either the insider or the outsider. Pike contends furthermore that the emic perspective focuses on the intrinsic cultural distinctions that are meaningful to the members of a given society (e.g., whether the natural world is distinguished from the supernatural realm in the worldview of the culture) in the same way that phonemic analysis focuses on the intrinsic phonological distinctions that are meaningful to speakers of a given language (e.g., whether the phones/b/and/v/make a contrast in meaning in a minimal pair in the language). The native members of a culture are the sole judges of the validity of an emic description. Similarly, the native speakers of a language are the sole judges of the accuracy of a phonemic identification.

The etic perspective, again according to Pike, relies upon the extrinsic concepts and categories that have meaning for scientific observers (e.g., per capita energy consumption) in the same way that phonetic analysis relies upon the extrinsic concepts and categories that are meaningful to linguistic analysts (e.g., dental fricatives). Scientists are the sole judges of the validity of an etic account, just as linguists are the sole judges of the accuracy of a phonetic transcription.

The binary of emic and etic is not without debate. Although the terms are discussed often in opposition to one another, critics argue that neither term is absolute. All emic interpretations are informed by whoever is making the observations, and all etic interpretations are rooted within some type of cultural context. As such, it has been suggested that emic and etic be considered as points along a continuum rather than discrete entities.

Related Topics

- ► Ethical issues in research with immigrants and refugees
- ► Methodological issues in immigrant health research
- ► Mixed methods
- ► Narrative research
- ► Survey development

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Suggested Resources

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For information on the American Anthropological Association: http://www.aaanet.org/

Emigration

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Introduction

Human migration is the physical movement by humans from one area to another. Throughout history, the migration of populations has continued under both voluntary and involuntary conditions. *Emigration* is defined as leaving one's native country, or country of origin, and settling in another. It is related to immigration, but from the perspective of the sending country. Human movement before the establishment of or within political boundaries falls under the general term migration. Persons make the choice to emigrate based on a variety of motivations including religious, political, and economic. For others, their motivation is personal in nature, for example, marriage or the desire to reside in a different climate. It should be noted that emigration differs significantly from involuntary or forced migration.

Forced migration is defined as the coerced movement of persons away from their home or home region. It is suggestive of violent coercion, and it is used interchangeably with the term forced displacement. Two examples of forced migration are population transfer and ethnic cleansing. Sanctioned by state policy or international authority, population transfer is the movement of a large group from one region to another; frequently, this action is based on ethnicity or religion. Ethnic cleansing refers to the policy of one ethnic or religious group to remove, by violent and terror-invoking means, the civilian population of another ethnic or religious group.

In the eighteenth, nineteenth, and twentieth centuries, with the hope of finding a more prosperous future, millions of Europe's poor immigrated to the United States, Canada, Brazil, and other locales. These waves of mass emigration affected greatly the future cultures and economies of the sending and receiving countries. The choice to emigrate can be based on incentives that attract persons away from their country of origin (pull factors), or they can be based on circumstances within the country of origin that encourage persons to leave (push factors).

Pull and Push Factors

Pull factors are incentives that make more enticing the prospect of emigrating. Some pull factors seen frequently include increased or better job opportunities, higher wages, better social programs, better schools, better opportunities for acquiring land/farms for self and children, increased political freedoms, to build a religious community, travel prepaid by relatives, and to join relatives who have moved already. Push factors are situations within the country of origin that encourage persons to exit the country. Push factors seen frequently include lack of employment opportunities or upward mobility, lack of political or religious rights, oppressive legal/political conditions, discord with other cultural groups, and shortage of farmland.

Modern Trends in Migration

According to the World Migration Report 2010, produced by the International Organization for Migration, in 2010 the number of international migrants was estimated at 214 million. If the average rate of growth holds steady over the next 20 years as was witnessed in the previous 20 years, the number of international migrants could reach 405 million by 2050. While the impetus of some modern migration includes factors such as political unrest, wars, and natural disasters, modern migration largely is economically motivated. For example, there are great disparities across countries in the world in terms of the wages that can be earned for similar work. Also, for some jobs in high-wage countries, at times there is a shortage of appropriately qualified citizens to fill these positions. Some countries, such as Great Britain and Australia, operate point systems that give lawful immigration visas to noncitizens who are qualified to fill the shortage. Noncitizens have an economic incentive to obtain in their own country the necessary skills and then apply for, migrate, and fill the job vacancy.

Migration that is motivated by economic disparities is seen within the European Union, where legal barriers to migration have been lifted between member countries. Countries that have higher prevailing wages, such as France, Germany, Italy, and Great Britain, are net recipients of immigration from countries with a lower prevailing wage, such as Greece, Hungary, Lithuania, Poland, and Romania. Some contemporary economic migration occurs, even as the migrant becomes an illegal resident of the host country. These emigrants will be at a clear disadvantage in the employment market. Examples include illegal immigrants who cross from Mexico into the United States, from Mozambique into South Africa, from Bulgaria and Turkey into Greece, and from North Africa into Spain and Italy.

Consequences of Migration

The consequences of migration can be subdivided into three categories: demographic consequences, social consequences, and economic consequences.

Demographic consequences include changes in the numbers of people within a region, as well as in how the people are concentrated or distributed. Public policy must address then the best ways to assist individuals, communities, and regions as new immigrants enter and settle an area. Social consequences of migration include the bringing together of different people, which can lead to conflicts; however, it has the potential also to establish understanding between diverse groups of people. The economic consequences of migration depend upon the "quality" (skills, age, educational attainment, health, etc.) of the migrants and the economic needs of the sending and host countries. Emigration is beneficial to overpopulated areas; it reduces pressure on the land. However, in underpopulated areas, emigration may slow development.

Related Topics

► Identity
► Immigration in the global context
► Immigration status

Suggested Readings

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Suggested Resources

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For information on International Migration Statistics. http://www.iom.int/jahia/jsp/index.jsp

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Emotions

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Anger, disgust, joy, sadness, fear, and surprise are basic human emotions. Emotions have different components with each component having different functions. Emotions have a cognitive component used in the evaluation of objects and events, a motivational component used in the preparation and direction of action, a facial and vocal expression component used in the communication of reaction and behavioral intention, and a subjective feeling component used in the monitoring of internal state and individual–environment interaction.

Cross-cultural research suggests that there are both universal and differential aspects of emotions. For example, facial expressions associated with the basic human emotions appear to be universal, while cultural differences exist among various aspects of emotion, such as managing emotional expressions, labeling and understanding emotions, and coping with emotions. For instance, people from different cultures may differ in their evaluation of events that would be associated with anger and of the behavioral responses that would warrant the emotional description of "angry." The existing cultural differences in emotions are likely to affect immigrants.

Upon entering a new culture, immigrants face many challenges. One such challenge may be adjusting to cultural differences in emotions. Recognition of cultural differences in emotions and emotional expression is important to immigrant health, as miscommunication and misunderstanding can result in significant negative consequences. For instance, a misunderstanding of culturally appropriate emotional expression can affect the formation of successful relationships with people. Thus, this entry will focus on emotions in relation to immigrant health by examining the role of culture in emotion components. Additionally, this entry will touch on the importance of recognizing cultural differences in emotions and emotional expression when diagnosing and treating mental disorders among immigrants.

It should be noted that research studies often attempt to study culture, which may be defined as a set of dynamic values and beliefs influenced by one's social and psychological world, by means of ethnicity. Although often necessary in conducting research, the method is limited in that it incorrectly implies that people of a certain ethnicity all share the same culture.

The question, "to what extent are emotions universal or cultural in nature," is useful when considering emotions and emotional expression among immigrants. Many studies provide evidence for cultural differences and similarities in emotion components. Within a cognitive model of emotions, as proposed by Mesquita and Frijda, the elicitation and manifestation of emotions are considered to involve the following components: (1) *antecedent events*, that is, events that precede the emotion; (2) *event coding*, that is, categorizing the event as a certain event type, such as humiliation or bereavement; (3) *appraisal*, that is, perceiving the event with respect to its implications, such as evaluating whether the event was caused by someone else or the self; (4) *physiological reaction patterns*, that is, the bodily reactions involved in emotions; (5) *action readiness*, that is, an impulse to act, such as the impulse to protect oneself from a danger when afraid; (6) *emotional behavior*, that is, overt behavior patterns often resulting from action tendencies; and (7) *regulation*, that is, monitoring and modulating emotional reactions to emotionally evocative events. Of these components, cultural differences in regulation processes, antecedent event types, appraisal tendencies, and behavioral generation (the process by means of which behaviors are selected from a person's emotional behavior repertoire) form major sources of cross-cultural emotion differences.

In considering regulation processes, there are cultural differences in both emotional suppression (inhibiting or avoiding emotions) and emotional enhancement (fully expressing or exaggerating emotions). Cultures have different display rules, which are rules that dictate the appropriateness of display of emotions depending on the social situation. In adapting and adjusting to a new culture, immigrants may not be fully aware of the culture's display rules and, thus, may offend or be offended by people of the host culture. For example, a woman who has migrated from China (where the display of anger is often considered to be inappropriate) to the USA may have difficulty managing conflict situations in which people from the host culture are more likely to freely express anger.

In considering antecedent event types, studies suggest that there are cultural differences in emotion antecedents (e.g., differences in events that elicit joy). For example, in one study, Japanese individuals reported anger in relation to interactions with strangers much more often than European and American individuals, while American individuals reported more anger in the context of relationships than European and Japanese individuals. Thus, there may be cross-cultural variation in emotional sensitivity to various antecedent events. Therefore, immigrants may find themselves in a new culture where they are expected to have specific emotions in a certain situation that are in conflict with the emotions that they generally experience in such situation.

There are also cross-cultural differences in appraisal tendencies. As part of the cognitive model of emotions, appraisal involves the evaluation of events in terms of their relevance for an individual's well-being and coping options. There is evidence of cultural differences in appraisal propensities that lead to the same situations being associated with different emotions. For instance, the high frequency of guilt among the Japanese may be linked to a tendency to blame themselves for negative events. Therefore, if a man from a culture where self-blame is less prevalent were to migrate to Japan, his tendency to attribute blame to external factors in a negative situation may lead to interpersonal conflict and misunderstanding.

Cultural differences in behavior generation are affected by the cultural availability and expected effectiveness of the various emotional behavior patterns. For example, the Balinese often react to frightening events by falling asleep, which interestingly is a culture-specific extension of the universal action tendency of avoidance of feared events or objects. Falling asleep is a culturally accepted way of both expressing and concealing fear that may not be recognized or understood by immigrants. There is the possibility that certain cultural behaviors may not even be part of an immigrant's emotional behavior repertoire, leaving immigrants with the task of learning new behavior patterns in order to effectively interact with others.

Ethnicity may also be a source of the observed cultural differences in emotions. There is evidence for ethnic differences in emotions and emotional expression. For instance, a study examining ethnic variation in trait emotions and levels of emotional conflict tactics found that Russian/Ukrainian immigrants and US-born European Americans reported more negative emotion (i.e., sadness, shame, fear, and anger) and less positive emotion (i.e., joy and interest) than either US-born African Americans or Jamaican immigrants.

Similarly, Russian/Ukrainian immigrants and US-born European Americans reported greater use of emotional expression during conflict than either US-born African Americans or Jamaican immigrants. However, there were significant differences within the two major racial groups. Russian/Ukrainian immigrants reported greater levels of guilt and less joy than all other groups, including US-born European Americans. US-born African Americans reported significantly less guilt than all other groups, including Jamaican immigrants, and greater contempt than Jamaican immigrants. Taken together, different ethnic groups (both of the same race and from the same country) appear to be associated with different emotional climates. Thus, there is the possibility that differences in emotions are also a function of ethnicity.

Yet, the ethnic differences may relate to societal standards that influence emotion and the cultural values different ethnic group members place on emotions and emotional expression, such as the cultural display rules previously described. For instance, in a classic study, American and Japanese individuals viewed highly stressful films in two conditions (alone and with an experimenter) while being videotaped. Both American and Japanese individuals showed the same emotions in their faces when viewing the films alone. However, when in the presence of an experimenter, Americans continued to show their facial signs of negative emotions, while Japanese individuals were more likely to mask their negative feelings with smiles. Thus, these results demonstrate cultural differences in display rules. In considering subjective aspects of emotional responses, a study compared Chinese Americans' (involving a culture that values emotional control and moderation) and Mexican Americans' (involving a culture that values open expression of emotion) emotional responses to a startling noise. The results showed that Chinese Americans, in line with proposed cultural values, reported experiencing less positive and negative emotion than Mexican Americans. Thus, rather than viewing these variations in basic emotions as a result of ethnicity, it may be more useful to consider the cultural influence on the perceived value of emotions and emotional expression. Therefore, upon entering a new culture, it is important for immigrants and people of the host culture to understand each other's cultural beliefs and values of emotion in order to avoid reliance on ethnic stereotypes. Yet, learning, understanding, and adapting to a new culture's implicit set of rules can be quite difficult for immigrants. Many times, new cultural beliefs and values do not perfectly map onto those held by immigrants.

A misunderstanding of cultural differences in emotions and emotional expression can affect communication between immigrants and people of the host culture. Intercultural communication often involves uncertainty and ambiguity concerning the ground rules of communication and interaction. When emotional behaviors do not conform to expectations, conflict and misunderstanding may arise. People's stereotypic ways of thinking may then be aroused and ultimately lead to negative value judgments and associated negative emotions about the misunderstanding and cultural differences.

One theoretical framework proposed by Matsumoto, Hirayama, and LeRoux, informed by the literature on stress and coping, suggests that immigrants will be more likely to have successful adjustment if they learn how to regulate their emotions so that they can engage in clear thinking about intercultural conflicts and misunderstandings. Once emotions are properly regulated, immigrants can engage in learning about the new culture and understand the intentions and behaviors that brought about conflict in the first place from a different cultural perspective. Because intercultural contact and change are significant life events that are inherently stressful, emotion regulation is a psychological skill that can help immigrants deal with life in a new and different environment. Indeed, research suggests that immigrants with better emotion regulation have less depression, anxiety, culture shock, and homesickness, and higher levels of happiness, well-being, marital satisfaction, language proficiency, and income.

There is the possibility that cultural differences in emotions are also a function of personality traits. A study examined cultural differences in emotion regulation as indirectly affected by individual differences in personality traits (i.e., neuroticism, extraversion, and conscientiousness) between American and Japanese individuals. The study found that Americans had higher emotion regulation than the Japanese. Additionally, Americans had higher scores on extraversion and conscientiousness, while the Japanese had higher scores on neuroticism. When examined together, the three personality traits demonstrated a complete indirect effect on the country differences in emotion regulation. Thus, personality traits may be one of the factors that account for cultural differences in emotion regulation. There are two ways of interpreting the causal mechanisms between culture and personality that affect emotion regulation. First, personality may be the product of culture and second, genetically based personality traits may shape culture. Further study of the causal links between culture and personality would be useful in better understanding how immigrants can adapt and adjust their emotions in new cultures.

Immigrants face numerous stressors when living in a new cultural environment that may contribute to poor mental health. Recognition of cultural differences in negative emotions is important in accurately diagnosing and treating mental disorders. Although depression and anxiety are prevalent across all cultures, there are cultural differences in symptom presentation. However, despite different ways of reporting distress, the major symptoms of depression are present across different ethnicities.

Cultural differences in the conceptualization of anxiety disorders exist as well. For example, *ataque de nervios* is considered a "culture-bound syndrome," which may occur among Latinos from the Caribbean, characterized by symptoms of trembling, attacks of crying, screaming uncontrollably, and becoming verbally or physically aggressive. Individuals often feel as though their emotions are out of control and that most episodes occur as a direct result of a stressful life event related to family. The cultural differences in the experience and expression of anxiety are distinguished as a culture-specific form of distress.

In terms of clinical considerations, clinicians should not assume automatic differences in emotions and emotional expression based on the ethnicity of their patient. Because research studies often use ethnicity as a proxy for culture, the patient's level of exposure and adherence to his or her culture or cultures and maybe even personality traits should be considered.

Despite the emphasis on culture throughout this entry, one should still question the extent to which culture is accounting for the differences observed in emotions and emotional expression. Various psychosocial factors should be considered when comparing different immigrant groups, such as socioeconomic status and health. An individual's years since immigration and level of acculturation are also important to consider. Factors such as undocumented status, pressures of acculturation, and exposure to anti-immigrant and racial prejudice may over time contribute to immigrants' increased psychiatric vulnerability. For example, a study showed that undocumented Latino immigrants with concerns of deportation were at heightened risk of experiencing negative emotional states, particularly anger. Additionally, even with progress in cross-cultural research, many research studies continue to use Western psychology constructs and related measures that may not be appropriate in investigating emotion among different ethnic and cultural groups. For example, a study demonstrated that the finding that Asian ethnicity and being high on interdependence makes Asians prone to emotional distress may actually be a result of emotional distress measures (e.g., Beck Depression Inventory) that pathologize Asians for being high on interdependence or low on independence.

There do seem to be cultural differences in various aspects of emotion. Cultural differences are often found in the emotion components of regulation processes, antecedent event types, appraisal tendencies, and behavioral generation. Immigrants often face the task of adapting and adjusting to a new culture's emotions. Misunderstandings of cultural differences in emotion components between immigrants and people of the host culture can lead to negative value judgments and associated negative emotions and conflict. Thus, immigrants' general well-being and mental health are positively affected by the recognition, understanding, and acceptance of cultural differences in emotions and emotional expression.

Related Topics

► Acculturation
► Anxiety
► Ataque de nervios
► Cultural background
► Depression
► Ethnicity
► Mental illness
► Personality

Suggested Readings

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Empathy

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Empathy is the ability to imagine what another person is experiencing – to view the world through his or her eyes and to walk in his or her shoes. Empathy can entail both cognitive and affective components. For example, imagine witnessing the following scene: a woman is walking down the street and as she passes by a group of people, someone refers to her using a derogatory ethnic slur. Cognitively, experiencing empathy for this woman would involve your ability to take her perspective, to imagine how she is thinking and feeling and to differentiate her likely internal experience from your own reactions to the event. Affective empathy would include your emotional responses to her experience. You may feel emotions that are congruent with what the woman herself is feeling (perhaps you feel fear, indignation, or anger toward the person calling her a name) or your feelings may represent your reaction to the woman's situation (e.g., you sympathize with her distress).

Empathy is generally understood to precede prosocial behavior. The experience of empathy tends to be associated with a benevolent attitude and an urge to help the person perceived to be in distress. Furthermore, those who do act on their impulse to help often experience positive emotions as a result. For example, witnessing the event described above may inspire you to approach the woman in question and to inquire whether she desires assistance. Empathy's link with prosocial behavior, in particular its tendency to reduce levels of aggression and prejudice, makes it relevant to immigrant health. With this in mind, this entry will examine empathy's role in improving attitudes toward immigrant groups, including a particular method used to facilitate empathy. Additionally, this entry will introduce the novel concept of ethnocultural empathy.

Encounters with racism (both at the individual and institutional levels) are stressful and detrimental to an immigrant's psychological well-being. Empathy plays an important role in reducing intergroup aggression and prejudice. Feeling empathy for an immigrant's experience is related to not only increased concern about the welfare of the individual in question but improved attitudes toward the racial, ethnic, or cultural groups to which the immigrant belongs. A powerful method of eliciting such empathy is perspective or role-taking. This practice involves either (1) imagining oneself in the other person's situation in an attempt to perceive as the other does or (2) imagining events similar to the other person's situation happening to oneself. For example, you may try to imagine what the woman may be feeling during such verbal harassment or you may think of what you would feel like if someone made derogatory comments about your ethnicity. Taking the perspective of an immigrant reduces aggression and prejudice at both the individual and group level: (1) It links you with the other person, in effect merging the self and the other, and (2) it increases perceptions of a shared humanity and common destiny; in other words, it increases perceptions of being members of the same overarching group (humanity), whereas before you were separate and dissimilar. Acts of aggression and prejudice tend to be justified by dehumanizing and distancing oneself from the victim. Empathy increases one's awareness of the other's humanity and connects oneself with the other, therefore reducing one's likelihood of both acting aggressively toward the other and endorsing prejudiced attitudes toward the other's group.

The perceived level of similarity between oneself and the other person is a key predictor in one's ability to take the other person's perspective. This tendency to be more empathic to those most like oneself is known as the similarity bias. Perceiving the other person as similar provides the basis for perspective-taking which then fosters empathy. The role perceived similarity plays in fostering empathy raises important considerations for how racial or ethnic cultural differences may impact interpersonal interactions. Immigrants are typically deemed less familiar and less similar to the resident population, and therefore tend to be viewed less favorably. The perceived lack of similarity may lead to reduced perspective-taking and therefore reduced empathy toward immigrants.

Recently, the construct of ethnocultural empathy has been developed to describe and measure individuals' experience of empathy for those from dissimilar racial and ethnic cultural groups. Ethnocultural empathy therefore relates to the ability of members of the resident culture to empathize with immigrants. Ethnocultural empathy is comprised of four factors: (1) empathic expression toward members of other ethnic groups (e.g., feeling disturbed upon hearing others make racist statements or jokes about ethnic groups different from your own), (2) awareness of society's view and treatment of different ethnic groups (e.g., awareness of how the media portrays different ethnic groups), (3) acceptance and understanding of ethnic group behavior (e.g., reporting little irritation or impatience when people from dissimilar ethnic backgrounds speak a language different than your own), and (4) the propensity and ability to understand the perspective of members of different ethnic groups (e.g., the ease with which you relate to and the degree of understanding you have for members of different ethnic groups).

It is important to remember that empathy is teachable. Empathy for immigrants therefore can be encouraged and enhanced by utilizing the methods detailed above. Encouraging perspective-taking in consideration of an immigrant's emotional experience not only seems to increase perceptions of similarity between individuals previously viewed as dissimilar, but it tends to increase empathy and favorable attitudes toward the individual immigrant and the immigrant's respective groups as well.

Related Topics

- ► Discrimination
- ► Emotions
- ► Prejudice
- ► Racism
- ► Stress

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Employment

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Introduction

Employment is defined as the work or occupation for which one is often paid. Employment is vital to society because it keeps money in circulation. For example, when an individual works, they receive payment or compensation. They then use the compensation to purchase goods or services, which indirectly compensates the person or company from whom they purchase the goods. High unemployment rates are usually indirectly linked to low consumer spending. Employment can come with many benefits, including health insurance and discounts on various goods and services. Those who may not benefit from employment are those who are injured, sick, or too young to work.

Employment rates for the last 40 years have shown to be fairly capricious in major international economies. From 2007 to 2009, a recession hit the international marketplace that affected millions of people around the world. The 2007–2009 recession (or the Great Recession) hit several economies, making the employment rate decline globally. The Great Recession hit the global economy as a result of the housing market collapse in the US economy. The US economic crisis started developing in early 2007, and grew into a full-blown financial crisis later that year. Even though the economic downturn took place in the United States, a ripple effect impacted the whole world.

US Employment Decline

In 2007, the employment–population ratio was 63% in the United States. In 2009, it dropped to 59.3% – a seemingly small drop. This decline in employment saw an increase in unemployment and by 2009 the unemployment rate had reached 9.3%, which was more than double the unemployment rate in 2007, of 4.6%. This means that by 2009, approximately 14,265,000 people were unemployed in the United States, compared to the 7,078,000 that were unemployed in 2007.

The manufacturing industry saw the largest number of unemployed workers, with 1,890,000 employees out of work. The second largest industry for unemployment was the retail industry with 1,844,000 employees out of work. Men were unemployed in larger numbers, with 8,453,000 men and 5,811,000 women out of work in 2009.

Global Employment Impact

United States suffered a devastating decline in employment between 2007 and 2009. Between 2007 and 2009, some nations did not suffer more than a 1% unemployment increase and some countries, such as Germany and the Netherlands, increased their employment–population ratios.

In the United Kingdom, the recession and subsequent decrease in employment–population ratio effected Eastern European immigration and the government saw a smaller group of migrant workers come to the United Kingdom. They also saw a decrease in international students, which affected the funding for higher UK education. The decrease was not so large, however, that the United Kingdom's economy suffered a major deficit. In fact, the proportion of the country's working-age population that was employed decreased by 1.4% between 2007 and 2009, a percentage significantly less than the United States.

Employment of Men and Women

Unemployment rates between men and women are very different, and a common trend seen among the majority of the global economies is that men have a higher unemployment rate than women. In the United States between 2007 and 2009, the male unemployment rate rose from 4.7% to 10.3%, while women saw less of a sharp increase – 8.1% from 4.5% (2010). In the United Kingdom, men saw an increase from 5.7% to 8.7%, while women experienced a significantly lesser unemployment rate at 6.5%, a 1.5% increase from 2007 (2010). With this increase in unemployed men, women became a prominent presence in the workforce, with some women becoming the sole providers for their households. These rates have greatly affected the number of individuals that are covered by health insurance since insurance is linked to employment.

Employment and Unemployment Among Minorities and Immigrants

Among minorities, African American men were unemployed in the largest numbers, with 1,448,000 (17.5%) unemployed in 2009. African American women also exceeded the unemployment rates of other minorities, with 1,159,000 (12.4%) unemployed in 2009. Hispanics were the second largest group of unemployed among minorities.

Unemployment among minorities can be more devastating than among the majority population because of the risk of discrimination. Although illegal, minorities face discrimination in the workforce, and can be subjected to unlawful termination at any time in their employment. Such illegal actions may be exacerbated in a financial crisis. Among immigrants, employment is vital to survival because the compensation they receive from work may be the only financial help they can get. Their relatives may be poor and unable to help them, or they may be the ones who are supporting their extended families. Among undocumented immigrants, their employment status may put them at risk for deportation. For many minorities and immigrants alike, employment is the only way they and their family will have access to health care.

There has been significant backlash in recent years from native US citizens regarding the risk of immigrants taking the jobs of native workers. It is believed that this is linked to the increase of unemployment rates among the US population. The other school of thought on this issue believes that although immigrants may be aggressive job seekers and acquire a lot of work, the work they do is unskilled and in the secondary labor market, a key economic support in the marketplace.

Conclusion

Although the economy has improved, employers are still very hesitant to hire new employees in the United States, and the unemployed find it difficult to get work. They either find themselves overqualified for a job, or completely discouraged at the possibility of never finding work again. With this sustained unemployment comes the termination of insurance and health benefits, which will cause millions of Americans to go into debt or poverty.

Immigrants are especially at risk of falling into debt or poverty due to unemployment and lack of health benefits. Undocumented immigrants without employment are at very high risk of poor living conditions and denial of health care. It is difficult for an undocumented immigrant to receive health care in the United States without subsequently being deported. Immigrants who are legally present may also have difficulty receiving health care such as Medicaid and will have to meet certain qualifications in order to receive care.

The social benefits of employment are also important, as the compensation that an individual receives from employment will be used to socialize and build relationships with others. Further, employment fuels the operation of countries and sustains the standard of living for the population. As a social dynamic and economic driver, employment is crucial to survival for all populations and serves as an indicator of the prosperity of nations.

Related Topics

- ► Access to care
- ► Health disparities

Suggested Resources

International Comparisons of Annual Labor Force Statistics, adjusted to U.S. concepts, 10 countries, 1970-2009. U.S. Bureau of Labor Statistics. Web. 01 Sept. 2010. http://www.bls.gov/fls/flscomparelf/unemployment.htm

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www.bls.gov

www.census.gov

Employment-Based Health Care Coverage

► Health insurance

End-of-Life Care

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Definition and Practice

Patients with a terminal illness can decide whether they want aggressive treatment that might prolong their life or whether they prefer to stop treatment, which could help them traverse the dying process more comfortably. End-of-life care refers to a broad spectrum of care given to terminally ill patients, focusing on making patients comfortable.

Many healthcare professionals can be involved in providing end-of-life care, depending on the patient's needs: for example, doctors and nurses, counselors, social workers, therapists, and spiritual care coordinators. In most cases, healthcare professionals work in teams to deliver end-of-life care to patients and their families in hospitals, nursing homes, hospice, and their homes.

The end-of-life care team takes a holistic approach, which means helping patients and their families with the medical, psychological, and spiritual issues surrounding the dying process. Terminally ill patients often receive medications and treatments to control symptoms such as pain, vomiting, or coughing. Patients can choose to decline life-sustaining procedures such as cardiopulmonary resuscitation (CPR), artificial breathing, or artificial feeding. Counseling is available if patients are anxious or scared. End-of-life care also helps patients to plan ahead, such as completing advance directives.

End-of-Life Care in the USA

In the USA, studies funded by the Agency for Healthcare Research and Quality (AHRQ) showed that patients who talked with their families or physicians about their preference for end-of-life care had less fear and anxiety, felt that they had more ability to influence and direct their medical care, believed that their physicians had a better understanding of their wishes, and indicated a greater understanding and comfort level than they had before the discussion. However, less than 50% of the severely or terminally ill patients in existing studies had an advance directive in their medical record. Furthermore, only 12% of patients with an advance directive had received input from their physician in its development. These reports suggest that many patients have not participated in effective advance care planning. In addition, the majority of people who die in the USA (80–85%) are Medicare beneficiaries age 65 years and older and most die from chronic conditions such as heart disease, cerebrovascular disease, chronic obstructive pulmonary disease (COPD), diabetes, Alzheimer's disease, and renal failure. Thus, patients with chronic illness also need advance planning.

Immigrants and End-of-Life Care

Predicting what treatments patients will want at the end of life is complicated by the patient's age, the nature of the illness, the ability of medicine to sustain life, and the emotions families endure when their loved ones are sick and possibly dying. Conspicuously, "cultural factors" strongly influence patients' decisions about end-of-life care. The following points of cultural diversity need to be considered in providing end-of-life care to immigrants: (1) emphasis on individualism versus collectivism, (2) definition of family (extended, nuclear, or non-blood kinship), (3) common views of gender roles, childrearing practices, and care of older adults, (4) views of marriage and relationships, (5) communication patterns (direct vs. indirect; relative emphasis on nonverbal communication; meanings of nonverbal gestures), (6) common religious and spiritual-belief systems, (7) views of physicians, (8) views of suffering, and (9) views of the afterlife. Ethnic minorities exhibit greater variability in their preferences for health care as compared with Whites of European descent. Although stereotyping should be avoided, certain styles of communication and decision-making may be more common in some cultures.

Many studies have found significantly lower rates of advance directive completion among Hispanics and

Asians. Among Hispanics, a view of collective family responsibility may lead to the lack of acceptance of advance directives. A consensus-oriented decision-making approach rather than formally appointing a specific family member to be in charge may often be more acceptable in this population. Among Asians, filial piety may influence adult children to decide aggressive treatment for their elderly parents. Elderly Asian parents may experience a reciprocal obligation to continue living for the emotional well-being of their adult children.

The American Academy of Family Physicians (AAFP) has published cultural proficiency guidelines and policy and advocacy statements about diversity in AAFP educational activities. Notably, sensitivity to cultural diversity is integrated within the AAFP's policy statement on ethical principles for end-of-life care. Specifically, the policy states: "Care at the end of life should recognize, assess, and address the psychological, social, spiritual/religious issues, and cultural taboos realizing that different cultures may require significantly different approaches."

Needs for end-of-life care would increase and become diverse because of changing demographics in the USA, which are associated with increasing life expectancy, more immigrants, changes in the ethnic make-up, and retirement of the baby boomers. Health professionals need to be prepared to timely provide accurate information to patients with a terminal illness and their families while considering the patients' cultural background, thus giving patients more choices to meet their healthcare needs.

Related Topics

- ► Cross-cultural health
- ► Cultural humility
- ► Health beliefs
- ► Hospice
- ► Religion, religiosity, and spirituality

Suggested Readings

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Mazanec, P., Tyler, M. K. (2003). Cultural considerations in end-of-life care: How ethnicity, age, and spirituality affect decisions when death is imminent. *American Journal of Nursing, 103*, 50–58.

Pace, B. (2000). Decisions about end-of-life care. *Journal of the American Medical Association, 284*, 2550.

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Suggested Resources

Clancy, C. M. (2009). Talking about end-of-life treatment decisions: Agency for healthcare research and quality. http://www.ahrq.gov/consumer/cc/cc070709.htm

End-of-Life Care: Questions and Answers. (2002). National Cancer Institute. http://www.cancer.gov/cancertopics/factsheet/Support/end-of-life-care

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End-Stage Renal Disease

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End-Stage Renal Disease and Common Associated Health Problems

End-Stage Renal Disease (ESRD) refers to the irreversible decline of kidney function that is not compatible with life. Generally people are diagnosed with chronic kidney disease which may progress to end-stage renal disease. The rate of progression varies and depends on numerous factors including other comorbidities and the type and etiology of the chronic kidney disease. It is important to make the diagnosis of kidney disease as early as possible and to be referred to a nephrologist, a doctor who specializes in kidney disease. People with ESRD suffer from other conditions secondary to their kidney failure. The kidneys are also involved in production of red blood cells in the body due to kidney cells synthesizing a hormone called erythropoietin. Patients with ESRD often become anemic, or have low blood counts. They may need to get iron replacement because iron is necessary to make red blood cells in addition to getting erythropoietin injections periodically.

Bone disease and mineral/electrolyte disorders can also occur among individuals with ESRD. Bone disease is usually from secondary hyperparathyroidism, in long-term dialysis patients. Osteitis fibrosa, a hyperparathyroid bone disease, involves increased bone breakdown and eventually bone marrow fibrosis. Another common problem is having high blood levels of phosphorous or potassium (mineral and electrolytes). To tackle these issues, doctors prescribe medications that are known as phosphorous binders to aid in the removal of the dietary consumption of phosphorous. High-phosphorus-containing foods include meat products and whole grains. It is also important to follow a low potassium and low phosphorous diet. Foods high in potassium include oranges, bananas, kidney beans, apricots, potatoes, and spinach.

Malnutrition is also a very common problem in people with ESRD. Dialysis patients are often malnourished because of poor appetite. In addition, they often do not consume enough protein and calories to maintain their weight. All the causes of the malnutrition seen in the ESRD populations are not known, but another factor may be the destructive metabolic stress of hemodialysis itself.

The number one cause of death in the ESRD populations is cardiovascular disease. It is essential to maintain normal blood pressure and lipid control. Often patients on dialysis achieve adequate control on dialysis and do not need to take blood pressure medications.

Renal Replacement Therapy

Fortunately, there are multiple modalities that allow prolonging life for patients with kidney disease, such as hemodialysis, peritoneal dialysis, and kidney transplant. Dialysis helps both maintain fluid and electrolyte balance in the body. Patients will develop severe volume overload and electrolyte abnormalities that quickly lead to death if they do not have dialysis. When patients are without renal replacement therapy, they may experience symptoms such as weight gain and difficulty breathing from the excess fluid buildup in their bodies and nausea, vomiting, anorexia, and fatigue from the accumulation of toxins that their own failed kidneys cannot clear.

Hemodialysis is the process of exchanging solutes from the blood via diffusion and removal of excess water by a pressure gradient. Two needles are inserted into an access site, one needle allows blood to leave the body and go through a dialysis membrane and the other needle allows the clean blood to return to the body. Most people get dialysis at a dialysis center three times per week. The incidence of dialysis is highest in Taiwan and the United States.

Peritoneal dialysis involves infusing a dextrose, or sugar, and electrolyte solution into the peritoneal cavity of the abdomen. After a period of time the fluid is drained out of the body through a single peritoneal dialysis catheter. People can choose to do exchanges throughout the day on their own or only at night with the help of a machine.

Dialysis Access

To start dialysis, one needs a way to connect the body to whatever method of renal replacement therapy that is being used. For hemodialysis, one needs an arteriovenous fistula, an artificial graft, or a temporary dialysis catheter. Temporary catheters can be used for a few days to months but often get infected and have to be removed. Grafts are made from foreign material but also have a large risk for infection and do not last long. Fistulas are made up of one's blood vessels by connecting an artery and vein. Sometimes, patients cannot have a fistula placed because their own blood vessels are not large enough to make the fistula. Grafts are usable more quickly than fistulas and need to be placed about 1 to 2 months before starting renal replacement therapy, but fistulas must be made 2–6 months prior to the initial dialysis.

For peritoneal dialysis, a catheter is placed through the abdominal wall into the peritoneal space. Once the catheter is externalized, or opened outside the skin to be available to use, a nephrologist waits about a week before starting peritoneal dialysis. Peritonitis, or the infection of the peritoneal fluid in the abdomen, is a common complication of peritonitis as well as exit site infections involving the peritoneal dialysis catheter.

Kidney Transplant

Kidney transplant is a favorable option for patients with ESRD because with current immunosuppressive therapy the transplanted kidney can last more than a decade. Transplanted kidneys can come from deceased or living donors. The process of finding an acceptable kidney is complex and includes assessing blood type compatibility, HLA (human leukocyte antigen) tissue typing, and antibody crossmatching. Complications of kidney transplantation include acute and chronic rejection as well as infections. Immunosuppressive therapy also has a number of side effects including toxicity to the kidney themselves over time as well as low blood counts, high blood pressure, and central nervous system damage.

Health Care Costs

Patients with ESRD have astronomical health care costs. In the United States, Medicare ERSD program pays for the majority of dialysis patients, a cost of about $40,000 per year on dialysis. Renal transplant is more economical in the long term with the initial cost of transplant about $40,000 and $10,000 annually for the following years of a functioning transplant.

Undocumented Immigrants in the United States

Immigrants who reside in a nation without legal permission make up a large part of the population in many countries. In the United States, it has been estimated that there are over 11 million illegal immigrants. It is difficult to know how many people suffer from ESRD, but it has been suggested that about 5,500 undocumented immigrants have ESRD.

Chronic dialysis is not paid for by the federal government in the United States, and states have varying policies on maintenance dialysis reimbursement. Examples of states that provide chronic dialysis include North Carolina, California, Arizona, and New York. Unfortunately, most states have only emergency dialysis funding for undocumented immigrants, and therefore, ESRD patients may have to be admitted to the hospital emergently for a series of treatments. Consequently, these patients have temporary catheters which, as discussed earlier, have higher rates of infection placed repeatedly for access. The Renal Physicians Association in the United States has stated that patients with ESRD should have access to federal funding for their renal health, and furthermore, that nephrologists should honor the confidentiality characteristic of the patient and physician relationship and not be expected to inform legal authorities regarding undocumented immigrants. Patients without access to nephrologists and chronic renal care often have higher blood pressures and more difficult transitions to dialysis. Providing health care to undocumented immigrants poses an ethical and financial dilemma that plagues many countries.

Related Topics

- ► Blood cholesterol
- ► Blood glucose
- ► Blood pressure
- ► Cardiovascular disease
- ► Hypertension
- ► Obesity

Suggested Readings

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Suggested Resources

KDOQI guidelines (These are a helpful reference for the care of patients with kidney disease). http://www.kidney.org/professionals/kdoqi/guidelines_commentaries.cfm#guidelines

National Kidney Foundation. http://www.kidney.org/

English as a Second Language

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English is the dominant or only official language in Australia, Canada, and the United States, the three largest immigrant-receiving nations in the world today. Approximately, 22% of Australia's population is foreign-born; the corresponding figures for Canada and the United States are 20% and 13%, respectively. Most immigrants to these countries come from developing countries in Latin America, Asia, the Middle East, the Caribbean, and Africa, where languages and cultures often differ significantly from those of the host countries. Immigrants who are not proficient in English face the challenge of learning to speak, read, and write in English as a Second Language (ESL). In the United States alone, there are 1.8 million who are limited English proficient (LEP). The inability to communicate effectively in the host country's language can be a barrier to integration into the host society and has health implications as immigrants who are LEP may have problems in understanding health care options and in accessing health care.

Inability to communicate in a country's official language is a marker of risk for poor health. Language and nativity were found to play an important role in access to health care among United States Hispanics (Latinos) who are the largest immigrant group in the United States. LEP Latinos were found to not use or be aware of local public health programs and other health resources. In addition to language barriers, isolation in new communities was also found to be a problem in accessing health care. An Australian study found that the social integration of non-Western immigrants was associated with good mental health. It is important to note that isolation and LEP can be mutually reinforcing. In the United States, 60% of legal immigrants who were eligible for citizenship but did not become citizens were LEP. In a country such as the United States where immigration status affects access to health care, acquiring citizenship can be a critical qualification in maintaining good health.

English medical terminologies are difficult to understand for someone for whom English is a second language. Most ESL patients feel that they could describe their symptoms and experience of illness better in their primary language and also understand the diagnosis and their physician's instructions better in their mother tongue. But there is often patient–physician language discordance as it is usually difficult to find same-language physicians. Interpreter services help to some extent to ease the communication gap between immigrants with ESL and their physicians. However, these services are not always available to all populations due to the great number of languages spoken by immigrants, high costs, and lack of adequate numbers of interpreters.

Language ability can also influence the use of preventive care. In the Canadian context, where 80% of Chinese Canadians are foreign-born, English ability was positively associated with mammography adherence among Chinese immigrants. Another Canadian study found that there was a significant association between poor English proficiency and self-reported poor health among women immigrants.

While all countries have English language health education materials and media campaigns, providing language access and assistance to limited English proficient (LEP) immigrants is a critical step to ensuring good health. Assistance can involve providing information in the immigrants' native languages and through ESL classes that are available for adults and through each country's public school systems. ESL classes can help individuals with limited English attain proficiency so that they can more fully participate in the host country, be aware of, and be able to access its health care systems more effectively.

Related Topics

- ► Language acculturation
- ► Limited English proficiency
- ► Translation services

Suggested Readings

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Suggested Resources

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Environmental Exposure

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Environmental exposure has significant impacts on human health. Exposure to environmental pollution, produced primarily by humans, can cause health problems ranging from minor skin irritations to sudden death. The largest sources of environmental exposure that have the greatest impact on human health include polluted air, water, and land. Migrants are exposed to additional environmental factors such as weather, travel conditions, and duress or coercion both during their migration process and after reaching their country or location destiny.

Air Pollution

Polluted air, both outdoor and indoor, harms human health in a number of ways. It can cause respiratory diseases like asthma, lung cancer, allergies, and chronic bronchitis – all of which are contributors to premature death. Breathing polluted air has serious consequences for women who are pregnant as it may cause complications during pregnancy, premature birth, low birth weight, and various physical and neurological problems in newborns. Pollutants in the air can also cause harm to humans by settling onto vegetation and in water ways – both of which end up in the food chain. Specific outdoor air pollutants that are known to trigger health hazards for humans include carbon monoxide, lead, nitrogen dioxide, ozone, particulate matter, and sulfur dioxide. The primary sources of these pollutants are factories, power plants, motor vehicles, and waste burning activities. Indoor air pollution is generated from activities such as cooking and heating with solid fuels on open fires or traditional wood burning stoves which result in high levels of smoke inhalation – especially in poorly ventilated homes. Poor ventilation is often due to substandard construction or lack of air conditioning systems. Indoor smoke from sources like fireplaces and other wood, gas burning activities, and tobacco smoke contains a range of health-damaging pollutants including small particles/particulate matter that can settle inside the lungs and carbon monoxide which can cause significant levels of toxicity of the central nervous system and cardio vascular system, and can even cause death.

Water Pollution

In 2000, a water quality survey conducted in the USA showed that over 30% of streams, 48% of lakes, and more than 20% of estuaries were polluted. The survey also found that almost 20% of water systems that serve over three million people were in violation of basic health standards. Contaminants found in drinking water that threaten human health include microbes from human and animal waste, chemical pollutants including pesticides and volatile organic compounds, metals such as arsenic and lead, and even chemical byproducts created by the very processes used to disinfect drinking water, like chlorine. The adverse health effects caused by these contaminants range from gastrointestinal illness to cancer and developmental problems. People who are most likely to be exposed to contaminated water include those who do not have access to proper sewer systems, who live near factories, landfills, hazardous waste sites, and large farms, and those whose water supply comes from shallow wells or surface water sources. Children are especially at risk because they consume more water and breathe more air than adults in comparison to their body composition and therefore take in more harmful toxins compared to their body weight.

Land Pollution

Land pollution includes the use of chemical additives in soil and on vegetation for agricultural purposes such as fertilizers and pesticides. It can also be caused by mineral exploitation, and industrial and urban waste dumping. Hundreds of millions of metric tons of solid waste are put in landfills every year. In industrialized nations, many open dump sites have been replaced by more sanitary landfills which provide better aesthetic control of the sites; but in less developed countries, open dump sites are still common practice. Even when dump sites are redesigned to control the noxious smells, fumes, and rodent infestations, industrial waste, often of unknown content, is commingled with domestic waste which leaks into the soil and ground water and contaminate water supplies.

Pesticides

The use of pesticides poses particular concerns because many people are exposed to them on a daily basis via sources such as food, water, and air. Pesticides are particularly dangerous because many of those used in commercial farming are not biodegradable. Pesticides are bio-accumulative, that is, they are retained in the body of the consuming organism and passed along the food chain.

People who live in or near agricultural areas are at much higher risk for adverse health problems caused by pesticides because their exposures are significantly higher. Pesticides are made up of various chemicals that are used to kill insects, molds, and other organisms that can destroy crops; they are used on lawns and inside buildings to control insect and rodent infestations. Even low levels of human exposure can be toxic; some of the most common effects on human health include skin rashes, burning eyes, cough, nausea, vomiting, diarrhea, sweating, twitching, and difficulty breathing. Humans exposed to pesticides are also at greater risk for certain types of cancer including lymphoma, prostate cancer, and childhood cancers. Women who are pregnant and are exposed to pesticides are at higher risk for miscarriages or giving birth to a child with birth defects.

Environmental Exposure and Immigrant Health

The World Health Organization estimates that roughly one-quarter of the diseases facing humankind today occur because of prolonged exposure to environmental pollution. Many of these diseases, however, are not easily detected and may be acquired during childhood only to manifest into serious health problems later in adulthood. Poor and improper waste management, for example, poses a great challenge to the well-being of individuals living in urban areas, particularly those living adjacent to dumpsites. To emphasize the link between environmental pollution and public health, the United Nations Environment Program commissioned a pilot study of the Dandora municipal waste dumping site in Nairobi, Kenya. Analysis of soil and water samples found heavy metals, polychlorinated biphenyls (also known as PCBs which were banned by the USA and the Stockholm Convention on Persistent Organic Pollutants) and pesticides – all known to have adverse affects on human health.

The health problems discovered among children living in Dandora included skin disorders and skin cancer; respiratory abnormalities including bacterial infections, chronic bronchitis, and asthma; abdominal and intestinal problems including liver cancer, kidney, and renal failure; dental disorders (dental carries and pain); ear infections; skeletal muscular pain; central nervous system impairments such as neurological damage, nerve damage, and headaches; eye infections, blood disorders like anemia; and other diseases such as malaria, chicken pox, septic wounds, congenital abnormalities, cardiovascular diseases, and lung cancer.

There is a shortage of information regarding the impacts of environmental exposure in immigrant communities around the world. Immigrant communities, like other marginalized communities, comprise vulnerable populations that are often exposed to a variety of environmental and occupational health hazards. Immigrant communities generally experience higher rates of poverty and health disparities which are typically the result of both inadequate access to health care and lack of culturally appropriate health care and information. Immigrants who do not have legal immigration status are especially vulnerable. For example, in the USA, various laws have been passed to ensure that immigrants who do not have legal immigration status are denied access to health care and restricted access even to legal immigrants. The Personal Responsibility and Work Opportunity and Reconciliations Act of 1996 denies most legal immigrants nonemergency federal health care benefits, also known as the Medicaid program. The Illegal Immigration Reform and Immigrant Responsibility Act, also passed in 1996, further denies most immigrants the option of applying for federal public benefits for the first 5 years of legal residency in the USA and makes immigrants who lack legal immigration status ineligible for any federal, state, and local public benefits.

There is little research about the risks of environmental exposure incurred specifically by immigrant populations; however, several studies have been conducted of populations living near sources of pollution, the vast majority of which are minority groups, low-income and subsistence level households, and other marginalized groups. Immigrants worldwide are found in these communities. In Massachusetts, the neighborhood of Boston Chinatown is populated primarily by first-generation Asian immigrants, and it is the only community in Boston that is located at the juncture of two major highways that account for 250,000 vehicles/day. The noise and air pollution caused by this level of motor vehicle traffic have been linked to elevated blood pressure, cholesterol levels, and impairment of reading and language skills in children. Components of vehicle exhaust and particulate matter have been associated with a variety of acute and chronic conditions including headaches, eye conditions, and asthma.

A Swedish study conducted in the county of Scania found that four of the five cities surveyed had immigrant populations that were more likely to be exposed to air pollution from various sources, primarily vehicle traffic related. Studies in England and Wales found that solid waste and other polluting facilities were disproportionally located in more economically deprived areas. A national study in France looked at eight different hazardous sites, including industrial, nuclear, incinerators, and waste management facilities and found that the towns with the highest proportion of immigrants hosted more of these hazardous sites. In Hungary, 15% of the 767 Roma colonies (three million people) are located within 1 km of illegal waste disposal sites including asbestos. Eleven percent of Roma colonies are within 1 km of animal carcass disposal sites. In fact, Roma are exposed to some of the worst environmentally polluted areas throughout Europe as they are often pushed to the farthest outskirts of cities and towns, away from access to clean water and other sanitation services, but near garbage dump sites and flood plains. In all of these circumstances, irregular immigrants, or those without legal documentation regarding their immigration status, bear the highest cost in terms of exposure. Their options for housing and jobs are extremely limited and as such, they are often confined to environments with the highest risks to human health.

A fair amount of research can be found regarding Latino immigrants, primarily from Mexico, living in the USA and their environmental exposure. In addition to working in and living near agricultural areas where exposure to agricultural chemicals such as pesticides is very high, Latino migrants in the USA also tend to live in industrial areas where pollutants are constantly discharged into the air by factories and heavy motor vehicle traffic. In addition, the highest numbers of abandoned hazardous waste sites which have been designated by the US Environmental Protection Agency (EPA) for cleanup, also known as Superfund sites, are located in states that also have the highest number of Latino immigrants. Those states are, in order of the largest number of immigrants: California, which has 37 Superfund sites, Arizona with two Superfund sites, New Mexico with 5; Florida with 24, Texas with 25, and New York with 49. Although there is a federal mandate to clean up these highly hazardous sites, the program has been underfunded and cleanup work is slow.

The US–Mexico border region is characterized by a particularly serious environmental hazard for many Latinos living in these mostly impoverished areas: polluted water supplies. Pollutants in drinking water in southern and western US states along the Mexican border are known to cause sudden and deadly illnesses. Parasites, bacteria, and viruses in contaminated water can cause diarrhea, abdominal cramps, weight loss, fever, chills, vomiting, dehydration, bloating, headaches, jaundice, and muscle pain. At even higher risk for serious and fatal diseases are individuals with weakened immune systems.

The children of immigrant farm laborers are at particular risk for environmental hazards because they breathe more air, drink more water, and consume more food in comparison to their body weight than adults. Although they may not work in the fields, because they reside near them and because their parents work in them, children are exposed to pesticides at home from their parents' clothing and from dust tracked in the house, at school, and on playgrounds. The toxic chemicals in pesticides pose serious risks to children's health but few studies have examined the neurological impact of pesticides on children of Latino migrant farm laborers. A study of children living near agricultural areas in Mexico, however, revealed high incidents of diminished stamina and coordination, memory impairment, and alarming differences in drawing recognizable representations of people and objects. In fact, the drawings were incomprehensible compared to the drawings of children of the same age who were not exposed to pesticides. There is also evidence that demonstrates the associations between parental or infant exposures to pesticides and childhood brain tumors, leukemia, non-Hodgkin's lymphoma (cancer of the lymphatic system), sarcoma (cancer in the connective tissues like bones, cartilage, and fat), and Wilm's tumor (childhood kidney cancer).

Much of the world's human migration occurs from rural to urban areas, especially within countries. The World Health Organization estimates that over three billion people live in cities and the United Nations Population Division estimates that within 30 years, nearly two- thirds of the world's population will live in cities. Most of this growth will occur in Asia and Africa; in fact, Asian cities already have more urban populations than North America and Europe combined. Growing urban areas attract migrants from impoverished rural areas, and many of the world's poorest migrants end up in slums where the environmental conditions coupled with inadequate facilities are a danger to human health. In the Southeast Asia Regions (SEA), four cities alone are home to 15 million slum dwellers (Delhi, Dhaka, Kolkata, and Mumbai). Slums are characterized by extreme poverty, lack of clean water and water supplies in general, lack of solid waste management, electricity, sanitation, and other basic services. Garbage often accumulates in huge quantities. Dwellings are often simple structures made of flimsy materials and poor construction. This makes them absolutely vulnerable to natural and man-made disasters such as landslides, earthquakes, floods, and fire. There is also a lack of security, making poverty stricken slum populations subject to crime and violence. Climate change will contribute to the unhealthy and dangerous living conditions of slum residents by causing flooding in coastal cities, heat stress, and exposure to new disease vectors. The stress of living in slums coupled with weakened social support systems that are characteristic of big cities creates further challenges in the areas of mental health.

The migration journey itself can expose humans to harsh environmental factors. Images of "boat people" have been witnessed around the world: people fleeing war-torn Vietnam, Cambodia, and Laos in the late 1970s and early 1980s; Cubans taking on the treacherous journey to cross the Atlantic to reach the USA; and refugees from the former Yugoslavia and surrounding countries fleeing war and genocide in desperate attempts to reach the Italian shores, are among just a few. One of the more closely studied groups of people who go through extraordinary efforts to migrate are those crossing the US–Mexico border on foot. Several factors make this a very treacherous journey. First, it can take several days of constant walking. Border and immigration enforcement efforts have pushed migrants to cross the border in the most desolate and dangerous terrain areas of desert and mountain passes. A study supported by the American Civil Liberties Union (ACLU) and Mexico's National Commission of Human Rights in 2009 estimates that at up to 5,600 individuals died crossing the border in the last 15 years, although there are no official records because many of those who die are either never found or not officially counted by border or other government agencies. The number of deaths has increased yearly since enforcement efforts have increased. Incidentally, the number of unauthorized immigrants into the USA from Mexico has grown from 8.4 million in 2000 to 11.9 million in 2008, despite the stepped up border enforcement.

Environmental exposures of migrants crossing the US–Mexico border on foot include extreme weather temperatures which can lead to organ failure and death. Some people die quickly due to the environmental stress, especially if they have pre-existing health problems. Migrants who have died in the desert areas that make up the border region also show signs of blunt trauma from falling on the prolific desert cacti and rocks. The heat generated from the desert sand can also burn through inadequate shoes, causing severe blistering of the feet, making it impossible to walk. People usually make this journey in groups and if they are not able to keep up the pace, they are often left behind in desolate, treacherous, and harsh terrain with no access to water, food, or shelter. Humanitarian organizations that go into the desert to provide lifesaving services to these migrants report treating individuals suffering from hypothermia, heat exhaustion, abrasions, snake bites, skeletal trauma, dehydration, severe sunburn, nausea and vomiting, miscarriages, and exhaustion. Migrants also drown in various rivers, canals, and other waterways that are used to cross the border, including the ocean.

More and more migrants are crossing into the USA via the Pacific Ocean and Texas Gulf because physical barriers have been erected along various canals in California, Arizona, and Texas to prevent undocumented migration. To cross the border via the Pacific Ocean, people must swim quite far from shore in order to not be detected by law enforcement monitoring this section of the border. Motor vehicle accidents are also big contributors to injury and death of migrants. Vehicles used to smuggle migrants into the USA are often poorly maintained and severely overloaded. They may reach dangerously high levels of speed if being chased by law enforcement. Migrants also suffer violence and abuse at the hands of their smugglers, as do many clandestine groups of people who migrate illegally, including the millions who are trafficked every year all over the world. Homicide and assault are not uncommon for unauthorized US–Mexico border crossers as smuggling networks are often tied to other criminal enterprises including drug and arms smuggling. And finally, natural disasters such as the enormous fires in California in 2003 and 2007 may result in injury or death. During these fires, law enforcement reported the apprehension of 200 individuals, some having suffered burns requiring hospitalization, and five who died in the fires.

Women are also especially vulnerable to sexual exploitation and violence during and after the migration process. The ACLU study reports that women are often offered "security" by their smugglers and others involved in the smuggling of humans across the border in exchange for sex. Women who refuse may be beaten and/or raped. All of these women are at risk for injury, pregnancy, and sexually transmitted diseases. Upon reaching their country or region of destination, or wherever traffickers decide, women are often easily exploited by working in unregulated sectors of the labor market, and most especially in the sex industry. Some estimates indicate that up to 80% of all trafficked persons are women and girls.

Related Topics

- ▶ Air pollution
- ▶ Border health
- ▶ Chemical exposure
- ▶ Environmental health
- ▶ Environmental justice
- ▶ Environmental tobacco smoke
- ▶ Heat stroke
- ▶ Hypothermia
- ▶ Intestinal parasites
- ▶ Lead poisoning
- ▶ Occupational and environmental health
- ▶ Pesticides
- ▶ Trafficking
- ▶ U.S.–Mexico border
- ▶ Violence

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Environmental Health

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This entry will describe the impact of environmental influences on the health status of immigrant populations. The health of populations is influenced by a variety of factors which reflect genetic inheritance, behavioral attributes, access to and quality of health care, as well as environmental influences. (For a seminal distillation of these factors please see Marc LaLonde's – A New Perspective on the Health of Canadians as published in 1981). Before we begin to explore this issue we need to address two important issues: the first of these is the definition of "environmental influences or factors" and the second is the consideration of "the act of immigration as a putative factor in the maintenance of health and the development of disease." This second issue has been examined via classical sequential cross-sectional studies following populations as they pass through different locations (For an example see the 1974 work of Kagan et al. which tracked the experience of populations in Japan, Hawaii, and California).

Definition of Environmental Health

The definition of environmental influences is sometimes broad; LaLonde in his already referenced work includes a wide variety of factors. Traditional environmental health is comprised of contaminants in the ambient environment that affect the health of populations. Other writers take a more restrictive view and hold that environmental exposures are inherently defined as involuntary exposures. Steenland and Savitz use the illustrative example concerning the burden imposed by tobacco consumption as being compartmentalized into personal behavior (active smoking) in contrast to secondhand smoke being characterized as an involuntary environmental exposure. This interpretation is lent further credence by the evolution of the term "Environmental Tobacco Smoke." With the approach of considering environmental exposures to be largely those that are imposed and of an involuntary nature we will explore the literature with regards to what is known regarding the putative impacts of such exposures on immigrant populations.

First, a word regarding the act of immigration per se. Many commentators have written about factors associated with immigration that complicate the interpretation of health status data from such populations. An early paper on this subject by Kasl and Berkman highlighted the powerful self-selection factors found in immigrant populations. These include the varied and hard to measure responses to changes in environment. Kasl et al. went further to point out that the screening of immigrant populations may occur as a result of international travel and entry into new occupations, thus "improving" the health status of these new arrivals. From this it follows that the very act of immigration needs to be thought about distinctly from environmental influences.

Healthy Immigrant Effect

One question to consider at the outset is the "healthy" immigrant issue. This holds that powerful selection factors may influence which individuals in fact immigrate**.** The health care utilization experience of recent arrivals tracks differently according to geographical and access to medical care contexts. Eamranond and Hu also note that Spain, which features relatively easy access to health care coverage for immigrant populations, reports a lower rate of health care utilization among immigrants than among native born residents. The Canadian experience, again reflecting the structural advantages of a health care system featuring universal access, finds persistent advantage to immigrant populations for chronic conditions versus comparisons to native born counterparts as noted by McDonald and Kennedy in their work. It is noted that some of these advantages erode with added years in Canada.

There are alternative hypotheses which are brought forward to explain the so-called "healthy immigrant." These range from a twist on the hygiene hypothesis which holds that early stimulation of the immune system yields greater resistance to disease later in life to the protective elements of cultural differences in terms of social support and people rich networks.

Other broad factors help determine and influence the health of populations such as recent immigrants including diet, access to beneficial exercise, and use of drugs and alcohol. It is not the place of this entry to decide this question. It is however important to remain aware of alternative explanations surrounding the health experience of immigrant populations.

Micro Versus Macro Environment

One may hypothesize that immigrants have a less robust control of both their "micro" and "macro" environments. This potentiates the likelihood that immigrants may be subject to more concentrated exposures and possibly for longer duration to environmental contaminants than native born populations. Documenting such realities is still very much a work in progress. This is one of the most striking results of consulting the extant literature with regards to the subject of this entry: the paucity of published research on the etiological importance of environmental sources on the health of immigrants. This lack of descriptive research is particularly challenging for the crafting of interventions with regards to immigrant populations given their heterogeneity when assessing various characteristics at the subgroup level. Some works, such as that of Kandula et al, recognize that such differences as framed by variables such as country of birth are critical to planning and evaluating the need for specific public health interventions which address immigrant health needs.

The pollutants most associated with the immigrant experience are a relatively small set of well-known environmental toxicants. Pollutants with documented differential impact on immigrants include lead (Pb), pesticide exposures (in residential settings such as public housing as well as in occupational sources such as the agricultural industry sector which can affect workers but also contiguous environments), as well as a developing literature with regards to air pollutants.

Internal Migration

Another issue of concern is the internal migration pressures which produce steady flows of migrants from the rural hinterlands to urban centers. These populations often encounter similar disadvantageous living situations similar to those which confront immigrants who cross national borders. A great proportion of this internal migration is fueled by the prospects of better employment, education, and social advancement. Marmot in a 2009 World Health Organization report assessing the social determinants of health cautions that inequities between rural and urban areas need to be addressed in a meaningful way, so that internal migrants are more adequately prepared for and received in urban environments.

It must be stated that internal migration imposes its own set of pressures on affected populations. Often times the shift from agrarian, rural settings to urban environments can be just as jarring as a journey of many time zones and across wide oceans. What is certain, however, is that a set of transcultural factors have contributed to a global trend favoring urbanization which has caused the growth of the "mega city," particularly in low and middle income nations. Such mega cities (Djakarta, Mexico City, Sao Paulo, Ibadan) are more often than not found in emerging economies that often bear the economic and developmental pressures already alluded to. Such pressures produce higher density in both the urban and peri-urban city scapes, more competition for existing housing stocks, greater unmet needs in terms of water distribution systems and sanitation infrastructure such as sewers and latrines, all played out in an environment which often places the migrant and immigrant having to navigate this complicated landscape in a similar manner. For in-depth coverage of this phenomenon please consult the activities and research trajectory of the UN-HABITAT organization.

The pressures exerted by urban life are not solely operating in the province of low income nations. A brief case is presented here which chronicles the difficulties and opportunities faced by immigrants in the metropolitan area of New York City (NYC). The reader should be aware that issues within the traditional province of environmental health (air, water, soil, noise, climate) exert strong influences on population health and are of growing importance in both research and practice.

Case Study: New York City

According to the Department of Homeland Security, sixty percent of all legal immigrants in the US live in 6 states, and 75 live in 10 (Department of Home Land Security, 2009). In 2010, 5 metropolitan areas accounted for 40% of all new legal permanent residents). This concentration of immigrant populations is a common trend worldwide. New York City (NYC) is a prime example of a place where immigrants face different environmental exposures, risks, and challenges than their native counterparts.

As of 2006, 37% of all NYC residents were foreign born. Many are new arrivals – between 1990 and 2007, 1.5 million immigrants moved to NYC. Lerner et al. discovered that these immigrants are more at risk for lead poisoning, pesticide exposure, residence in low rent apartments, the development of asthma, childhood obesity, and the development of behavioral issues.

For immigrants in New York, the home can be a significant source of exposure to environmental hazards. Over half the immigrant population pays 30% or more of their annual income on housing. This proportion is even higher in the poorest of immigrant populations. Immigrant housing is often overcrowded and in poor condition, with insects, rodent infestations, and poor air quality. These deficient housing conditions may contribute to asthma and lead poisoning, with children being at particular risk. In addition, cleaning agents and pesticides used in the house, and available for sale in neighborhoods, place residents at additional risk. Unfortunately, with a lack of affordable housing being constructed, and the tendency for immigrants to move into neighborhoods of their own ethnicity, the issue of poor housing may continue to exist for NYC immigrants.

The broader immigrant neighborhoods and communities produce additional exposure and risk. As stated earlier the sale of chemicals, cleaning agents, and pesticides on the street is common, especially in Hispanic communities. (Hispanic communities contain one-third of immigrant children living in NYC). While these physical risks are clearly present, many non-tangible exposures also exist in these environments. The stress of living in a new environment, especially one of poor life quality, may have a negative effect on residents' psychological state. A Milano Graduate School publication chronicles how immigrant children suffered a disproportionate amount of anxiety and psychological trauma from the September 11 attack and the Flight 547 crash in Queens. In addition, the presence of violence and crime in these immigrant neighborhoods may have a negative effect on resident mental health. Because of language limitations (15% of immigrant families do not have a member over the age of 14 who can speak English), these neighborhoods are often inescapable, lacking social and economic mobility for residents.

It is easy to focus on specific, quantifiable exposures concerning the environmental health of a population. However, the environmental context of an immigrant is much broader than chemical or biological exposure. In the case of New York City, the biggest changes in environment from native countries are the ones more difficult to measure – lifestyle, environmental stress, access to native foods, and culture. Thomas R. Frieden, Commissioner of the NYC Department of Health, acknowledged this in writing that immigrant health is negatively affected in the USA by new environmental influences, extending to differential levels of concentrated tobacco marketing and exposure to unhealthy diet.

The NYC immigrant population is a pertinent example of how sudden and severe changes in context and culture can exert strong effects on mental health, and put immigrants at increased risk for chronic disease such as heart disease, diabetes, and obesity. Combined with the lack of access to care and primary prevention in the New York City foreign born community, this may pose a serious threat to health status. These complications can sometimes produce varied outcomes in heterogeneous populations exposed to the same stimuli.

The differential responses to the tragedies of September 11 and the Flight 547 crash serve as an example of a similar environmental exposure affecting native and foreign born populations differently. Immigrants responded with increased rates of posttraumatic stress disorder, depression, prescription drug use, and less health care utilization. Lack of primary care physicians may have contributed to this difference, and the lack of primary care in the immigrant population may have exacerbated the difference in reaction to these disasters. The difference in response to the same event, however, indicates that outcomes from individual exposures are complicated by the host factors found in the exposed populations. In the case of environmental health, immigrants in New York City appear to have intangible differences form their native born counterparts.

Difference in risk, exposure, and response exist within the broader heterogeneous immigrant population. Some variability makes sense – new immigrants will find jobs and homes most often through the social networks of family and friends, creating communities of singular ethnicity, and particular hazards. However, because of the multitude of immigrant communities represented in NYC, this variance presents a problem when considering interventions. Variance within a single immigrant community exists too. Immigrant children are especially at risk for exposure, as they have even less control over their environment than adults of the same population. This underscores the importance of the active study of children and adolescents as sensitive or susceptible populations as seen in the National Children's Study.

New York City provides an example of a great amount of available data on the immigrant health experience in contrast to the often marked paucity of information pertaining to immigrant health. The past decade has shown an increase in concern and study of immigrant health, and acknowledgment of the disparities that exist across ethnicity, age, and gender. In this regard, New York City serves as an example of the potential benefits achieved as a result of successful research and dissemination of information pertaining to immigrant health.

Being a city of considerable size, population, diversity, and disparity, it is not surprising that a number of risks and exposures exist in New York City. What is instructive here is the disproportionate risk and exposure that immigrants, especially immigrant children, bear. It is also clear that given the demographic importance of the immigrant populations in New York City that interventions mounted to improve immigrant health also raise the health status of the remaining (US born) population.

Resistance to Environmental Stressors

The ability for communities and populations to exhibit resistance to environmental stressors and other provocations has captured much recent attention under the broad term of resilience. Resilience has been calibrated in global populations as well as in populations faced with the challenge of natural disasters and other broad scale environmental stressors. The particular definition of resilience involves both substance and context. Almedom and Glandon write that the ability of populations to respond to changes, exposures, or stimuli in an effective and competent manner fall under the concept of resilience. Given the heterogeneity of host factors found in immigrant populations it is reasonable to assume that research probing resilience in different immigrant populations will be a topic of growing importance. In short, why are certain populations less prone to the deleterious impacts of environmental factors?

The impact of the acute heat wave which occurred in the summer of 1995 in Chicago, Illinois is of use in this consideration. Some of the impact resulted from characteristics of the host populations but also as a result of the capacities and efficacy of social and civic institutions (such as police and fire departments as well as departments of social service). One result which emerged from Klinenberg's book on the subject is that although Latinos comprised about 25% of the city population and are disproportionately poor and sick, this population accounted for only 2% of the heat related deaths. Initial commentary regarding this protective effect posited that Latinos benefited from intact social networks. Klinenberg, however, interpreted this result as the influence of the concentrated density and vitality of the neighborhoods selectively populated by Latinos, in contrast to neighborhoods subject to the corrosive influences of abandonment and more commonly inhabited by African Americans. In the end, Klinenberg's analysis demonstrates that fragility of a diverse set of social institutions set in motion events that caused excess heat related mortality. Lessons were learned and policy modifications were instituted as borne out by the result of a similar 1999 heat wave in Chicago. During this more recent heat wave, while still causing excess heat related deaths; the final toll was less than one-quarter of that recorded in 1995. The core responses featured public health warnings, access to air conditioned public spaces, door-to-door checks mounted by police and public safety staff of vulnerable individuals, and other measures at the population level.

Factors Associated with the Built Environment

Such successful policy and programmatic responses also find analogs in more traditional ambient environmental interventions being pursued globally. One salient example is the recent reductions in air pollution achieved in Mexico City, Mexico. These reductions have been achieved by the initiation of a variety of engineering controls (introduction of low sulfur fuels) and behavioral modifications (reductions in car use). In the USA attention has turned to the influence of the built environment in terms of creating positive influences on population health. In the September 2003 special issue of the *American Journal of Public Health*, immigrant populations were identified as one of the at risk populations relative to the built environment because of primarily poor housing stock and other environmental stressors such as unsafe pedestrian environments, and greater exposure to air and water borne contaminants.

This differential impact is one that will be seen in many built and ambient environmental factors as we move forward in time. The impacts of climate change are widely believed by many analysts to impose disproportionate burden on the global poor but also upon those living in high risk areas which are more prone to the ravages of flood, drought, and other extreme weather events. This brings into sharp relief the proposition that immigrants will potentially be adversely affected through an extension of factors which drive environmental justice inequities in the USA and elsewhere. A case can be built that supports the notion that the strength of these sociopolitical forces will only intensify as immigrants will likely be subjected to often hostile immigration policies and a skeptical response on the part of native born populations faced with uncertainties which stretch from globalization to the halting recovery from a worldwide recession.

Ultimately, ensuring environmental health for immigrants improves the environmental health of all. This will require improvements in *physical* and *social* infrastructure. The physical infrastructure is the world of better housing stock, mass transit to lower air pollution burdens, better water and sanitation systems. This can be paired with social infrastructure such as improvements in population-based risk factors which are affected by behavioral changes in diet, exercise, smoking cessation, etc. Equally important is the interplay between the built environment and personal risk factor reduction. The nexus (particularly the influence of perceptions of safety and access on physical activity) of these factors will likely form an agenda item of increasing importance for environmental health specialists and land use planners in the future.

Additive Effect of Environmental Exposures

The consideration of the impact of multiple environmental stressors upon the health status of populations has spurred attempts to arrive at estimates of the possibly additive, synergistic, or perhaps antagonistic relationship between and among such stressors. The concept of cumulative risk speaks to the marshaling of either quantitative or qualitative data to express such additional risks imposed upon specific geographic locations. This comes into sharpest focus when regulatory authorities are attempting to site a new source of environmental stress in a given place. This prompts questions relating to other place-based risks to which this population is exposed, and whether the new risk skews this cumulative risk to “unacceptable” levels.

Johnson, in an innovative design implemented in Detroit, Michigan, attempted to separate the risk for developing asthma into a set of host factors as well as an aggregate risk score called the environmental risk index (ERI) for each household. The ERI did not attempt to characterize the ambient environment but rather concentrated upon factors associated with the design, construction, and condition of the dwellings inhabited by the study participants. Johnson and her coauthors found that immigrant populations, in terms of asthma, are appropriate populations to view the combined impact of culture and environment. The complexities of managing asthma as a medical condition also were found to increase the importance of English fluency, and birth in the USA was associated with improved health outcomes. The prevalence of asthma was highest among moderately acculturated immigrants compared with new immigrants. This suggests along with the work of other investigators already cited that “Western” risk factors begin to predominate for Arab-Americans as the population becomes more established. Brugge and colleagues found that such differences in terms of the distribution of asthma among native and foreign-born populations at the community level in Boston are not always obvious or straightforward. This research team urged further work at the neighborhood level while recognizing the difficulties that they faced in recruiting a sample of sufficient power to answer the hypotheses of interest.

Two main themes are of interest in this consideration of the impact of environmental factors on the health of immigrants. The first is the relative paucity of either descriptive or analytical information regarding the distribution of environmental exposures across these populations as well as a need for clear identification of the impact of these factors on health status.

Given that there is growing momentum in the interest of global researchers on the immigrant experience, perhaps this knowledge gap will be addressed in the relative near term. This is especially important to achieve given the second theme that emerges from a consideration of immigrant health status relative to environmental exposures. This second theme concerns the heterogeneity that is consistently displayed in the distribution and magnitude of risk factors found within immigrant subgroups. It is critically important to comprehend such differences in the mounting of successful public health interventions.

Assessing Immigrant Environmental Health

Certain systemic realities are important to comprehend when assessing the environmental factors which affect the health status of immigrant populations. These include, as summarized by Eamranond and Hu, restrictions on access to health services in such countries as the USA, the often xenophobic social environments found in many countries which impedes the ability of the immigrant population to trust the institutions of the host country, and a wide array of host factors that are quite different between newly arriving immigrant populations and native born populations.

Thus researchers and program planners are faced with specific methodological differences in gathering valid data on immigrant populations. Kasl et al. offers some salient recommendations concerning how such studies should be implemented. He urges the formation of three cohorts: pre-migrants, nonmigrants, and host country residents, within which frequent characterization of both health status and psychosocial factors are performed. Kasl suggests further that the measured environmental exposures should include the physical, social, and behavioral aspects of the studied populations. Such analyses would be carried out in a rigorous manner that reflects to the extent possible sensitive measures of adaptive responses to stress and other potentially harmful stimuli.

The rigor of such recommendations is challenging to implement but also illuminating in the quest to unravel the impacts of both immigration and the environment. In the end, if environmental conditions are improved to the benefit of immigrants, the health status of the overall population will surely benefit as well.

Related Topics

► Environmental exposure
► Environmental justice
► Environmental tobacco smoke
► New York City
► Occupational and environmental health
► Occupational health
► Occupational injury
► Sanitation
► Water

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Suggested Resources

Pratt Center. http://www.prattcenter.net

National Children's Study. http://www.nationalchildrensstudy.gov/Pages/default.aspx

UN-HABITAT. http://www.unhabitat.org/

Environmental Justice

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Environmental justice is a concept born out of the struggles of lower-income communities and communities of color against disproportionate environmental burdens. The grassroots environmental justice movement in the USA grew in the 1980s from the recognition that the incidence of hazardous and polluting sites was higher in communities with fewer economic resources and political power. The environmental justice movement unites African Americans and Native Americans with immigrants of color, in particular Latinos and Asian Americans, but also immigrants from the Caribbean, Africa, and the Middle East. The movement redefined the environment as where people "live work, and play" and criticized the mainstream environmental movement for not adequately addressing environmental issues as experienced by people of color and the poor. An early instance of the use of the term "environmental racism" occurred in 1982 in the fight against the siting of a toxic landfill by a predominantly African American community in Warren County, North Carolina. In this case, a national faith-based organization, the United Church of Christ, supported the grassroots environmental efforts explicitly in terms of civil rights.

Through the 1980s and into the 1990s, numerous studies documented the disproportionate incidence of polluting facilities in poor and minority communities. The landmark 1987 report Toxic Waste and Race by the United Church of Christ found that race was the most significant indicator of the location of commercial hazardous waste facilities across the country and that three of every five Black and Hispanic Americans lived in a community with uncontrolled toxic waste sites. In a 1993 study reviewing 64 empirical studies of environmental disparities by income and race, Goldman found that all but one showed disparities by race and/or income. In 1999, the Institute of Medicine found that while the exposure of low-income communities and communities of color to environmental health risks and their disparate health status has been well documented in the literature, there have been gaps in research that establishes the direct link between exposure and illnesses.

The environmental justice movement coalesced nationally in the early 1990s. The 1991 National People of Color Environmental Leadership Summit in Washington, DC drew more than 500 delegates representing African Americans, Latino Americans, Asian Americans, and Native Americans from all 50 states as well as several other countries. Summit participants adopted 17 Principles of Environmental Justice, which are widely viewed as the guiding principles of the movement. The national momentum generated by the Summit led to President Clinton's 1994 Executive Order 12898, "Federal Actions to Address Environmental Justice in Minority and Low-Income Populations." This order required all federal agencies to ensure that they do not discriminate in their environmental and public health programs.

Immigrants and Environmental Justice

Immigrant communities, especially Latino, Caribbean, and Asian, are well represented in the environmental justice movement and share many of the characteristics of other environmental justice communities. In their 2001 book *From the Ground Up*, Cole and Foster include the farmworker movement of the 1960s as one of the foundations of the environmental justice movement. For example, the United Farm Workers, led by Cesar Chavez, organized to ban the use of hazardous pesticides.

In addition to the effects of racial discrimination and poverty, immigrant communities face additional challenges that can place them at risk for environmental injustice and exposure to environmental health risks. These factors include lack of proficiency with the English language, lower educational attainment, legal status, lack of access to health care, and specific cultural practices. The workplace is a significant factor in environmental health risks for immigrants. Certain industries, such as agriculture and janitorial services, have high percentages of immigrant workers who face various occupational safety and health hazards. The urban and rural communities in which immigrants live also present environmental injustices. The remainder of this entry will review the health impacts of environmental injustice on various immigrant communities where they work and where they live. Examples are drawn primarily from the experience of Latino and Asian immigrant communities, though other immigrants from Africa, the Caribbean, and the Middle East experience similar conditions.

Where Immigrants Work

Immigrant workers face environmental hazards in both urban and rural contexts. For example, Latino immigrants still comprise a large majority of the farmworkers in the USA. In the fields, workers are exposed to pesticides and often are not provided with the proper training or equipment to safely use these products. Workers can then bring these residues back home, where their families and children can also face exposure.

In cities, Latina and Asian workers, predominantly women, make up a large portion of the workers in the textile and garment industry. In these factories, they are exposed to poor ventilation, fire hazards, and chemicals such as formaldehyde and other dye preservatives. Likewise, Latina and Asian workers are concentrated in the microelectronics manufacturing industry. For example, in Silicon Valley, 70–80% of the production workforce are Latinas and Asians. In the "clean rooms" for manufacturing chips and assembling circuit boards, workers are exposed to numerous toxic chemicals. Studies have documented high rates of occupational illnesses, including respiratory disorders, miscarriages, birth defects, and cancer.

Where Immigrants Live

Rural Latino communities, where many farmworkers live, can also host a disproportionate burden of polluting facilities. For example, in the early 1990s, in California, the state's three Class 1 toxic waste sites were located in three majority Latino towns – Kettleman City, Buttonwillow, and Westmorland. In Kettleman City, residents won a historic battle against the siting of a toxic waste incinerator in 1993, after winning a court case in which the judge determined that the residents (who were 40% monolingual Spanish speakers) were not meaningfully involved in the public process because of lack of Spanish translation.

More than 1.5 million Latinos in the USA live in *colonias* along the US–Mexico border. These unincorporated communities often have substandard housing and lack access to potable water and sewage treatment, leading to risk of waterborne diseases such as giardiasis, hepatitis, and cholera.

In urban areas, Latinos also face environmental injustice. About 66% of Latinos live in areas where the air quality does not meet federal Clean Air Act standards. Air pollution from automobiles, factories, and power plants contribute to risks for asthma, cancer, and other diseases. Though nationally Latinos have a lower asthma rate than Whites or African Americans, there are areas where Latino asthma rates have been found to be much higher. For example in New York City, Latinos have the highest rates of adult asthma (6.4%) of all ethnic groups, compared to 3.5% for Whites and 4.6% for African Americans.

Latinos and Asians in urban communities have also had to deal with polluting facilities and the cleanup and redevelopment of toxic waste sites. In Chicago's Little Village neighborhood, home to the largest Mexican

American population in the USA outside of East Los Angeles, residents have led a successful struggle to remediate a Superfund site, which had hosted an asphalt plant for over 70 years. The same community is surrounded by two power plants that contribute to about 2,800 asthma attacks and 40 premature deaths each year.

Asian immigrant neighborhoods also host disproportionately high numbers of polluting facilities and contaminated sites. For example, Laotian refugees have settled in large numbers in Richmond California in the San Francisco Bay area. Richmond, a city of over 100,000, is comprised of 36% African Americans, 26% Latinos, and 12% Asian. Richmond is host to over 350 industrial facilities. In July 1993, the accidental release of concentrated sulfuric acid by the General Chemical plant sent more than 20,000 residents to the hospital.

Housing conditions for lower-income immigrant communities can also present environmental hazards. Lead paint in older homes contributes to lead poisoning. To the extent that Latino and Asian immigrants are also of lower income, they have less access to lead free housing. Latino children are twice as likely to have elevated blood lead levels as White children.

The transportation system in urban communities also poses health threats to immigrants. Not only is a large portion of air pollution from transportation sources, but many times transportation facilities and heavily trafficked roads are located in immigrant neighborhoods. For example, five of the six transit bus depots in Manhattan are located in Northern Manhattan, which are predominantly lower-income African American and Latino communities. In densely populated neighborhoods, such as Chinatowns in many cities, high levels of traffic and congestion contribute to pedestrian accidents and injuries.

How Immigrants Live

Cultural practices also contribute to environmental health risks, such as lead and mercury exposure. In Latino communities, these practices include consumption of lead in candy imported from Mexico and eating food cooked or served in pottery with lead glazes. Some Mexican folk remedies, such as the lead-based *greta* or *azarcón* and mercury-based *azogue*, are used to treat indigestion. Commonly used cosmetic products used by Latinos have also been found to contain high levels of mercury.

Immigrant fishing and gardening practices combined with lack of English proficiency also contribute to consumption of contaminated fish and vegetables. Immigrant families often come from places where they practiced subsistence gardening and fishing. In the USA, many immigrants continue these practices, in part because of economic necessity. In Richmond California, two Laotian families were growing vegetables on an abandoned battery factory, which exposed them to lead. Warning signs were posted in only English and Spanish.

Immigrant anglers often depend on the fish they catch to feed their families. They are often fishing in polluted waters, where fish can be contaminated with mercury and other toxic chemicals. Oftentimes, state advisories warning anglers of contaminated fish are posted only in English.

Related Topics

- ► Air pollution
- ► Asian Americans
- ► Asthma
- ► Blacks
- ► Built environment
- ► Chemical exposure
- ► Civil Rights Act of 1964 (U.S.)
- ► Community
- ► Community organizing
- ► Cultural competence
- ► Cultural humility
- ► Discrimination
- ► Environmental exposure
- ► Environmental health
- ► Farmworkers
- ► Hispanics
- ► Latinos
- ► Lead poisoning
- ► Public health
- ► Race
- ► Racial disparities
- ► Racism
- ► Sanitation
- ► Water

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Environmental Tobacco Smoke

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Second-hand smoke, or environmental tobacco smoke (ETS), is smoke that fills enclosed spaces when people burn tobacco products. No amount of ETS is considered safe, and people are potentially exposed to ETS thousands of times per day – from tobacco smoke in the home, automobiles, public places, the workplace, even to exposure in conversations with peers who recently smoked. Linked to various chronic conditions, ETS has emerged as a significant health risk in America and is a particular threat to immigrant populations. Due to its inextricable link to tobacco use, which has a long history engrained in American culture, ETS remains a prominent health issue in the USA, which is difficult to combat.

Tobacco has been around for thousands of years. While small amounts of nicotine were found in human remains and pipes in the ancient world, there was no evidence of routine use of tobacco for several thousands of years later. Tobacco was introduced to Europe as Columbus and other explorers made voyages to the Americas and disseminated it throughout the world as intercontinental sea-passage and trading arose. As smoking tobacco continued to spread in popularity throughout the globe, manufacturing companies of tobacco products were established and smoking tobacco products like cigarettes and cigars became increasingly commonplace. By 1901, yearly sales in the USA totaled 3.5 billion cigarettes and 6 million cigars, and 4 of 5 American men smoked at least 1 cigarette every day. Due to the worldwide popularity of tobacco use, many immigrants who entered the USA in the 1900s were already smokers or started smoking as they assimilated into American culture. The smoking industry continued to prosper and grow through advertisements to men, women, and minorities. Without knowledge of tobacco's negative effects, smoking became a well-incorporated component of American culture, practiced daily in homes, workplaces, and public places.

Not until the twentieth century did the health problems associated with tobacco and tobacco smoke exposure become more widely documented. Risks of tobacco smoke came to light in the USA in 1964 with the Surgeon General's report on "Smoking and Health." This report drew attention to the various negative health outcomes associated with using tobacco products. The report also suggested that cigarette smoking was responsible for a 70% increase in the mortality rate of smokers compared to nonsmokers as well as increased incidences of lung cancers, chronic lung conditions, and heart disease. For the most part, the 1964 report focused on the health risks of active smoking and did not present the effects of tobacco smoke on the nonsmoker. Only briefly touching on the indirect consequences of ETS by highlighting the notion that smoking during pregnancy could affect the fetus and often results in newborns of lower birth weight, the 1964 report did not fully delve into the extensive dangers of tobacco smoke, many of which were still being investigated.

The report was effective in beginning to change the perception of active tobacco smoking. Prior to the report, less than half of those polled believed smoking to cause cancer, while in the 4 years after dissemination of the report, more than three-quarters of those polled believed smoking to cause cancer. While many people began to view smoking more negatively, it also became apparent that eliminating tobacco smoke and its burden on the health of Americans was more complicated than simply highlighting these risks. Addiction, culture, and social habits emerged as complicating factors in the battle against tobacco use.

Despite the 1964 findings, many people continued to use tobacco products. Through chemical addiction to the product and targeted advertising toward minorities, the tobacco industry continued to prosper. In the 1970s, tobacco companies specifically targeted American immigrant populations using cigarette smoking as an American marker of high social status. The companies used tactics to appeal to immigrants of varying degrees of assimilation and even advertising to populations of future immigrants in their countries of origins.

While the concept of the negative health ramifications of smoking on the individual smoker was taking hold, more than 20 years passed by before the Surgeon General released a new report warning that tobacco smoke affects more than just the individual using the cigarette. In 1986, the Surgeon General released a report titled "The Health Consequences of Involuntary Smoking," which identified chronic diseases that result from individuals' exposure to ETS. It concretely cemented research findings and set forth a new understanding of tobacco use. The report detailed the chemical composition of tobacco smoke and the health outcomes associated with toxicity from exposure to it, even as a nonsmoker. Furthermore, the report implicates the necessity for further governmental regulation to protect and prevent further disease burden from ETS. The report reframed smoking as more of a community issue than an individual problem.

From the Surgeon General's reports, and other tobacco research, we currently know that tobacco smoke contains over 4,000 known chemicals; at least 250 are known to be harmful and more than 50 of them are known to cause cancer in humans. Collectively, tobacco products cause 600,000 premature deaths a year, 50,000 of which are a result of heart disease or lung cancer brought about by ETS. The International Labour Organization estimates that ETS continues to be a problem, as approximately 200,000 workers die every year due to ETS within the workplace. The WHO estimates that around 700 million children, or almost half of the world's children, breathe air polluted by tobacco smoke, and thus are subject to the health risks associated with ETS. Children exposed to ETS are 1.5–2 times more likely to start smoking themselves.

Tobacco smoke exposure is now known to cause health problems with several organ systems, including the lungs and heart, as well as have a high incidence of varying types of cancers. Pulmonary complications arising from tobacco smoke exposure range from long-term and irreversible problems like chronic obstructive pulmonary disease, to short term and reversible problems such as reactivity of the airways or impairment of motility of tiny hairs within the airways, called cilia, that filter out dust and other particulate matter. Chronic exposure to ETS can also lead to problems with breathing such as airway obstruction and impairment of an individual's ability to breathe without medications. Long-term ETS exposure can also increase the risk of development of lung cancers, many of which can be terminal.

While chronic exposure to ETS can lead to significant long-term pulmonary morbidity, even exposures of short periods of time can negatively affect an individual. Environmental tobacco smoke can trigger or exacerbate breathing problems in individuals with underlying medical conditions such as asthma. Particulate matter within ETS can irritate the lungs and make breathing more difficult or even cause an asthma attack in which the airways spasm, a potentially life-threatening scenario. Even for those without underlying respiratory issues, ETS can cause problems, as acute exposures can impair the proper function of airways causing breathing problems such as coughing, chest tightness, or wheezing.

In addition to pulmonary complications, ETS is a risk factor for cardiovascular disease. Tobacco smoke exposure can lead to atherosclerosis, or hardening of arteries, throughout the body causing problems that range from high blood pressure to coronary artery disease. Hardened arteries are less flexible and can manifest as high blood pressure, which may require pharmacologic interventions. Additionally, atherosclerosis in the periphery, such as the arteries in the legs, might lead to pain in the legs called claudication. When atherosclerosis occurs within the arteries of the heart, patients can experience chest pains and shortness of breath with exertion, or even heart attacks or death. Atherosclerosis of the arteries that supply blood to the brain can lead to mini-strokes called transient ischemic attacks (TIAs) or even debilitating strokes that might lead to one-sided weakness, an inability to speak, or death.

Not only has tobacco smoke exposure been linked to pulmonary and cardiac complications, but tobacco products are linked to several types of cancers. In addition to lung cancer, which has been linked to tobacco smoke exposure regardless of primary or environmental level, recent research has even suggested that ETS has a role in the development of breast cancer, nasal sinus cancer, and nasopharyngeal cancer in adults, as well as leukemia, lymphoma, and brain tumors in children.

As the health perils of ETS have become more apparent, the need for policies limiting ETS to nonsmokers has become warranted. The first in the line of limitations was a banning of smoking within public places. Recognizing that ETS places employees at significant health risk on a daily basis, the ban of smoking within office-based settings was one major step in eliminating ETS. Bars and restaurants in many states have followed suit, yet some states continue to allow smoking in public places. While smoking bans were the first step toward eliminating ETS, it is still very present in homes, especially those of disadvantaged populations.

Although restrictions of tobacco marketing increased within the USA, the 1980s and 1990s represented a time of increased marketing in developing countries including the rapidly developing Asian market. The marketing was clearly successful, as Marlboro was fighting with Coca-Cola to be the number one brand worldwide during this time. Although the damning health risks of ETS continue to mount, the tobacco industry continues to adapt its marketing strategies to enable continued growth and brand recognition.

The tobacco industry continues to prosper by using the same marketing tactics that made tobacco hugely popular within the USA. Philip Morris International (PMI) launched high tar and nicotine tobacco products in Indonesia. The higher tar and nicotine cigarettes are marketed as a rugged man's variant of the type of cigarette most frequently smoked by Indonesians and introduced them to the Marlboro brand. As the notion of harm from tobacco smoking has become more globally prevalent, the tobacco industry has also recycled marketing of filtered cigarettes or low tar products to 20 markets throughout the world (including Brazil, Ukraine, and Russia), despite the finding of a US federal district court that such a claim is fraudulent. The tobacco industry has also looked to marketing its products to youths by aligning itself with musical performances and concerts geared toward young people.

As the tobacco industry continues to expand its marketing to other countries, there will remain barriers to further progress in the prevention and elimination of ETS. Within the global setting, perhaps the largest obstacle to the reduction of tobacco product usage and ETS is the lack of knowledge and regulatory bodies limiting ETS to nonsmokers. Within the US immigrant population, multiple limitations exist to further reduction of tobacco use and ETS. These include, but are not limited to, the social acceptability of smoking in one's prior country, lack of health services, stress and coping mechanisms developed by immigrants of specific cultures, communication barriers to the harms of tobacco products and ETS, and socioeconomic status.

Related Topics

- ► Asthma
- ► Cancer
- ► Cancer prevention
- ► Cardiovascular disease
- ► Smoking
- ► Tobacco control
- ► Tobacco use

Suggested Readings

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Epidemiological Paradox

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The epidemiologic paradox describes a set of research findings showing that some groups of Hispanic immigrants to the United States have rates of mortality and health outcomes that are similar to native-born, non-Hispanic Whites and better than native-born, non-Hispanic Blacks. This pattern contradicts the standard social science model of racial and ethnic differences in health and mortality. This model understands elevated health risks and mortality levels of African Americans relative to Whites to be due to socioeconomic disadvantage and discrimination, which in turn influence a variety of proximate risk factors for health, including health behaviors, access to and quality of health care, and stress. Given this framework, and the fact that Hispanic immigrant groups are relatively socioeconomically disadvantaged in the United States, with particularly high levels of poverty and low levels of education, their health and mortality in comparison to other major racial and ethnic groups in the United States are paradoxical.

The epidemiologic paradox has been documented most clearly for Mexican-origin immigrants, the largest national origin immigrant group in the United States. Because Cubans are a relatively advantaged group, their good health outcomes in comparison to other groups are not considered paradoxical; because Puerto Ricans are a relatively disadvantaged group, their poor health outcomes in comparison to other groups are consistent with the social science model of racial and ethnic differences in health. A variety of health outcomes have been used to document the paradox, but most research has focused on infant birth weight and mortality and adult mortality.

Three explanations have been offered for the paradox. Although these explanations are distinct, they are not incompatible, and they have all found support in empirical research studies. The first involves data issues. Mortality rates may be downwardly biased by the incorrect reporting of racial identity on death certificates, namely, Hispanic deaths may be incorrectly counted as White or Black deaths. More importantly, Hispanic immigrant deaths may go unrecorded in US vital statistics data because of the selective return migration of the sickly and/or elderly to their countries of origin, which has been called the salmon bias. Analyses of Medicare data that exclude return migrants show that conventional estimates of Hispanic mortality rates are too low, but the paradox pattern in Mexican immigrant adult mortality rates is still observed even when accounting for this source of bias. The paradox pattern has also been shown in Mexican immigrant infant mortality rates as early as 1 hour following the birth of the child, when return migration to Mexico is practically impossible.

The second explanation argues that immigrant culture protects immigrant health by proscribing certain health behaviors – in particular, the use of tobacco and alcohol, especially among women – and emphasizing kin and co-ethnic networks as sources of support. Studies have shown that immigrant health deteriorates over time in the United States, suggesting a process of unhealthy acculturation to US norms and behaviors. Across all racial and ethnic groups in the United States, immigrants have lower mortality than their native-born counterparts, which is consistent with the idea of unhealthy acculturation, although cross-sectional differences may reflect differences in the composition of immigrant groups arriving at different points in time, rather than a process that unfolds over time. Regression to the mean has been posed as an alternative explanation for native-immigrant differences. The culture argument is also limited by the fact that nonmigrants in sending countries are not equally protected – in other words, immigrants' health is not only better than that of those they encounter in their country of destination, but also better than the health of those they leave behind, who are presumably protected by the same culture.

This last pattern suggests the third and final explanation for the immigrant health paradox, which is that immigrants are a selectively healthy group. Most simply, the idea is that healthy people will be more likely to migrate than unhealthy people. Immigrants are likely also selected on a number of unmeasured characteristics that positively affect health, such as a sense of efficacy (or control over destiny), tolerance for risk, and a positive outlook. An ideal test of this hypothesis requires data on emigrants and nonmigrants in the sending community. Unique pooled origin-destination data on infant mortality among Puerto Ricans shows a clear pattern of selective migration in which recent Puerto Rican migrants to the United States have a lower risk of infant mortality than either women on the island or women who migrated to the mainland several years earlier. A recent study of households in Mexico, however, showed small and largely insignificant differences in the health of emigrants and nonmigrants.

Related Topics

- ► Birth weight paradox
- ► Health disparities
- ► Hispanic health paradox
- ► Immigrant health disparities

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Epilepsy

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Epilepsy is a common chronic neurological disorder characterized by recurrent unprovoked seizures. Seizures are transient signs and/or symptoms of abnormal, excessive, or synchronous neuronal activity in the brain. In primary practice, epilepsy ranks as the second most commonly reported neurological condition worldwide. Epilepsy affects quality-of-life in patients and their caregivers and can result in high societal costs through loss of work productivity and high medical care expenditures.

Epidemiology of Epilepsy

The prevalence of epilepsy in developed countries ranges from 4 to 10 cases per 1,000. Studies in developing and tropical countries have reported higher prevalence rates of epilepsy, ranging from 14 to 57 cases per 1,000 persons, for example, in Panama, Ecuador, Colombia and Venezuela. The median incidence rate of epilepsy in developed countries ranges between approximately 25 and 50 per 100,000 person-years while in developing countries it ranges from approximately 30 to 115 per 100,000 person-years. The reason for the high reported rates in developed countries is probably related to methodological aspects of the studies, but in some regions in the world, specific infectious causes such as neurocysticercosis (a parasitic illness) are endemic.

In developed countries, the incidence of epilepsy tends to exhibit a U-shaped curve with the highest rates in children and in the elderly. This same pattern has not been found in developing countries, where the incidence of epilepsy appears to peak in early adulthood.

SMR (Standard Mortality Ratio) in epilepsy ranges between 1.2 and 9.3 and depends on study methods and population. It should be noted that most data on mortality in epilepsy is derived from industrialized countries. Overall the information that proves that mortality is increased in patients with epilepsy versus different type of controls is very solid and comes from well-designed controlled studies.

A study in the Canadian population showed that the prevalence of epilepsy was higher in Whites and nonimmigrants compared with immigrants. Possible explanations for the lower prevalence of epilepsy in Canadian immigrants may be that people with epilepsy are less likely to migrate for health-related, personal, or regulatory reasons.

Given that the incidence and prevalence of epilepsy in developing countries is high compared with developed countries, it is possible that patients without epilepsy who start living in a developed country may decrease their risk to develop epilepsy by changing their environment and avoiding exposure to some factors such as potential infectious causes of epilepsy.

Types of Epilepsy

Seizure types are classified first according to the source of the seizure within the brain. Seizures could be localized (partial or focal-onset seizures) or generalized seizures. Partial seizures are further divided on the extent to which consciousness is affected and the localization. If the level of consciousness is not affected during the seizure, they are classified as simple partial seizures; when consciousness is affected they are called complex partial seizures. Partial seizures can also be localized in different parts of the brain, such as seizures originating in the temporal, parietal, occipital, or frontal lobes of the brain. A partial seizure may spread within the brain, a process known as secondary generalization. Generalized seizures are divided according to the effect on the body but all involve loss of consciousness. These include seizures of various types including absence (petit mal), myoclonic, clonic, tonic, tonic–clonic (grand mal), and atonic seizures.

Causes of Epilepsy

Different causes of epilepsy have been described in some age groups. During the neonatal period and early infancy the most common causes include CNS infections, hypoxic brain injury (due to lack of oxygen supply to the brain), diverse encephalopathies (generalized brain dysfunction), trauma, congenital CNS (central nervous system) abnormalities, and metabolic disorders. During late infancy and early childhood, febrile (fever-related) seizures are common, but also other causes like CNS infections and trauma. In addition, during childhood there are well-defined epilepsy syndromes.

During adolescence and adulthood, CNS lesions and idiopathic epilepsies (epilepsy of unknown cause) are less common. Some causes that are frequent in this age group are trauma, brain tumors, illicit drug use, and alcohol withdrawal. In older adults, cerebrovascular disease is the most common cause. Other causes include CNS tumors, trauma, and degenerative diseases such as Alzheimer's.

In some regions of the world, particularly in resource-poor countries, epilepsy may be related to infection such as malaria, neurocysticercosis, paragonomiasis, and toxocariasis. Overall neurocysticercosis (brain infection due to parasitic infection) has been recognized as the most frequent cause of seizures around the world.

The cause of epilepsy is an important consideration for immigrants, especially for those migrating from developing to developed countries. Some causes of epilepsy, such as neurocysticercosis, that are highly prevalent in developing countries are now recognized in developed countries. An example of this situation is the occurrence of several cases of neurocysticercosis in the south of the United States, clearly related with the migration of Mexicans and other people from Latin America where neurocysticercosis is an endemic disease and the most common cause of seizures.

Epilepsy Diagnosis

Physicians have to confirm the diagnosis of epilepsy, in order to provide adequate treatment for patients. Conditions that can mimic seizures are syncope (sudden drop in blood pressure leading to loss of consciousness), pseudoseizures (seizures that have psychological origin), migraine, and less frequently transient ischemic attacks (sudden, brief stroke-like phenomena). The initial evaluation includes a detailed neurological examination, routine EEG (electro encephalogram/ brain-wave recording), and brain imaging (CT or

MRI). Potential candidates for epilepsy surgery will require other tests such as positron emission tomography (PET), single photon emission computed tomography (SPECT) single intracarotid sodium amobarbital test (Wada test), functional MRI, or magnetoencephalography (MEG) as supplementary tests. Some patients will require an invasive investigation to localize the seizure onset and focus via a procedure that involves placing electrodes on top of the brain. Brain mapping using electrocorticography is another procedure used in the process of invasive epilepsy testing in some patients. Immigrants with epilepsy who have the opportunity to arrive to developed countries may benefit from availability of such advanced diagnostic tests, in addition to highly trained specialists.

Treatment

Epilepsy is usually treated with medications. An accurate differentiation between generalized and partial seizures is important in determining the best treatment for the patients. In many cases anticonvulsant medications will be lifelong and can be associated with major effects on quality-of-life. The choice among anticonvulsants and their effectiveness differs by epilepsy syndrome. For many years few anticonvulsants were available for patients. Currently there are close to 20 medications available to treat patients with epilepsy and most of them appeared after 1990. The medications available for use in patients with epilepsy are carbamazepine, clonazepam, ethosuximide, felbamate, fosphenytoin, gabapentin, lacosamide, lamotrigine, levetiracetam, oxcarbazepine, phenobarbital, phenytoin, pregabalin, primidone, tiagabine, topiramate, valproic acid, and zonisamide. Medications released after 1990 are called the second generation of antiseizure medications and the most commonly used treatments are lamotrigine, topiramate, and levetiracetam. Compared with the first generation of anti-epileptic drugs, the second generation has a similar efficacy to control seizures, although the side effects profile may be better.

The main goals of epilepsy treatment are to decrease the frequency and severity of seizures and to avoid side effects. Many patients can be treated adequately with one anti-seizure medication (monotherapy), although some will require the use of two or more medications to control seizures (polypharmacy). It is very important to measure serum levels of epilepsy medication to evaluate adherence (compliance), to determine drug interactions, and to correlate potential side effects in patients. Children or adults with cognitive problems may benefit from routine screening of drug levels.

In many developing countries only two or three medications are available to treat seizures. The benefits of antiepileptic drugs for immigrants with epilepsy that arrive to developed countries and have access to a wider array of epilepsy treatments are significant. The term refractory or intractable epilepsy is used when a person with epilepsy cannot be brought under control after two adequate trials of different drugs. A classical study of patients with previously untreated epilepsy demonstrated that 47% achieved control of seizures with the use of their first single drug and 14% became seizure free during treatment with a second or third drug.

Epilepsy surgery could be an option for patients whose seizures remain resistant to treatment with antiepileptic drugs. The best candidates for epilepsy surgery are patients with focal abnormalities that can be located and therefore removed. The goal for these procedures is total control of epileptic seizures, and many patients will require anticonvulsant medications after surgery.

The main goal of the evaluation for epilepsy surgery is the location of the epileptic abnormality, in order to determine if surgery will affect normal brain function. The most common surgeries are the resection of lesions such as tumors, arterial-venous malformations (abnormality of blood vessels in the brain), and other lesions that are closely related with epileptogenic areas.

The most common type of intractable epilepsy is temporal lobe epilepsy, and the most common procedure is the anterior temporal lobectomy, which includes the resection (removal) of the whole temporal brain region or other related surgical treatments. Surgery for temporal lobe epilepsy is effective, durable, and results in decreased health care costs. Approximately 60–70% of patients are seizure free after surgery for temporal epilepsy.

Epilepsy surgery in developing countries is compromised. The lack of equipment, specialists, and advanced therapies impedes the possibility for many patients to have epilepsy surgery. A significant advantage of immigrants with epilepsy coming to a developed country is the possibility of having much-needed epilepsy surgery. However, some immigrant groups may not have health insurance or may not live in areas where specialized epilepsy surgery care is available. These immigrants may continue to have negative outcomes due to lack of health care access.

Other Epilepsy Treatments

The ketogenic (high fat, low carbohydrate) diet has been used mainly in some children with severe, medically intractable epilepsy. The mechanism of action is unknown, but its efficacy is well recognized for patients with intractable general epilepsy during childhood.

Electrical brain stimulation has also been used extensively in recent years to treat patients with epilepsy. Vagus nerve stimulation (VNS) is given with a computerized electrical device similar in size, shape, and implant location to a heart pacemaker. The device is connected to the vagus nerve in the neck producing stimulation in the brain. All the evidence suggests that 50% of patients experience improvement in seizure frequency and also there is improvement in severity. The success rate is not as good as epilepsy surgery, but it becomes a good alternative for patients who decline epilepsy surgery, patients that failed to respond to epilepsy surgery because of different reasons, and patients who are not candidates for epilepsy surgery.

Deep brain stimulation is another treatment for epilepsy. Other therapies such as the use of the Gamma Knife or other devices used in radiosurgery are currently under investigation as alternatives for treatment in some patients.

While all of these newer therapies such as vagus nerve stimulation, deep brain stimulation, and ketogenic diet are promising, most of them are not available in many developing countries. All of them require highly trained specialists and expensive equipment.

Related Topics

- ► Compliance
- ► Disability
- ► Health disparities
- ► Healthy immigrant
- ► Immigration in the global context

Suggested Readings

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Carpio, A., & Hauser, W. A. (2009). Epilepsy in the developing world. *Current Neurology and Neuroscience Reports, 9*, 319–326.

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Suggested Resources

Epilepsy Foundation (USA). http://www.epilepsyfoundation.org/

International League Against Epilepsy. http://www.ilae-epilepsy.org/

ESL

► English as a Second Language

Ethiopia

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Tenasystillin! This short greeting, the most common one in Ethiopia, is roughly translated as "May God grant you health," and speaks volumes about the importance of good health and well-being to Ethiopians. However, health in Ethiopia and among its diasporas is better understood in the context of Ethiopia's history, geography, culture, and other relevant factors. Although a comprehensive discussion of such factors is beyond the scope of this chapter, a brief overview is presented below in the hope that it will give the readers a better understanding of the important health-related successes and challenges faced by Ethiopian immigrants and emigrants.

Background

Ethiopia, formerly known as Abyssinia and now officially called the Federal Democratic Republic of Ethiopia, is located in a region of northeast Africa (the Horn of Africa). It is a land-locked country that shares its borders with Eritrea, Djibouti, Somaliland, Somalia, Kenya, and Sudan. As of 2009 estimates, Ethiopia's population is approximately 85 million, with more than three million people living in the capital of Ethiopia, Addis Ababa, which is located in the center of the country. In terms of size, Ethiopia is roughly one-and-a-half times the size of the US state of Texas or slightly smaller than France and Spain combined. The Ethiopian landscape is quite varied. Prominent features include the Afar desert in the northeast to various mountain ranges, for example, Simien Mountains in the west and Bale Mountains in the southeast. Rift Valley bisects the Ethiopian Highlands from a northeast to southwest direction. Ethiopia's geography plays a significant role in the prevalence of various medical illnesses in certain parts of the country. For instance, in the highlands, malaria typically follows the end of the rains, whereas it is endemic in the lower areas.

Administratively, Ethiopia is divided into nine regional states and two city administrations. As many as 80 different ethnic/linguistic groups make up the population of Ethiopia, with the major groups being the Oromo, Amhara, Tigrai, Sidamo, Gurage, and Somali. By some estimates, over 80 languages are spoken in Ethiopia, with the most significant being Amharigna (Amharic), Tigrigna, Oromifa (Oromigna), Somali, and English. The main religions in Ethiopia are Christianity (∼50–60%) and Islam (∼33%). The latter is mostly concentrated in the eastern part of the country.

Ethiopia is one of the oldest independent countries, not only in Africa, but also in the world. With the exception of a brief Italian occupation from 1936 to 1941, it has maintained its independence for centuries. Emperor Haile Selassie, who had ruled Ethiopia from 1930, was deposed in 1974 by a military junta, the Derg. A social state was established by the Derg, which was toppled in 1991 by the Ethiopian People's Revolutionary Democratic Front. Four years later Ethiopia's first multiparty elections were held, and Meles Zenawi was elected the Prime Minister. In 1993, with the help of the United Nations, a referendum on Eritrean independence was held. Due to overwhelming support, Eritrean independence was declared in May 1993. Five years later, a border war with Eritrea broke out, which lasted until 2000.

A broad overview of health in Ethiopia requires taking into consideration current trends related to population and health. Based on 2009 estimates, Ethiopia is one of the ten fastest growing countries in the world, with a population growth rate of approximately 3.2%. It also has one of the highest birth rates in the world with 43.66 births/1,000 population and a total fertility rate of 6.12 children born/woman; both of these indicators are among the top ten in the world. On the other end, the death rate is about 11.55 deaths/1,000 population and the net migration rate is −0.02 migrant(s)/1,000 population.

Regarding migration, due to various issues like famines, lack of economic opportunities, and political instability, many Ethiopians left their homeland and settled in neighboring countries, as well as many faraway lands, especially the United States, Canada, Europe, and Israel. More recently, many Ethiopians have started to return and it is expected that the repatriation of Ethiopian refugees residing in Sudan will continue for several years. Furthermore, Ethiopia itself also served as a haven for many refugees from the surrounding countries, most of whom were escaping similar problems in their own lands. The number of refugees in Ethiopia is estimated to be approximately 100,000 with Sudan being the single largest country of origin for the refugees (about 67,000). Somalia and Eritrea are also major sources of refugees to Ethiopia. As with Ethiopian emigrants, many refugees are also starting to return to their homes. It is estimated that the number of internally displaced persons in Ethiopia is at least twice the number of refugees. This is the result of the abovementioned border war with Eritrea, as well as ethnic clashes in various regions. Not surprisingly, access to health care among refugees and internally displaced persons tends to be lower than the general population, and metrics of health in these populations – rarely available – tend to be among the lowest.

As with the native population, travelers and immigrants to Ethiopia are the beneficiaries of recent improvements in Ethiopia's public health system, while still having to contend with its current limitations. To fully appreciate the recent public health advances in Ethiopia, it is helpful to consider its history. The foundations of the public health system in Ethiopia were laid in the early 1940s and in 1947 the Ministry of Public Health was officially established. As recently as 1953, there was not a single Ethiopian physician in the country, and all physicians were foreigners (estimated to be about 80 at that time). To respond to this challenge, the government devised a formal public health policy in the early 1960s with the aid of the World Health Organization (WHO). Ethiopia's public health system has made huge strides in the last 50 years or so, though certain aspects remain underdeveloped. These are discussed in more detail below.

Public Health Successes in Ethiopia

The current public health approach in Ethiopia is based on the Health Sector Development Programme (HSDP), which consists of a 20-year health development approach, broken down into 5-year programs. The goals of these programs, among others, include further developing preventive health care, increasing access to health care for rural populations, increasing health care capacity, and a greater cooperation between government and other entities, such as nongovernmental organizations and the private sector.

One feature of HSDP that has had remarkable success is the Health Service Extension Programme (HSEP), which was started in 2003. Under the HSEP, two female health extension workers in each "kebele" (the smallest administrative unit covering a population of approximately 5,000) perform outreach work, focusing on four aspects of public health: hygiene and sanitation, disease prevention and control, family health services, and health education and communication. To date, approximately 25,000 workers have been trained and deployed. Although the initial goal of achieving universal primary health care coverage by the year 2008 with the HSEP was not met, the coverage of publicly funded health care arose from 61% in 2003 to 87% in 2007. Furthermore, Tewodros Adhanom, Ethiopia's Minister of Health, stated in 2008 that Ethiopia is expected to achieve universal primary care by 2010.

Given the limited scope of this chapter, an overview of public health challenges facing Ethiopia can be given via a discussion of Millennium Development Goals (MDGs). MDGs consist of 8 international development goals that all 192 UN member states have agreed to achieve by the year 2015. As three of the eight MDGs are directly related to health – child health, maternal health, and disease control – progress in achieving these goals, or lack thereof, is often helpful in monitoring certain aspects of public health. More specifically, MDG4 aims to reduce child mortality, with a target of reducing under-five mortality rates by two-thirds over the period 1990–2015. MDG5 aims to reduce the maternal mortality ratio (MMR) by three quarters over the period 1990–2015. MDG6 aims to have two targets achieved by 2015: (1) to have halted, and begun to reverse, the spread of HIV/AIDS; and (2) to have halted, and begun to reverse, the incidence of malaria and other major diseases.

Based on the last national major health survey done in Ethiopia in 2005, under-five mortality rate declined from 204 to 123/1,000 live births between 1990 and 2005. This is significantly better than the rate achieved by Sub-Saharan Africa as a whole, where the mortality rate declined from 184 to 158/1,000 live births. Likewise, the infant mortality rate in Ethiopia also declined from 122 to 77/1,000 live births in 2005. Though this remains high in comparison to some other countries – for instance, the rate in the United States is 6.22 and in Japan it is 2.79 – this downward trend is much steeper (better) than the decrease observed in Sub-Saharan Africa (99/1,000 live births). Often the measles immunization rate is used to measure progress toward MDG4. In Ethiopia, the coverage rates arose from 38% in 1990 to 72% in 2007, versus from 56% to 72% in Sub-Saharan Africa. Overall, under-five mortality rate decline appears to be on task for achieving MDG4.

Regarding MDG5 of reducing MMR, based on local surveys (national survey results not available) it is estimated that MMR was 1,400 deaths/100,000 live births in 1990. Based on the national health survey of 2000, MMR was 871 deaths/100,000 live births. This had been reduced to 673 deaths/100,000 live births per 2005 national survey. In Sub-Saharan Africa, there was negligible progress during this time and in 2005 the rate was 900 deaths/100,000 live births. Other indicators of maternal health, such as prenatal coverage and the percentage of deliveries assisted by a skilled attendant, also improved in Ethiopia during this time, though not so in Sub-Saharan Africa. Overall, MMR appears to be declining, as a firm conclusion cannot be based due to lack of national survey data from 1990 and due to various statistical issues with the other data.

Regarding the HIV/AIDS aspect of MDG6, HIV prevalence had remained stable at around 2% over the last 5 years – the average for Sub-Saharan Africa is approximately 6%. The number of people with HIV/AIDS who are receiving antiretroviral therapy increased from 3,880 in 2004 to 109,930 in 2007. This coverage rate is estimated to be 41%, which is higher than the coverage rate of Sub-Saharan Africa (30%). The TB case detection rate increased from 15% in 1995 to 34% in 2007. This is substantially lower than the average detection rate in Sub-Saharan Africa (48%) and international standards (70%). Likewise, the TB treatment success rate increased from 61% in 1995 to 84% in 2007. This compares favorably to the treatment success rate in Sub-Saharan Africa (76%) and is nearly the same as the international standard of 85%. Regarding malaria, a substantial reduction in malaria morbidity and mortality was observed in Ethiopia. Overall, there appears to be good progress regarding controlling HIV/AIDS and malaria, though TB detection rates remain below international standards.

Public Health Challenges

In terms of health-related indicators, Ethiopia has made substantial progress on many fronts, though many daunting challenges still remain. Poverty remains a significant challenge for Ethiopia as it is one of the poorest countries in the world. According to the United Nations Development Program (UNDP) Human Poverty Index, Ethiopia ranks 99 out of 103, with 45% of the people living below the poverty line. In 2000, the WHO estimated that "As a proportion of GDP, Ethiopia's public sector spending on health between 1990 and 1996 (1.2%) was at the 25th percentile of African countries, and below average for lowest-income Africa. . .In real terms, this translates into less than US$ 2 per capita. . ." More recent data indicates that per capita spending has been increased, though it remains less than US$ 5. By some estimates, a basic package of health services costs approximately US$ 13, a substantially higher sum. Not surprisingly, Ethiopia continues to face significant public health challenges, including having one of the lowest rates of supervised deliveries in Africa, low contraceptive prevalence, and some of the highest rates of malnutrition and fertility in Africa. According to 1995 estimates, about 75% of the population suffered from preventable communicable diseases and malnutrition. Life expectancy at birth for the total population is 55.41 years, which is among the lowest in the world. The majority of the population continues to reside in the rural areas, which poses significant challenges for public health outreach efforts, especially given the limited transportation infrastructure. Regarding MDG-related specific health care challenges, although service coverage has increased over time, improvements have not been uniform. For instance, routinely scheduled services, such as immunizations, have improved significantly more than those that rely on 24-h availability of clinical services, such as skilled care at birth, which is considered the single most important factor in reducing maternal mortality. As mentioned above, TB control also remains a significant challenge. According to WHO, Ethiopia is one of the top three in Africa with regard to incident cases of TB. Due to inadequate infrastructure, a dearth of health personnel, and limited health education and awareness in the community, the TB detection rate in Ethiopia remains inadequate to meet the target for TB control. Despite improvement in HIV/AIDS related care, prevention of mother-to-child transmission of HIV/AIDS in Ethiopia is only 10%.

Although the nonphysician health care workforce has increased significantly, Ethiopia continues to have one of the lowest physicians-to-population ratio. As per WHO, Ethiopia is estimated to have fewer than 0.03 physicians/1,000 population overall, which places it among the bottom. Given that physician coverage in rural areas tends to be much lower than urban areas, this ratio is likely to be much worse in certain settings. Furthermore, the health care workforce itself is not immune to the illnesses and diseases prevalent in the population. Recent data from Ethiopia, Kenya, Malawi, Mozambique, and Zimbabwe show that 43% of deaths or medical retirement of health workers were known or suspected to be caused by HIV/AIDS, and 37% were known or suspected to be due to tuberculosis.

Other challenges include a high female illiteracy rate (75%), poor access to sanitation (10% of the population has access to safe sanitation), and poor access to safe water (27% of the population has access to safe water). Many of these factors affect both natives and immigrants equally. For instance, many major infectious diseases pose a potentially high risk for those who immigrate to Ethiopia. HIV/AIDS certainly has a significant presence in the country as mentioned above. In Ethiopia, the primary mode of HIV transmission is heterosexual contact. As such, women are more vulnerable to infection than men, with urban women at highest risk. In rural areas the difference between genders appears to be negligible. Other subpopulations at higher risk for HIV infection include people in prostitution, police officers, and members of the military. Food- or waterborne diseases, such as bacterial and protozoal diarrhea, hepatitis A and E, and typhoid fever, also occur commonly. Malaria remains a significant concern, particularly for immigrants and travelers to certain parts of Ethiopia. Other infectious diseases that require precaution are meningococcal meningitis, rabies, and schistosomiasis.

Health Among the Ethiopian Diaspora

Due to the widespread emigration of Ethiopians to various regions of the world and the lack of large, high-quality studies of the medical problems facing them, there are significant challenges in drawing overall conclusions that are applicable to all groups. However, information is available regarding Ethiopians living in certain places, which does allow for some meaningful observations. Ethiopian immigration to the United States, for the most part, is a relatively recent phenomenon, essentially starting in the early 1980s. The Refugee Act of 1980 was the first formal policy the United States adopted toward the African refugees. Soon after, Ethiopians started to voluntarily arrive to the United States and, along with Eritreans, formed the largest refugee group until 1999. Migration data indicates that approximately 65% of the immigrants are male. Most immigrants identify themselves as Christians, are from urban areas of Ethiopia, and are from Amharic-speaking linguistic groups. Different sources give various estimates of the number of Ethiopians living in the United States, though the most reliable estimate is 350,000–500,000. The largest number of Ethiopians live in Washington, D.C., with Los Angeles, New York City, Dallas, Houston, and the San Francisco Bay area also housing a significant number. In general, Ethiopians living abroad have better access to health care than their native counterparts, though it should be kept in mind that most Ethiopian immigrants still lack access to a primary care physician.

Overall, Ethiopian immigrants, especially those who are new immigrants, tend to have similar medical problems as seen in other similar immigrant and refugee groups. A study that examined the global health status of Ethiopian immigrants living in Boston and Washington, D.C. found that 72% of the studied sample had a positive PPD test (a test used to detect tuberculosis), though only 1% had active tuberculosis. These rates were consistent with those found in Ethiopia at that time. Other significant laboratory abnormalities included intestinal parasites (about 37%), anemia (about 15%), eosinophilia (14%), positive syphilis serology (7.5%), and hepatitis B surface antigenemia (9.4%). Much of these data are comparable to that collected in Ethiopia.

HIV/AIDS remains a significant concern among Ethiopian immigrants, much like it is for the Ethiopians in Ethiopia. Although the data are limited, Ethiopian and Eritrean immigrants seem to have the highest reported cases of AIDS among all African immigrant groups in the United States. As HIV/AIDS data for African immigrants is included with African Americans, it is difficult to obtain such data pertaining only to Ethiopian immigrants residing in the United States. A study conducted in California regarding HIV/AIDS related attitudes and behaviors among Ethiopian immigrants found that there is a general awareness of HIV/AIDS among Ethiopian immigrants, though they have limited insight into their own HIV risk behaviors. On the plus side, most Ethiopian immigrants are aware of the risks of blood contact and sexual modes of HIV transmission. However, a number of them also incorrectly believed casual contact, kissing, and sharing eating utensils can cause HIV transmission. Furthermore, overall, they determine whether someone is at high risk for HIV by appearance and social standing.

A significant number of Ethiopian immigrants believe that HIV/AIDS in the United States is a disease of prostitutes, drug users, and homosexuals. Most believe that HIV/AIDS in heterosexuals is a problem only in Africa and would not affect them in the United States. Like in many parts of Ethiopia, Ethiopian immigrants who test HIV positive in the United States tend to keep it a secret from family and friends for fear of stigma and isolation. Ethiopian immigrant women generally are not able to ask men about their sexual history or about using condoms; this places them at a potentially higher risk for HIV transmission. Due to the prevalence of gonorrhea and syphilis in Ethiopia most immigrants tend to be aware of these sexually transmitted infections. However, their knowledge of other sexually transmitted infections is limited. As a group, the Ethiopian male immigrants report engaging in high-risk behaviors, including, not using condoms, having multiple sexual partners, and consuming alcohol.

Needless to say, immigration is a major life stress event, and overall it has been associated with an increased likelihood of being diagnosed with a mental health problem. Although mental health can be difficult to study across cultures, some studies of Ethiopian immigrants have been conducted and have revealed important information. A study of Ethiopian immigrants in Canada found that over the course of a year 85% of the studied population used one or more type of health services. However, only 12.5% of individuals with a mental disorder (defined as depression, anxiety, and/or posttraumatic stress disorder) received services from formal health care providers. Furthermore, a metaanalysis of 7,000 refugees, many of whom were Ethiopians, found that "refugees resettled in western countries could be about ten times more likely to have posttraumatic stress disorder than age-matched general populations in those countries." Due to the nature of this study, it is not possible to conclude with certainty that this specific conclusion is applicable to the Ethiopian immigrants. However, there are much data indicating that the rates of posttraumatic stress disorder, and often depression and anxiety as well, among immigrants are higher than the general population. At least one study, conducted in Israel, has found higher rates of suicide among the population of the Ethiopian immigrants in Israel, in comparison to other immigrant groups there.

Traditional Medicine and Beliefs

Although space constraints do not allow a detailed discussion of traditional medicine and medical beliefs among Ethiopians, and thus, Ethiopian immigrants, it is important to note that cultural beliefs and norms play a huge role in their lives. For example, much like in many Asian cultures, the concept of patient autonomy and the patient's "right to know" is a limited one. In fact, among Ethiopian immigrants it is not unusual for the family to withhold certain information from the patient. When it comes to disclosing bad news, the priority is not to necessarily disclose the information rapidly or promptly, but rather, in "an appropriate" time, place, and manner. So, for instance, unless it requires immediate attention, tragic news is often not told in the evening and is often deferred to the morning when the recipient of the news may be surrounded by friends and family. Furthermore, results of tests and other medical information are often disclosed not to the patient first, but the family, who in turn may give the information to the patient. Denial may be employed frequently by patients and their families so as to minimize the distress from an imminent death. Likewise, it is not unusual that at times Ethiopian immigrants may even expect their Western physicians to withhold certain information or to only partially disclose information so as to not undercut a patient's hope or will to fight the illness.

Other traditional beliefs that many Ethiopian immigrants carry with them to their new home countries include the concept of health being a state of equilibrium within the body and between the body and the outside. This equilibrium is delicate and can be disturbed by numerous factors, for example, excessive heat or cold, the sun, worms, and eating or drinking too much. For example, many Ethiopian immigrants believe that when the sun strikes a part of the body that is sweating or unclean, *mitch* ("sunstroke") can develop, which manifests as irritation or rash. Many Ethiopians also believe that the heart regulates other organs in the body by producing heat that radiates throughout the body, and prolonged excess of cardiac activity can cause *lib dekam* or "tired heart," which manifests as chronic fatigue.

In part of Ethiopia, a large number of children (as high as 80–90%) have had their uvulas removed due to the belief that if a sore throat develops and the baby still has his or her uvula, the baby will suffocate. As this procedure is often done without sterile conditions – by a traditional healer, using scissors, horsehair, or a special knife – it is possible for the baby to develop tetanus, meningitis, or sepsis. In the Gondar region, in response to eye disease, eyebrows are often cut vertically and blood is allowed to flow into the eyeballs as a treatment. There have been documented cases of Ethiopian immigrants refusing transparent bottles for their babies. This is due to the Ethiopian belief that some people carry *buda* or the "evil eye" and they can poison a substance by looking at it. Therefore, a translucent bottle is preferred to guard against this. Multiple sources have also documented that Ethiopians generally prefer injections to tablets. There also exist some traditional beliefs around pregnancy. For instance, many Ethiopians believe that a woman can be pregnant for more than 9 months and that during menopause, a woman can have a pregnancy that "turns to bone." Amharic Ethiopians especially believe that the stomach does not digest on its own but instead houses Ascaris worms whose job is to transform food into waste.

Touching upon two issues discussed above, HIV/AIDS and mental health, two traditional beliefs are important. In Ethiopia, sexually transmitted infections are often attributed to other factors besides sexual intercourse. This includes contagion from a female dog, urinating facing the full moon, or urinating on a hot stone or where a female dog recently urinated. Many also believe that these infections are cured by drinking sheep fat, cactus milk, by having multiple sexual partners (to "weaken" the disease), washing lesions with the blood of a goat, or drinking one's urine. Needless to say, some of these beliefs can unfortunately delay appropriate treatment, exacerbate the symptoms, and lead to further transmission. Mental illness is often attributed to evil spirits and often treated with holy water and exorcism. Spirit possession or *zar* occurs more often in women than men, and the possessed individual often presents in a manner which would be often considered psychotic in Western countries. *Zar* can be appeased by bribery (food items, clothes, beads and such), though there is no cure per se.

Finally, the issue of female genital mutilation/circumcision needs to be mentioned as this remains a significant problem among native Ethiopians and is being seen more and more by Western health care providers due to increased contact with Ethiopian immigrants. The underlying belief is that a woman with an intact clitoris is likely to be hyperactive and hypersexual. Though obviously inaccurate, unfortunately this belief is widespread. By some estimates, in certain parts of Ethiopia, the rates of this practice are as high as 90%. Three types of female mutilation/circumcision are practiced in Ethiopia. This includes clitoridectomy, in which the clitoris itself or the hood of the clitoris is removed. Excision involves the removal of the clitoris, as well as a partial or total removal of the labia minora. Infibulation involves excision along with the removal, or scraping, of the inner walls of the labia majora. The two sides are joined together, leaving a hole smaller than a grain of corn for the voiding of urine and the passing of menses. Various parts of Ethiopia practice these different procedures.

In the southern region of Ethiopia, as well as some other parts, female genital mutilation/circumcision is not practiced. Though no firm data are available as to how often this practice is still being carried out by immigrants in their adopted countries, at least one study indicates that most Ethiopian women in Israel have undergone this practice. More and more Western health care providers are recognizing that this practice is still being performed outside Ethiopia and are speaking against it. However, a small minority has argued that since many immigrant parents insist on this practice taking place, it is better for these types of procedures to be done by Western providers, using sterile conditions and anesthesia, so as to minimize pain, risk of infections, and other potential complications. Others, however, have strongly argued against Western providers playing any role in these types of procedures, and there has been a push to prosecute parents who force this procedure upon their children.

Conclusion

Ethiopia is an ancient country with a rich past and potentially a very bright future. At present, it faces some big public health challenges, while it continues to make significant gains at the same time. Emigrants to Ethiopia are certain to be drawn into Ethiopia's tug of war with HIV/AIDS, malnutrition, poverty, maternal and child health, access to clean water and sanitation, and so on. At the same time, they have the historical opportunity to watch Ethiopia advance on many fronts, as detailed above, which have improved, and will continue to improve, the lives of its people and raise standards of living to new heights. Likewise, the Ethiopian diaspora is part of a historical and exciting trend in the world, where migrations of people to lands thousands of miles away from their native land is happening at an unprecedented scale. No doubt Ethiopian immigrants have much to offer to the lands where they settle, bringing with them the incredible diversity of their culture. However, as with any other group of people, not all of their beliefs and behaviors are ideal, and many are or will be in conflict with the mores and values of their adopted lands. The difficult, but also rewarding, task of reconciling various belief systems has already begun, though it remains to be seen how – or even if – it will ever end.

Related Topics

- ► Acquired immune deficiency syndrome
- ► Africa
- ► Internally displaced persons
- ► Refugees
- ► Sanitation
- ► Tuberculosis
- ► Water

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Ethnic Cleansing

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Ethnic cleansing is the attempt to eliminate an unwanted ethnic group or groups from a society within a geographic area with the intent of creating ethnic homogeneity. This may occur through forced migration, deportation, or forcible displacement of persons belonging to a particular ethnic group(s). The term is also used broadly to describe all forms of ethnically motivated violence, inclusive of murder, rape, and torture. Ethnic cleansing may encompass removal of all physical remnants of the targeted group through destruction of monuments, cemeteries, houses of worship, and other edifices. Some definitions are broader in scope to also include genocide, the deliberate and systematic destruction of a racial, political, or cultural group. In that case, ethnic cleansing may be considered a continuum ranging from forced emigration and population exchange to deportation and genocide.

Others consider genocide distinctly separate or different, but related in that ethnic cleansing can lead to genocide, with mass murder used to "cleanse" the land of a particular ethnic group. The intent of the perpetrator should be used to distinguish the two: for genocide, the goal is the destruction of the unwanted ethnic, racial, religious, or political group; for ethnic cleansing, the goal is ethnically homogeneous lands. On the other hand, in 1992, the U.N. General Assembly declared ethnic cleansing to be "a form of genocide."

A literal translation of the Serbo-Croatian phrase *etnicko ciscenje*, the term “ethnic cleansing” first became widely used in the 1990s to describe the brutal treatment and mass killings of various ethnic civilian groups, including Bosniacs (Bosnian Muslims), Serbs, and ethnic Albanians, in wars that erupted in areas of the former Yugoslavia: Bosnia, Herzegovina, the Krajina region of Croatia, and the Serbian province of Kosovo. The term was also used in 1999 to describe violent treatment by Indonesian militants of the people of East Timor after the latter voted for independence, and during the 1990s for Russian military operations against Chechen separatists, leading Chechens to flee their homeland.

Scholars disagree about whether ethnic cleansing originated in the twentieth century with the rise of powerful nation-states driven by nationalism and racist ideologies combined with advanced technology and communications. However, there are countless examples of historical efforts prior to the twentieth century aimed at genocide and forced migration around the world, wrought upon those of the “wrong” ethnicity, religion, nationality, or political belief. These date back as far as the ninth and seventh centuries B.C. with the forced resettlement of millions of people by the Assyrians. Other historic examples are: the mass execution of Danes by the English in 1002; removal of Germans from Czech territories in the Middle Ages, and of Jews from Spain in the fifteenth century; and the forced displacement of Native Americans by White settlers in North America in the eighteenth and nineteenth centuries. In this century, examples include massacres of Armenians by the Turks in 1915–1916; the Nazi Holocaust of European Jews in the 1930s and 1940s; the displacement of 15.4 million people fleeing or displaced within Europe in the 1945–1950 postwar period, including the expulsion of Germans from Poland and Czechoslovakia; the Soviet Union’s deportation of ethnic minorities from the Caucasus and Crimea during the 1940s; the forced migrations and mass killings in the former Yugoslavia and Rwanda in the 1990s, creating the largest wave of refugees and displaced persons since 1945; and, more recently, the displacement of a massive population in the Darfur province of Sudan.

Survivors of ethnic cleansing experience high rates of posttraumatic stress disorder, depression, and other forms of mental illness, while long-term psychological effects have yet to be studied. Women in particular were frequently targeted for especially vicious treatment, methodical rape and enslavement, in part because they were considered the biological and cultural “carriers” of the next generation of their ethnic group. Women and children were often left defenseless when men left to join resistance groups.

Two ad hoc international tribunals were created by the United Nations Security Council in the 1990s to investigate allegations of war crimes and crimes against humanity, including ethnic cleansing, and to prosecute violations of international humanitarian law in the former Yugoslavia and in Rwanda. The International Criminal Court (ICC) was established in July 2002 as a permanent tribunal to prosecute individuals for genocide, crimes against humanity, war crimes, and the crime of aggression. Genocide, crimes against humanity, and war crimes all constitute “ethnic cleansing” within the ICC’s jurisdiction.

Despite continuing controversies over its definition, the concept of ethnic cleansing is well established in international law. Even so, mechanisms to effectively prevent and deal with ethnic cleansing have yet to be developed and implemented.

Related Topics

- ► Amnesty International
- ► Displaced populations
- ► Ethnic identity
- ► Ethnic minority group
- ► Genocide
- ► Internally displaced persons
- ► Refugee

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Ethnic Enclaves

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Global economic trends, local immigration policies, and immigrant preferences have contributed to the widespread emergence of ethnic enclaves in diverse geographic settings. The study of ethnic enclaves has a long history in the USA, which experienced its first great wave of immigration in the early twentieth century. These settings have been studied primarily from the perspectives of economic and community development as a mode of incorporation for immigrant adaptation to new societies. Ethnic enclaves are complex environments with interlocking economic, physical, social, and institutional dimensions that may have implications for immigrant health.

From an economic perspective, ethnic enclaves may offer employment to immigrants, which may be particularly beneficial in providing a livelihood for those who may be undocumented or lack the language skills of the host culture. Enclaves can also provide access to credit, employment information, and "on-the-job" training in lieu of specific educational requirements. Conversely, a lack of documentation, language skill, and educational background can lead to exploitation in enclave settings such as low wages, poor benefits, and hazardous labor conditions. Such conditions are typically related to poor health.

Access to ethnic specific markets in thriving enclave settings may allow residents to maintain the diets and health practices of their culture of origin. Ethnic enclaves are often located in communities of low-income. Disinvestment in ethnic enclaves may contribute to a loss of jobs and businesses that cater to the ethnic economy. This process may, in some cases, produce food deserts, prompting shifts in dietary habits that are associated with poorer nutrition.

The physical design of an ethnic enclave may also influence health behaviors such as walking outdoors, running, and bicycling. Whereas lower neighborhood crime rates have been associated with greater physical activity and social interaction among residents, immigrants who reside in ethnic enclaves with higher crime rates may experience greater victimization, isolation, and reluctance to participate in outdoor activities. Residents in communities plagued with crime are also less likely to seek needed health care services.

The collective resources available to residents from social networks are known as forms of social capital. Social networks typically include family members, friends, and other acquaintances inside and outside of neighborhoods of residence. Forms of social capital that may be present within ethnic enclaves include the psychosocial resources that support newcomers in their adaptation to the host culture and may buffer them from some forms of discrimination. Social capital may include benefits that are provided collectively by the ethnic enclave such as its resilience or political power to bring health resources into a neighborhood. Social control is a form of social capital reflected in the values that discourage or promote the health behaviors of enclave residents. Cultural capital may provide residents with a sense of community and access to traditions and practices that may support health.

While a vast and complex system of institutions delivers health and social services to immigrants and refugees, disparities have been observed in the access and utilization of health and mental health services among immigrants when compared to their native-born counterparts. An ethnic enclave's institutions may influence the accessibility, availability, and acceptability of health and mental health care as well as the presence of traditional healers. For example, mainstream organizations such as hospitals may tailor their services to serve specific immigrant populations within ethnic enclaves, while barriers within mainstream services may give rise to private and/or self-help organizations that are formed and led by community members. In general, the more institutionally complete the enclave setting, the more likely immigrants will be to meet their health-related needs despite barriers.

As in all neighborhoods, health is also shaped by the quality and accessibility of basic services such as police and fire protection, sanitation, parks and recreation, and schools. Churches, social clubs, and neighborhood associations provide services as well as opportunities for residents to participate in community life, which can be particularly beneficial for immigrant newcomers.

The study of immigrant health dynamics within ethnic enclave settings is growing as interest in the roles of ethnicity and geography in social disparities in health is accelerating. To date, research suggests that the relationships between ethnic enclaves and immigrant health vary by ethnic group, neighborhood quality, the characteristics of residents, and the health indicator under consideration. Additional research will be necessary to create more responsive health care systems and stronger health infrastructure for immigrant populations in diverse enclave settings.

Related Topics

- ► Community
- ► Segregation
- ► Social capital
- ► Social networking

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Ethnic Group

- ► Ethnic minority group

Ethnic Identity

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Ethnic identity refers to an individual's sense of belonging to a socially constructed group that shares a common culture, race, language, religion, and/or place of origin. It includes the individual's beliefs and attitudes toward that group that can change with time and context. Developing a positive ethnic identity is of fundamental importance to the psychological well-being of all minority individuals. For immigrants in particular, leaving their country to settle in another poses particular challenges concerning the extent to which they can or wish to maintain their original heritage and how much they can or wish to adopt the new cultural practices, values, and identities of their host culture. An immigrant's ethnic identity is oftentimes multifaceted (i.e., incorporates multiple ethnic identities) and reflects the qualities of their acculturation experiences, as well as their own psychological adjustment to their new environments.

The term ethnic identity surfaced in the 1800s as scientists became interested in understanding the psychological aspects of migration to and from Europe. At the turn of the twentieth century, it was believed that globalization would lessen the impact of ethnic identity, but it in fact did exactly the opposite. Ethnic identity reemerged during the civil rights movement as a way to explain the psychological struggles of African-Americans in the USA. With the surge of immigration to the USA and Europe especially, it also became an important tool for discerning the complexities of an immigrant's adjustment. Today, ethnic identity affords sociologists, anthropologists, and psychologists worldwide such a tool for the more than 200 million people living in a country other than the one in which they were born, for their native-born children and subsequent generations, and for the problems of prejudice and discrimination that persist in our societies. Scholars such as Jean Phinney, John W. Berry, Rubén Rumbaut, and Alejandro Portes have made great contributions to our conceptualization of ethnic identity among immigrants and have urged practitioners, researchers, educators, and policy makers to consider its implications in their work.

Ethnic Identity Development

Ethnic identity includes components such as self-identification (labeling of one's ethnicity), pride (sense of belonging to an ethnic group), knowledge (understanding of ethnicity and the group), satisfaction (attitudes toward one's group), and value (degree of importance of ethnic identity). Importantly, each of these changes from early childhood to adolescence and into adulthood. Frances Aboud has demonstrated that children learn to self-identify with a particular ethnic group between the ages of 4 and 7. At around 8–10 years old, they begin to understand that ethnicity stays the same over time. As a child's cognitive abilities grow, so too do they begin to appreciate ethnicity concretely (e.g., through food and language) and behaviorally (e.g., through actions and customs).

It is not until adolescence that ethnicity is conceptualized as something abstract and changeable through time and context. Jean Phinney highlights these differences between age groups and further posits that ethnic identity formation occurs in stages predominantly during adolescence. In childhood, ethnic identity is acquired from the influences of family rather than through personal exploration (i.e., foreclosed ethnic identity). Adolescence, characterized by identity formation, often includes ethnic identity confusion and discovery as well (i.e., moratorium stage). As adolescents continue learning about their ethnic group and its role as a separate subgroup to the larger majority, they begin to more clearly understand and accept their own ethnicity (i.e., achieved stage).

These identity components and the process of ethnic identity formation are influenced by the social and cultural contexts of development. For children, the family, school, community, and larger society all directly affect the attitudes and feelings toward their ethnic group. When a family is warm and supportive, feelings toward their ethnic group tend to be stronger and more positive. Importantly, family customs, gender role expectations, and language maintenance take place within the larger society, further shaping ethnic identity in youth. If messages from school, neighbors, and the media contradict or negatively portray characteristics of their ethnic group, children and adolescents are likely to experience greater conflict in their ethnic identity resolution. An example of many Dominican-Americans in the USA described in the work of Cynthia García Coll and Amy Marks highlights this influence of the larger society. Dominican-Americans are characterized by strong family ties, high maintenance of cultural traditions, and high levels of ethnic pride. Dominican-American children develop a secure sense of belonging to their ethnic group as a result. In adolescence, however, many Dominican-Americans with darker skin color and Afro-Dominican features are ascribed as being "Black" by community members around them (e.g., police). The negative racial stereotyping and discrimination that occurs as a consequence makes them less likely to label themselves American and more likely to retain their original language and customs. For many second-generation Dominican-Americans especially, this creates profound psychological struggles in their attempt to integrate into mainstream North American culture. These difficulties foster a susceptibility to mental health issues such as depression, anxiety, and suicidal ideation.

Ethnic Identity and Acculturation

The term ethnic identity has often been used interchangeably with acculturation, but it is best understood as an aspect of an immigrant's acculturation process. In John W. Berry's work, acculturation is described as the process of psychological change that occurs when one cultural group comes into sustained contact with another. Explained in this way, there are two components to consider: the retention of one's culture of origin and the adoption of the culture and customs of the new society. Inherent to the bidirectional interplay between these two aspects of acculturation is the ethnic and national (i.e., pertaining to the larger society) identity of an individual. It is important to note that the process of acculturation does not entail a choice between an ethnic or national identity, but rather involves a complex interaction between the two that results in an independent resolution of each; that is, an individual can identify strongly or weakly with either their ethnic or national identities or both.

These psychological adaptations and subsequent ethnic identity changes take place within the larger social structures of the immigrant's receiving community. Sociologists such as Minh Zhou and Alejandro Portes have argued that an immigrant's skin color, geographic location, and residential accessibility to upward mobility ladders are among the many contextual factors that contribute to an immigrant's adaptation and ethnic identity formation. Countries differ in their immigration laws, in the degree to which they historically welcome immigrants, and in the cultural background of the immigrants they prefer. Within specific countries, there are also large differences between and within cities regarding existing community resources, economic and educational supports, and social capital available to receive immigrants from particular regions or cultures. In addition, the neighborhood characteristics of the immigrant's location including foreign-born concentration, socioeconomic status of residents, crime rates, and institutional resources of the area also impact the quality of an individual's acculturation experience and ethnic identity formation. For example, cities such as Miami in the USA are particularly welcoming of Hispanics where they comprise nearly 68% of the population, nearly all of whom identify Spanish as their first language, and half of whom are Cuban. Cubans have also benefited from immigration policies and financial incentives that have facilitated their adjustment compared to Haitian-Americans in the area. Nevertheless, being Cuban in Coral Gables (per capita income of approximately U$60,000) has its marked advantages to being Cuban in Hialeah (per capita income of nearly U$13,000). Cubans in Coral Gables are more likely to have a strong, positive ethnic and national identity as a result.

In sum, the social contexts that support retention of an ethnic identity are more likely to foster a strong ethnic and national identity (i.e., integration). Others that generally discourage or alienate specific immigrant populations are more likely to promote strong ethnic identities and weak national identities (i.e., separation) or weak ethnic identities and strong national identities (i.e., assimilation). Researchers have consistently shown that integrated individuals (i.e., individuals that possess a strong ethnic and national identity) fare better on measures of mental health, behavioral, and academic outcomes.

Ethnic Identity and Well-Being

The complexities of forming, maintaining, and reconciling ethnic identities within these social structures can, and oftentimes do, have a direct impact on immigrant individuals' physical and mental health outcomes. For example, most US immigrants, by way of being a racial or ethnic minority, have experienced discrimination, stigmatization, or stereotyping at some point in their lives, whether overtly (e.g., through physical or verbal threats) or subtly (e.g., through exclusion or microaggressions). Oppositional identity theorists contend that many such individuals, for whom neither minority nor majority social norms are easily adopted, will instead form oppositional identities. Oppositional identities may involve dress, language, or behaviors that are not consistent with either an ethnic or national orientation. For example, adolescents may be conflicted with doing well in school lest they be perceived as "acting white." In turn, they may resort to hiding such behaviors or revert to putting forth less effort in school, withdrawing from peers or negatively affecting their academic performance and upward mobility possibilities in such a way. Oppositional identities often lead to declines in grades, increased behavioral problems, and decreased self-acceptance.

Numerous studies have also demonstrated that having a weak, negative ethnic identity is associated with poorer self-esteem. Social identity theorists Henri Tajfel and John Turner suggest people naturally aim at having a positive social identity that enhances one's self-esteem. Often, being perceived positively involves a choice between the ingroup versus outgroup. Immigrants who may be viewed negatively by the larger society are frequently conflicted by this choice. They may be able to sustain a strong ethnic identity, overcome the difficulties of belonging to the outgroup, and ultimately possess a higher self-esteem and resiliency. They may also internalize the devaluation of their outgroup and choose to adopt the ingroup or majority identity instead. Many such individuals later feel as though there is a degree to which they never completely belonged and experience self-esteem issues regardless. Another option still involves internalizing the devaluation of their outgroup, sustaining a high ethnic identity all the same, and generally maintaining a low self-esteem due to the taxing nature of such psychological struggles. While this does not include all positions an immigrant may take and their potential outcomes, it does provide a sense for the relationship between ethnic identity and self-esteem. Importantly, an achieved ethnic identity includes positive feelings toward one's group. These positive feelings alone are often the source of the personal strength and high self-esteem needed for many resilient ethnic and racial minorities.

Research has generally shown that having a strong, positive ethnic identity is related to more positive academic outcomes, fewer behavioral and mental health issues, and protection from risky health behaviors such as substance use, drug use, and smoking. Beginning in childhood, individuals exhibit more positive coping styles and positive peer relationships when ethnic identity is strongest. It further moderates the negative impact of ethnic and racial discrimination. For immigrant youth in particular, having a secure ethnic identity is of utmost importance throughout the course of their adjustment to a new neighborhood, school, language, and customs. Social adjustment and academic achievement is also highest for second-generation immigrants when they identify strongly with their ethnic group. Individuals particularly at risk for physical and mental health disorders are those for whom conflicts are twofold; that is, they boast weak ethnic identities and are female, Black, homosexual, or poor. A strong support network in these cases is crucial.

Bicultural and Multicultural Ethnic Identities

Historically, research considering ethnic identity aimed to explain how and why an individual identifies with a particular group at the expense of a majority or national identity. Such research further argued that attempting to merge both an ethnic and national identity leads to "culture shock." Today it is understood that forming ethnic or national identities can co-occur; that is, individuals can possess a strong sense of belonging to both their ethnic and national group and engage in exploration of each simultaneously. Such "biculturalism" involves identifying with and being competent in two or more cultures. Recent studies on bicultural individuals suggest they oftentimes fare better than their monocultural peers in measures of self-esteem, anxiety, and academic outcomes. Some researchers describe the related cognitive skills needed for biculturalism as "frame switching," which involves moving between two sets of cultural interpretive frames, including the different languages, customs, and values of each, in response to socio-environmental cues.

In sum, whether an immigrant experiences his or her ethnic identities as a culmination of multiple ethnic selves (multicultural), a balance between two ethnic identities (bicultural), or a competition between the traditional ethnic identity and the new national identity, it is clear that forming and maintaining ethnic identities is a complex process that involves the bidirectional influence of context and culture on the individual. Environmental factors such as poverty, discrimination, and language difficulties can be rather easily ameliorated through a warm and supportive family, effectively redirecting ethnic identity from a weak resolve to a strong and secure sense of belonging. As such, the role of ethnic identity on the health and development of immigrants can be profound. Future research is needed to further investigate how gender, age at migration, and generation of the immigrant shape immigrants' ethnic identities. Studies that more comprehensively capture ethnic identity development across the life-span and incorporate person-environment interactional models will go a long way toward enhancing our understanding of ethnic identity in a world where the well-being of immigrants is becoming increasingly important to our societies.

Related Topics

► Acculturation
► Culture shock
► Self-concept
► Social capital

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Ethnic Minority Group

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Introduction

"Ethnic minority group" can be defined as any sociological group based on common ethnicity of its members. The group typically constitutes a minor part of political voting of the total population of any particular society at any particular point of time. Ethnicity, in particular, can be defined as social identity that is associated with shared behaviors and patterns. The factors affecting these patterns include, but are not limited to race, skin color, religious affiliation, language, type of clothing, eating habits, pattern of social interaction, and health behaviors. These patterns collectively give unique features to the group. Other commonalities (including genotype and phenotype) and preferences for certain common geographic area for residence make these groups even more unique.

Ethnic Identity of a Member as a Basis of Ethnic Minority Group

Although the concept of "ethnic identity" of a member of ethnic minority group remains vague, Tajfel has defined it as "that part of individual self concept which derives from (his) knowledge of (his) membership of social group (or groups) together with value and emotional significance attached to that membership." However, in order to explain this concept comprehensively, various components have been taken into account. These components are self-categorization (identifying oneself as a member of particular social group), commitment and attachment (strong personal involvement in the group), exploration (seeking information and experiences about one's ethnicity), ethnic behavior (speaking language and eating food, etc.), in-group attitudes (positive attitude such as pride and good feeling about one's group or negative attitude such as wish to belong to another group), ethnic values and beliefs, importance of group membership, and ethnic identity in relation to national identity.

Types of Ethnic Minority Groups

The categorization of ethnic minority groups can be extensive, but, for example, in the USA, per the census, it has been broadly classified into Latino, African American, Asian, American Indian, Alaska Native population, Native Hawaiian, and Pacific Islander. However, it should not be confused with racial group or nationality of origin which happens frequently. Applying genetic meaning to defining ethnic group would equate it with race and would not take cultural components into account. In order to appropriately use the terminology of "ethnic group," one must account for genetic as well as cultural dimensions.

Importance of the Concept of Ethnic Minority Group in Health Care

The discussion about "ethnic minority group" in the health care sector is important due to the variations in occurrences and presentations of various medical diseases in various "ethnic minority groups" and the disparities in the health care they receive as compared to general population, despite their significant number in the US society. Health disparities are defined as diseases, disorders, and conditions that disproportionately afflict individuals who are members of racial, ethnic minority, underserved, and other vulnerable groups.

This disparity was perhaps first best mentioned in 1985 in the landmark document, *Report of the*

Secretary's Task Force on Black and Minority Health. It was then that attention to the burning problem of this disparity was achieved. This report highlighted that the ethnic minority populations suffered disproportionately from heart disease, stroke, cirrhosis, diabetes, infant mortality, unintentional injuries, and homicide.

Despite numerous federal, state, and local initiatives implemented to address these and other health-related disparities in ethnic minority populations, the differences in occurrences of various illnesses and injuries remain prevalent. History clearly suggests that the advances have been taken to provide uniform health care and to mitigate this disparity based on ethnic and racial differences. However, Bach argues that US ethnic minority communities might be receiving lower quality of care due to differences in their primary health care providers or differences in the site of care. The same review also discusses the current disparity in surgical procedure number and quality outcome due to race and ethnic variables. In particular, groups such as African Americans and other marginalized groups, suffer higher rates of morbidity and mortality from just about every major cause of death, including cardiovascular disease, cancer, diabetes, and HIV/AIDS.

Culturally Competent Care as a Solution for Disparity in Health Care Among Ethnic Minority Groups

As this disparity is now well supported in literature, the term "culturally competent care" has been well emphasized. This includes achieving awareness about cultural differences among different "ethnic minority groups," gaining knowledge (collecting information about patient's race, ethnicity, and spoken and written languages), and acquiring skills and abilities (provision of language access services, and support from organizations for cultural competence) to work among these groups. Despite the evidences about the advances in this direction, need for further efforts in education, practice, research, policy, and advocacy exists to mitigate this disparity and provide better health care to different ethnic minority groups. Moreover, as these groups are in minority and not well represented at higher authority level, better awareness and collaborative efforts are essential to assure the same health care level to them as compared to general population.

Related Topics

- ► Access to care
- ► Cultural humility
- ► Ethnic cleansing
- ► Ethnic identity
- ► Ethnicity

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Ethnicity

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Historical Background and Definition

There are several ways to define ethnicity. This term can be used to describe how an individual identifies his or herself in relation to a particular race or culture. It is how one is self-labeled when assigning group affiliation. Ethnicity also explains the way of life of a distinct group of people, based on a set of shared values and customs. This term is a construct that changes depending on how the situation develops and its context. Such contexts include religion, language, culture, kinship, and nationality.

An ethnic group comprises those who share common religious, cultural, or life-style practices, which make them unique from another ethnic group. Ethnic affiliation determines how one lives and self-conceptualizes in the context of society. Specific cultural traits related to an ethnic group are usually related to the native language, food, and clothing, which develop from time spent in isolation and cultural differences. It is through geographical location and social isolation that ethnicity is maintained. For example, many immigrants who come to the USA maintain their cultural distinctiveness in food and language while assimilating with the host country. This type of ethnic stability is found in parts of a country where certain ethnicities have isolated themselves to a specific locale and promote sales and purchase of native food and goods with restaurants and other businesses for that ethnic group.

Ethnicity or Race?

The terms "race" and "ethnicity" are not always clearly distinct. As a result, these terms have been utilized interchangeably and inappropriately in the literature. For example, ethnicity was a term used from the mid-fourteenth century until the mid-nineteenth century to describe racial characteristics. During World War II, this term was utilized to describe Jewish, Italian, and Irish immigrants. Since the 1960s, "ethnicity" has become a popular term in the field of social anthropology to denote group relationships and classification of people.

Ethnicity can be viewed as how an individual is part of a distinct group of people while race is oriented toward how one is categorically different than another group. Unlike race, which distinguishes populations based on physical characteristics, ethnicity describes a social group that shares a common history, cultural identity, and geographical location, regardless of racial difference. For example, a Hispanic or Latino is considered to be an individual from Cuban, Mexican, Spaniard, South or Central American, or other Spanish culture or origin. Some ethnic groups base their identity on affiliations within ethnic groups. In this instance, the most important and binding component of one's attachment to a group of people is the belief that that group of persons is unique and whose cultural bond is shared. Members within the group define the group characteristics and ownership. This definition of ethnicity also focuses on the personal feelings of the individual about their ethnicity within that ethnic group. In turn, one's affiliation with that ethnic group is typically to serve the needs of the individual. Such affiliations allow the individual to collaborate with members within their group or compete in society.

The concept of ethnicity is unidimensional whereas race is multidimensional. When one speaks of ethnicity, the reference is strictly linked to a single genealogy or ancestry. This link can be real or presumed by the members associating themselves with a particular racial group. Race is a social construct utilized to categorize people based on skin color, ancestry, or country of origin, which can be multiple genealogies or ancestries. In addition, race is related to biological, genetic, religious, and linguistic similarities; however, ethnicity does not include the two latter traits. Time is the major factor by which ethnicity is defined, in that religion and language are two phenomena that develop and evolve with time. In both cases, the two terms can be considered social constructs. A final note with respect to race is its distinction resting on physical features to include skin color, facial features, and traits that are considered similar among races.

Dimensions of Ethnicity

Primordialism and Circumstantialism

The viewpoint of primordialism supports the notion that human beings desire to be a part of similar groups of people whose way of life reflects theirs. Changes within ethnic groups are gradual, seek a place of social acceptance, and have time-enduring cultural practices. Primordialism holds that ethnicity is not based on the pros and cons of financial loss and gains but rather feelings, and that it is a state of being which is unchangeable, fixed, and based on community interests. Circumstantialism, on the other hand, is diametrically opposed to the viewpoints of primordialism in that ethnicity is viewed as fluid and experientially organized. Circumstantial ethnic identity is based on political, economic, and social status driven by history circumstances and inequality whereas instrumental ethnic identity is linked to nature, socialization, and biology otherwise inherited.

Instrumental and Symbolic Ethnicity

One might also conceive of ethnicity as being formed based on political and social bonds between members of the same ethnic group. Such bonds include marriage, friendship, kinship, ritual beliefs, and practices. In turn, these social contracts evolve into informal political groups that set out to accomplish goals and objectives that strengthen the ethnic socioeconomic infrastructure, which is an instrumental perspective.

The process of ethnic identification is usually in a self-identifying format whereby which the individual determines which group or groups with which they relate most closely, such as Hispanic or Latino. Noyoo identified two components of ethnicity: instrumental and symbolic. The former term is derived by deprivation from material goods while the latter refers to individuals' ability to maintain their cultural identity. For example, a Hispanic who immigrates to the USA may not have access to traditional goods and services provided by the host country; however, the immigrant may still have access to his or her cultural festivities celebrated annually in his or her native country through community-sponsored events.

Expounding on symbolic ethnicity, this term can be defined by how groups of people base their identity on their cultural differences. Years of social and political conflict have created a rift between some ethnic subgroups. As an example, two African groups, the Hutus and the Tutsis, were segregated into majority and minority ethnic groups based on their occupations. Regardless of their shared language and physical appearance, the Belgian governing body that led to the colonization of Rwanda also created political competition between these groups. Even though these two African groups were similar in that they shared a culture, their occupational assignments brought about ethnic isolation and cultural differences among the Rwandans.

If we apply the concepts of symbolic ethnicity to the Rwandans, one could say that such ethnic conflicts have led to liberalization and democratization certain parts of Africa. This situation can potentially destroy civil society, thereby decreasing a country's life span. Finally, ethnicity can also be viewed as a way by which individuals accumulate wealth or political power. This perspective views ethnicity as a strategy to access resources within society to include gainful employment and an education.

Language and Culture

Immigrants may arrive to a country whose language and culture may differ from theirs. In addition to learning to navigate through a different socioeconomic and educational system, management within the healthcare system prompts a different kind of knowledge in terms of the linguistic and cultural norms the immigrant may need to remain a healthy member of society. Ethnically diverse groups must either know the language and culture or interpreters and translators must be available during every day communications within the educational, business, and medical contexts. Because ethnic diversity is wide and varied, the dialect of the interpretation or translation may be different from that of the immigrant's native country. Ethnic differences among immigrants may signal differences in understandings about the origins and treatments of specific diseases and differing opinions regarding non-Westernized medical treatment such as alternative or herbal medicine. The extent to which immigrants retain such beliefs may be associated with the length of time spent living and adapting to the norms of the host country while maintaining or decreasing ethnically based social norms.

Acculturation

Once understood as operating unidirectionally, we have come to understand that acculturation may occur bidirectionally. An individual from another country may assimilate with the cultural norms and customs of the host country, while also retaining the language, norms, and customs of his or her country of origin. The extent to which immigrants adopt the culture of their new country or retain the culture of their country of origin varies across individuals and across immigrant groups, and also varies depending upon the particular aspect of the culture. For instance, an individual may become completely bilingual, but may not adopt the value system of the receiving country. In some instances, the immigrant may integrate both paths into his or her lifestyle, which leads to a variety of relationships and social contexts in which the individual is accepting of and accepted by both ethnic groups.

Recent research has shown that acculturation directly affects Hispanics' ability to assess their own health and seek out health care services. On the other end of the spectrum, a Hispanic paradox exists in that some literature points to poorer health outcomes for highly acculturated Hispanics. More recent research contradicts this notion and purports that less acculturated Hispanics tend to rate their health as fair or poor. Nevertheless, ethnicity and the immigrants' association with the ethnic norms of the host country appear to affect, whether negatively or positively, health outcomes of individuals who have been exposed to more than one culture.

Knowledge of the different models of acculturation is important to understand ethnic identity. It can be described from a bidimensional model as a means to describe differences in ethnic identity. Integration within the culture of the host country can be considered biculturalism while assimilation describes the one who chooses to identify only with that of the host country. The greatest sense of social isolation may come from the immigrant who does not assimilate with either culture. In any case, ethnic identity with the new society can be considered a form of nationalism.

Census and Nationalism

Every 10 years, the USA conducts a census to quantify all citizens based on various social, economic, biological and psychological factors. This process of recording and publishing information is utilized to allot government funds to medical, educational and other public institutions and social services. In this context, ethnicity is a term that catalogues the various groups of people that live in the census of those living in the USA. The US Census identifies race as what the individual self-identifies or reports. The individual is grouped based on the person's own concept of culture and society. Races are considered to be any of the following: White, Black or African American, American Indian or Alaska Native, Asian Indian, Chinese, Filipino, Japanese, Korean, Vietnamese, Native Hawaiian, Guamanian or Chamorro, Samoan or Pacific Islander. The term Hispanic, which was once considered a race, has been removed from census and has been replaced with the following ethnicities: Hispanic, Latin or Spanish origin. Unlike the USA, countries such as France and Switzerland do not collect ethnicity information from its residents. On the other hand, countries like India catalogue ethnicity based on the native language of that group; this society is based on a caste system whereby occupations are linked and fixed to a family's pre-existing socioeconomic status.

Nationalism and ethnicity are closely related in that these terms are characteristically ethnic. Nationalism is an expression of multi-ethnic beliefs and ideas that share civil rights versus cultural origins. In that regard, some immigrants may be unsure of how they may classify themselves as between nation and ethnicity. For example, Mexicans living in the USA belong to an ethnic group (Hispanic or Latino), but also belong to the country of Mexico, regardless of whether they return to their native city. Nationalism can be viewed as the basis of multiculturalism within the host country, if the country's policies promote such concordance. Policies that promote integration can create a sense of psychosocial and physical well being for immigrants migrating to that host country. For example, the USA has set a precedent for the variety of immigrants it allows to migrate and live as refugees. In all, integration within society is closely tied to state and national institutions that promote biculturalism rather than total assimilation to the values and norms of the host country.

Immigrant Health

Health is often viewed as a sense of well-being from a mental, physical, and social standpoint, without illness present. Depending on one's ethnic group and immigration status, health may be considered a right or a privilege. In any instance, health is what affords one to a become productive member in society, facilitating access to employment and, thereby, an adequate standard of living. Immigrants arriving to the USA from developing countries sometimes find that their new host country offers certain health care services not traditionally accessible in their country. This accessibility, in turn, places that group at reduced risk for specific diseases or debilitating ailments that could compromise their ability to earn or maintain a living. In this context, ethnicity is a sociopolitical means to enforce federal laws promoting equal access to such services, decrease disparities in public services for specific minority groups, increase employment opportunities, and address environmental risks affecting certain ethnically diverse populations.

In the USA and other countries, ethnic diversity affects the development of economic growth, particularly service and health industry. Research has shown that immigrants who navigate through a healthcare system different from that of their host country, who have low or poor health literacy rates, or who have limited linguistic ability in the language of the host country are more likely present with poor health outcomes. The lack of healthcare services for this population can be attributed to several additional factors, including socioeconomic status, education, and cultural barriers. Such factors are directly linked to the institutions that are available to these ethnic groups and the amount of fiscal funds targeted for designated ethnic populations.

Ethnic Identity and Psychosocial Health

Immigrant attitudes, characteristics, and reactions of the society within the host country often arise in response to the interaction of ethnic identity, immigration, and well-being. This interaction is moderated by individual characteristics of the ethnic group, specifically their attitudes about whether to assimilate with the cultural norms of the host country or retain those of their native culture. This decision will be driven by how accepting the immigrant feels in the host country and whether pluralism, i.e., the acceptance of multiple cultures and ethnic groups, is accepted among the native ethnic group. Positive outcomes usually result from an ethnic identity that is encouraged by a supportive community. On the other hand, social pressures to assimilate may lead the immigrant to form a new national identity while negative attitudes toward assimilation foster solidarity toward the native cultural group.

Ethnic identity within the host country is determined by a number of factors. First, the psychological status of the immigrant pre-arrival to the USA will directly affect the perceptions of negativity and stereotypes within the host country. Second, the level of security of ethnic identity will generate psychological well-being of the immigrant, among the acculturating groups and resolution of within group conflicts. Confident feelings about one's ethnicity are prerequisite for the immigrant's valuation of his or her ethnic group and affirmation of his or her affiliation with it. Third, an individual's ethnic self-conceptualization may differ from the ethnic identity ascribed to him or her by others. Conceptualizations by the immigrant and by others may fluctuate with time and situational factors.

Ethnic identity is developed and maintained by one's self-esteem, psychological stability, and physical health within one or more cultural groups. When an immigrant arrives to the host country, ethnic stability cannot come without adaptation. If the migrated individual relates positively to the values and norms of the host country, he or she tends to develop a strong identity with the host country while maintaining that of his or her native origin. Furthermore, a secure sense of identity of self enables an immigrant to address conflict within and outside his or her ethnic group while maintaining positive relationships and a sense of solidarity within such groups.

Several moderating factors affect ethnic identity immigrants that are transitioning to another country. These factors include age, generational status, and sex. The tendency is for young women to be more accepting of assimilation toward Westernized culture as it may provide females with increased rights and liberties. Older female immigrants may remain in the home and maintain practices of their native country. So identity and adaption to the host country are also closely linked to the generation and point at which immigration took place. New immigrants tend to have a strong sense of affiliation with their native culture and country with degrees of adaptation occurring over time. The degree to which adaptation occurs will depend on a variety of chronological and sequential factors including ethnic identity level with the native country, socioeconomic status, and education that enable to immigrant to choose instead of be forced to conform to the norms and values of the host country.

Summary

Immigration brings about the intersection of race, culture, and ethnicity. Individuals may decide to leave their country and travel to another for several reasons, which are not limited to schooling, job access, and relatives who reside in the host country. Movement abroad may occur in the hope of creating a better socioeconomic lifestyle for themselves and their families. Individuals who immigrate tend to be healthy enough to look for work or study abroad when they arrive to the host country. In contrast, some immigrants may arrive with preexisting medical conditions, which may worsen in the absence of adequate working and living conditions and healthcare access. Such conditions can be genetically linked to their ethnic group such as the Auschwitz BRCA1 cancer gene.

Ethnic groups have differing ways of coping with the stressors of life. In many instances, the lack of social support from immediate family or friends who already reside in the host country may predispose some immigrants to illness. This combination of social, working, and living conditions in the host country can lead to increased susceptibility to disease. Furthermore, if the immigrant does not access healthcare for routine checkups, chronic diseases can potentially worsen and compromise the immigrant's ability to work productively. For example, Mexican immigrants tend to maintain a nuclear link with their immediate family and those who have immigrated to the host country. In addition, they may seek out social and health service support from their ethnic group because of the shared beliefs and practices held within that population.

In sum, physical, mental, and spiritual health is requisite for an immigrant to conceptualize his or her ethnic identity and how it ties in with the country of residence. Socioeconomic factors discussed weigh in heavily in terms of individuals' ability to adapt to, isolate from, or assimilate their ethnic background with that of the host country. Historically, the use of the term ethnicity has brought about discriminatory attitudes and social isolation among certain ethnic groups. However, the use of this term to describe an immigrant remains an instrumental part of identification within the USA and international communities.

Related Topics

► Acculturation
► Discrimination
► Family
► Health care utilization
► Health determinants
► Health disparities
► Language
► Race
► Racism
► Religion, religiosity, and spirituality
► Social networking

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Ethnocentrism

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Ethnocentrism is a universal ideology that ascribes superiority to the familiar, such as one's own group or culture, and regards other cultures as strange, immoral, or inferior. Ethnocentrism emerges from culturally constructed and historically contingent boundary-making characteristics, such as language and even accent and dialect, physical features, ethnicity, religion, nationality, and territory, that create contexts and situations for in-group favoritism and also shape behaviors, attitudes, and social relations toward other groups and cultures. Empirical evidence from cognitive psychology, however, suggests the persistence of bias in favor of one's own group even though these predispositions are influenced and shaped by culture and social environment. Ethnocentric views, policies, and practices have guided systematic efforts such as religious missionary proselytizing and European colonial domination to bring about changes in the developing world. Research in anthropology and psychology shows the appropriations of ethnocentric ideologies and practices in promoting ethnic conflict and war, and shaping consumer choice and voting practices.

In the contemporary global epoch characterized by the intensified flows of people, ideologies, and forms of knowledge across national and cultural borders and boundaries, health care professionals and researchers who work with immigrant communities increasingly emphasize and consider the material and cultural contexts including social and economic inequalities that shape beliefs and attitudes toward health and nutrition, and sometimes even intervene in situations of health risk and crises. Anne Fadiman's exemplary informal ethnography, *The Spirit Catches You and You Fall Down: A Hmong Child, Her American Doctors and the Collision of Two Cultures*, illustrates a cultural impasse with devastating results when two equally hegemonic forms of knowledge, i.e., Western medicine, and Hmong understanding of disease, illness, and treatment, collide with one another.

The opposite of ethnocentrism is cultural relativism. Cultural relativism is an idea and world view that considers all cultures and groups to be equally cultured because every group's social practices are characterized by order, harmony, and refinement. According to proponents of cultural relativism, traditions, values, and beliefs must be considered within the context of the community or culture in which they are found. Cultural relativism, a foundational concept in anthropology, provides a systematic and theoretical basis for contesting ethnocentrism in public discourse, policy and practices, and in textual and mass mediated representations of non-western cultures and communities. From its beginnings in the late nineteenth century, founding figures in anthropology like Franz Boas have argued for the centrality of cultural relativism in cross-cultural analysis.

Health care professionals and researchers who work with immigrant communities have typically resisted making judgments about cultural practices and beliefs and traditions lest such judgments be construed as ethnocentric. However, health care professionals and researchers increasingly agree that there are limits to cultural relativism, and that the criteria for taking a stand against a cultural practice should be based on whether or not the practice constitutes harm. Researchers today routinely take a stand against war crimes, violence against women and children, female infanticide, authoritarian regimes, and the curtailment of civil liberties and rights in several contexts and situations. In recent years, applied social researchers have provided expert testimony to denounce female circumcision on the grounds that it constitutes a form of torture and as a practice of female subordination under the guise of cultural tradition and religious edict. Rather, applied researchers argue that female circumcision persists due to societal constructions of honor, respectability, and marriage norms. Human rights activists have re-conceptualized female circumcision as female genital mutilation on the grounds that it can lead to chronic infections and fatalities, pain during sexual intercourse, increased difficulties in childbirth, and psychological trauma and stress.

Related Topics

- ► Alternative and complementary medicine
- ► Cultural background

- ► Culture-specific diagnoses
- ► Ethical issues in research with immigrants and refugees
- ► Ethnography
- ► Xenophobia

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American Anthropological Association. http://www.aaanet.org

Ethnography

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Ethnography is a primary theory and methodology embraced by researchers in the health and social sciences to advance understanding of the actions and choices of people vis-à-vis health, health programs, healthcare access, and risk and decision-making processes involved in prevention, maintenance, and treatment. In the realm of immigrant health, ethnography has become the main vehicle by which researchers assess what health means to individuals and groups, how it is understood, and the kinds of barriers that contribute to persistent disparities and inequalities. One of the central tenets of ethnography is the importance of the particularities of everyday life in relation to larger contexts that influence health and healthcare access. Insisting that daily life often holds the key to crucial scientific breakthroughs, ethnographic approaches have been critical to comprehending the failure of public health programs to "prevent" risky behaviors in intervention programs that target HIV prevention, dietary changes, exercise practices, and harm reduction in substance abuse, among many other examples.

Ethnography is both method and theory, allowing researchers to embrace the subjective meaning of behavior – not just what people do or say they do, but why and how their motivations and behavioral intentions are constructed or shaped. Theoretically, ethnography provides a basis for challenging positivistic approaches to health and immigration, and many schools of thought, from phenomenology to symbolic interactionism to political economy, have nurtured ethnography itself as a body of knowledge. Methodologically, ethnography is empirical and includes in-depth description of everyday life and practices; it has been explained as an art or science that is used to describe others.

Ethnography is conducted through fieldwork that is often long-term, although some researchers are recently drawn to its reduced RAP (Rapid Assessment Methodologies) and RAM (Rapid Assessment Procedures) forms. Researchers, or ethnographers, employ participant observation, meaning that they live in or otherwise experience a research site in order to gain an insider or emic (as opposed to etic, or outsider) perspective with the insistence that data must be understood in relation to lived lives. Through this "insider's" point of view, ethnographers seek to allow meanings and modes of understanding to emerge, rather than imposing them from outside. Taking part in the daily life of research consultants (or "informants"), interviews, life histories, and open-ended questions are among the ways in which data may be collected. This allows people to express their views and ways of thinking without predetermining them. The depth of detail amassed through these practices is sometimes called "thick description," a term coined by Clifford Geertz in his writings on an interpretive theory of culture. The data gathered from ethnography are often referred to as qualitative, as opposed to more quantitative or statistically based methods.

The scale of the ethnographic research focus may often be small, that is, limited to a particular community, group, or even person (in the case of a life history.) However, the descriptive and analytic capacities of ethnography allow for a uniquely holistic research perspective that places these individuals, communities, and groups within larger worlds. As immigration, globalization, and various forms of transnationalism proliferate, ethnography has been crucial to understanding both the universal and the unique issues faced by people throughout the world.

The centrality of participant observation to ethnography requires knowledge of the language, history, and culture of the place and/or group of people to be studied. Therefore the training for ethnographic research and its ideally long-term nature require unusual preparation relative to other research methods. Ethnography also requires that researchers be able to conduct studies "on the ground," outside of university or institutional settings where other kinds of research projects are often situated. Due to the unique ability to take into account and center what people say and think and to understand these holistically, ethnographic methods have grown increasingly popular as researchers seek community participation and local perspectives, and to build long-term collaborative research relationships.

Ethnography and Immigrant Health: Some Insights and Studies

For ethnographers, health and health care are intrinsically linked to social contexts. These social contexts are structured by the inequalities found in daily life and are expressed through health disparities. This is especially true for immigrant health concerns, as immigrants are categorized and classified in ways that directly affect both their health and their access to care. Immigrant health disparities can be seen, then, as the material, empirical evidence for social inequities. Paul Farmer, an anthropologist and physician describes this linkage through the framework of "structural violence." For Farmer, structural violence refers to systematic violence that is attributable indirectly to those who are members of a specified social order. Through the lens of ethnography, immigrant health disparities and the structural violence they are embedded in are expressed not merely through statistical trends, but are witnessed through the conditions of everyday life. As a primarily qualitative methodology, ethnography's strengths can best be illustrated by providing several case studies as examples.

In the USA, a significant percentage of migrants work in agricultural labor and experience particularly acute health care disparities. As a result, migrant farmworkers exemplify the challenges immigrants face in maintaining health and in achieving health care. A study by Seth Holmes of migrant farmworkers in the Central Valley of California illustrates the structural violence experienced through hierarchical categorizations based on ethnicity. Holmes conducted his fieldwork through participant observation while he lived in a shack in a migrant camp. He spent his time each day engaged in picking berries with the farmworkers, interviewing employees and residents, and observing the activities at the local migrant clinic. Taking participant observation to its logical extension, Holmes also migrated from the mountains of Oaxaca, Mexico, with Triqui farmworkers he had come to know, across the US–Mexico border and through the Arizona desert, where they were caught by the Border Patrol. Ultimately the farmworkers continued on to Oregon where they secured false social security cards, and obtained employment on a farm in Washington state.

What Holmes found through his ethnographic fieldwork was that income, difficulty of work, and residence patterns on the farm were all structured according to ethnicity. On the bottom of this structure were the indigenous Mexican Triquis who picked the strawberries, which was the most labor intensive job, requiring them to bend over for long periods of time, causing back problems. They were also required to work while fields were being sprayed with insecticides. The Triquis also made the least amount of money, and lived in the worst housing on the farm, which was the farthest away from the farm headquarters. Unfortunately, Holmes found that the conditions causing health risks for Triqui workers were often not seen by the physicians that treated them. These doctors often blamed their patients for the injuries that they suffered, and failed to recognize the role played by the larger social order and international policies in creating the conditions that led to such injuries.

Ethnography also provides a powerful methodological tool for studying immigrant health in the context of the hospital or clinic. In an ethnographic study of a health clinic in Albuquerque, New Mexico, Sarah

Horton found that inequalities in immigrant health care access are structured by ethnicized and racialized categories of deservingness. Horton's study was based on 2 years of research including 90 hours of participant observation, interviews with the clinic's providers, physician assistants, 4 nurses, 3 clerical workers, social worker, immigrant advocates, and over 30 patients. Horton also conducted follow up interviews with clinic staff for 3 years following the main study.

Horton's study focused on the differential access to health care of Cuban refugees versus Mexican immigrants. While Cubans receive federal assistance for health care due to their refugee status, Mexican migrants must rely on the Medicaid Managed Care plan (MMC) in order to cover health care costs. Horton's thesis was that the policies of MMC introduced a logic of deservingness or moral worth onto the documentation status of its clients. While Cuban immigrant healthcare costs are covered by the federal government, coverage for Mexican migrants is paid from county and state funds. As a result, Mexican migrants are seen as a burden on society. This financial burden interpolated into a discourse of risk and responsibility as a measure of moral worth, and hospital staff and administrators appeared to attribute risk and responsibility based on ethnicity or national origin. Cubans and Mexicans were then seen by the public health system as deserving or undeserving of public benefits, categorizations that are reinforced by the clinic's staff. Horton argued that the end result of this policy of differential access is that it further discourages Mexican migrants from seeking care.

Legal status of migrants is often a significant vector for health inequities as well as a substantial barrier to accessing healthcare. In these cases, ethnographic methods have been central to including the perspectives of immigrants who may otherwise "fall through the cracks" or may be afraid to participate in more qualitative studies where they do not know researchers and have no ongoing links to them. In an ethnographic study of undocumented immigrants in Germany, Heide Castañeda found that the condition of "illegality" itself functioned as a risk factor. A German "Denunciation Law" mandates that unauthorized immigrants be reported to authorities if they seek public social services, and are also not covered by the state for emergency medical care. As a result, any health condition requiring medical care may result in deportation. Despite Germany's restrictionist immigrant policy, nonprofit and nongovernmental clinics have begun to fill in the gaps of health care needs for unauthorized migrants. Castañeda spent over 6 months of participant observation at a German clinic and conducted 61 semi-structured interviews with physicians, staff, unauthorized migrant patients, and local experts on immigrant health issues in Germany. Physicians reported to Castañeda that patients at the clinic arrived "sicker" on average than in a normal practice and often waited to obtain medical treatment, resulting in the exacerbation of their illness. Stress and fear due to illegality and deportability have begun to pose mental health risks unique to unauthorized migrants. Castañeda found that a pattern of "stress narratives" arose as she conducted her research relating directly to issues surrounding migrants' lack of documentation, leading one doctor to refer to the correlation between mental health and illegality as the "illegal syndrome."

In addition to providing insights into the health of immigrants and their access to institutional forms of care, ethnographic methods also provide a window into how immigrants perceive health and health care from an emic (insider) cultural perspective. As more and more hospitals and clinics are beginning to institute "cultural competency" programs as a way to close the cultural gap between patient and provider, ethnography is uniquely suited to inform these programs and policies. Many immigrants' knowledge of health and expectations regarding health care are situated in culturally specific bodies of knowledge. As a result, many immigrants report that doctors "don't know anything," because the patient and doctor are working with different sets of medical frameworks.

In a study of Mexican immigrant health in San Diego, Leo Chavez examined the ways in which traditional Mexican cultural knowledge of health influenced their health care practices in the USA. Chavez, in association with the Center for US-Mexican Studies at the University of California, San Diego, conducted interviews with 2,103 individuals born in Mexico, but living in California. The interviewees were sampled following contacts' networks of social relations. Because many were undocumented, this allowed researchers to establish and maintain the trust and rapport necessary for ethnographic research. Interviews began as structured, closed questions, which were followed by more open-ended interviews in order to obtain more qualitative information. Although a small minority sought traditional medical care from a *curandero*, or traditional healer, approximately a third of the migrants interviewed sought their health care in Mexico. Chavez found that migrants' decision to seek care in Mexico rather than their place of residence was due in part to lower cost in Mexico and language issues in the USA. Migrants' also expressed their dissatisfaction with the quality of care they received in the USA.

Finally, ethnographic methods applied to immigrant health show that assumptions and beliefs about health are not universal and vary from culture to culture. In *The Spirit Catches You and You Fall Down*, Anne Fadiman traced the struggles of the Lees, a Hmong family from Laos who have resettled in California. When their daughter began to show signs of epilepsy, their encounter with the Western medical system was fraught with misunderstandings and clashes between Hmong spiritualism and practices with Western biomedical models. Fadiman's encounter with the Lee family and with the doctors who treated Lia Lee are set against a long-term history of US involvement in Laos, Hmong culture and resettlement in the USA, and immigration and issues associated with it, such as assimilation and discrimination.

The common thread between all of these case studies is the linkage of the phenomenology of reporting lived individual experience within the context of larger sociocultural frameworks. Whether it is Holmes' witnessing the experience of migration, Horton's observations of how clinic discourse both reinforces and is shaped by public policies, or Fadiman's understanding of divergent cultural diagnostic explanations and medical expectations, ethnography strives to provide both a window into the perspective of immigrants themselves as well as contextualizing that emic description within an etic analysis. Ethnography gives both a voice and understanding to the subjective experiences of immigrants as they negotiate their own health and well-being within larger systems of health care. These subjective experiences must not be gathered solely through interviews and reported behavior, but also through observation and participation in order to gain a holistic picture of immigrant health experiences.

Ethnographic research and analysis provide a bridge between the scale of individual lived experience and the scale of social structure in which they are embedded. Health disparities are shaped by social inequalities, and immigrant health in particular is characterized by a greater prevalence of inequality, which makes contextualizing health and health care concerns within social and cultural frameworks of even greater importance. The fine detail of ethnography requires a level of solidarity between the researcher and their subjects, which is facilitated through long-term participant observation. This solidarity, enabled by immersive research methods, results in a knowledge that is "thicker" and richer (albeit often limited in scale to a particular group or site) than would be possible via surveys and statistical analysis alone. As the cultural perspectives and health inequalities of immigrants are particularly salient to immigrant health researchers, ethnography provides a unique methodology and perspective that has the potential to illuminate both the subjective meaning of lived experience as well as the structural frameworks that channel and constrict immigrant health.

Related Topics

- ► Alternative and complementary medicine
- ► Cultural competence
- ► Cultural humility
- ► Curandero
- ► Emic
- ► Explanatory model of illness
- ► Farmworkers
- ► Health beliefs
- ► Immigrant visa status
- ► Migrant day laborers
- ► Migrant farmworkers
- ► Occupational and environmental health
- ► Undocumented

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Etic

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The term *etic* originates in linguistics, and is regularly used within the field of anthropology as well as other social and behavioral sciences. The word *etic* can be used to describe perspectives, constructs, data, or methodology, and in all uses serves a descriptor of positionality. Sometimes referred to as the outsiders' view, *etic* perspectives provide description and assessment of conceptual schemes, categories, and/or culture based upon external evaluative categories. *Etic* perspectives strive to be culturally neutral and objective.

Etic is often discussed in opposition to *emic*. *Emic*, or insider, perspectives attempt to recognize and understand the meaning of a concept from within the cultural framework in which it is being observed. An *emic* approach attempts to assess and convey conceptual schemes, categories, and/or culture in terms of members' own indigenous and meaningful criteria. *Emic* views attempt to represent subjective experience and cultural understanding. In addition to the insider/outsider contrast, the *etic/emic* comparison has further been described as global/focal, universal/particular, and second-order versus first-order conceptualization.

The binary of *etic* and *emic* is not without debate. Although often discussed in opposition to one another, critics argue that neither term is absolute. All *emic* interpretations are informed by whoever is making the observations, and all *etic* interpretations are rooted within some type of cultural context. As such, it has been suggested that *emic* and *etic* be considered as points along a continuum rather than discrete entities.

Related Topics

► Cultural background
► Emic

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ETS

► Environmental tobacco smoke

Eugenics

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Eugenics seeks to improve a population by selectively breeding so as to increase the prevalence of mental and physical characteristics within that population that are deemed to be desirable.

The basis of the eugenics movement was represented by the belief that heredity is key to improving humans. The foreseeable effect of this movement was improvement of humankind. Genes were to be selected in order to provide future generations only with certain features and the "unfit" were to be removed or doomed to segregation.

Eugenics originates from Great Britain, where Francis Galton coined the term in 1880. Gradually, Galton's theory of heredity gained more and more supporters. Charles Benedict Davenport continued Galton's idea and organized a series of studies which sought to prove that heredity plays a role in human traits as laziness, wanderlust, and pauperism. The most important research carried out by Davenport focused on heredity as it relates to feeblemindedness, insanity, epilepsy, criminality, deaf-mutism, genealogy, immigration, and sterilization. Davenport's book *Heredity in Relation with Eugenics* seeded fear in Americans' minds with respect to the consequences of immigration and the potential for changes in the races as they existed. As genetics became more and more popular among scientists, the members of Galton's Society, including Davenport, tried to envision a method of applying genetic theory in order to improve the human race. The solution identified by the Galton's Society was to control human procreation.

In this context, America's interracial marriages came to eugenists' attention as a source for uncontrolled racial changes and potentially undesirable results. The best solution recommended for these couples was sterilization. In time, ideas and ways of processing race differences were to strengthen the "necessity" for having a purified supreme race.

Initiated in Great Britain and continued in America, the eugenics movement had followers in Europe too. Here, the eugenics movement reached its height during the Nazi regime. In 1939, Hitler authorized the provision of mercy death for the individuals with "lives not worth living."

For Nazis, the cruelty had no limits. Nothing was considered to be too much in order to eliminate the unfit and purify the race. Euthanasia of the ones with lives not worth living was not enough; "greater" plans were to follow. The *Jewish Question* had to be addressed, Gypsies were considered as an issue, mentally ill and sexual and racial pathologies were also placed on the list of "problems." The best solution for all these problems according to Hitler was mass extermination.

Although barely noticed, resistance against the eugenics movement existed. Herbert William Conn from Wesleyan University and Herbert Spencer Jennings, a Johns Hopkins biologist, stated the importance of the environment in human evolution and development. Yet, although they resisted eugenics, they did not entirely reject it. Others, such as T.H. Morgan and Franz Boas, were categorical in their rejection, adding more importance to the human social and behavioral differences. Some scientists underscored the importance of nature and nurture in the developmental process of humankind. Among them, Dewey, Jennings, and Lippman helped public opinion to turn against the eugenics movement. Immigrant communities in the USA opposed eugenics, emphasizing the importance that the environment has on humankind's evolution.

Political backlash against immigrant minorities and restrictive immigration policies have always been present in many European countries and in the USA. Most explanations of the adoption of restrictions on immigration have focused on ethnic competition for material resources and on national political factors.

Brigham reamiend steadfast in his bias against Black Americans, which he premised on theories of heredity, despite research demonstrating that the intelligence of the Black immigrants was not inferior to Whites. Although the scientific evidence contradicted Brigham's ideas, he continued to believe that the ethnic diversity of America constituted a threat to the national welfare.

Eugenics taught humanity a harsh lesson on how science can be used to turn against people. The eugenics movement represented an excuse for exterminating the "unfit" individuals and for removing the "burden" that such people can place on the society's shoulders. It was actually a movement designed to solve societal problems by means of medical methods.

In short, based on real or imagined differences, every immigration law adopted in the USA excludes at least some categories of individuals. The laws adopted between 1789 and 1875 discriminate against every foreign citizen. In 1875, no convicts and no prostitutes were allowed; in 1882, idiots, lunatics, and individuals who could not pay a tax of 50 cents and needed public care were discriminated. From 1882 to 1943, restrictions were imposed on Chinese people. In 1885, restrictions were applied for cheap contract laborers. In 1891, restrictions were imposed on immigrants with contagious diseases, paupers, and polygamists. In 1903, no epileptics, insane persons, beggars, anarchists were allowed. In 1907, no feebleminded children under 16 years of age without their parents and immigrants unable to support themselves due to their physical or mental inability were permitted to live in the USA.

Both the Act of 1924 and the Act of 1952 granted residency based on national origin with a particular discriminative nuance toward Asians. The Immigration Act of 1965 focused on non-European countries and the Third World countries. The criteria of admission were based on skill or for family reunification.

Europe's history was also marked by immigration restrictions. The migration of labor force has continuously increased due to economic reasons. Destination countries include UK, Germany, Spain, Italy, Austria, Holland, Swiss, and Switzerland. To limit the access of immigrants, neighboring countries established agreements that permitted entry of only especially qualified individuals to immigrate.

Related Topics

- ► Genocide
- ► Holocaust
- ► Immigration processes and health in the U.S.: A brief history

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European Court of Human Rights

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The European Court of Human Rights (ECtHR) is an international Court, which operates within the Council of Europe.

History

In 1950, the Council of Europe drafted the European Convention on Human Rights (Convention for the Protection of Human Rights and Fundamental Freedoms), which entered into force in September 1953, signed by all Member States. The objective of this Convention was to implement the rights set forth in the Universal Declaration of Human Rights 1948, adopted by the United Nations.

ECtHR was established in 1959 under this Convention, in order to monitor the protection of human rights in the signatory countries. ECtHR worked with this structure between 1959 and 1998 when the Member States of the Council of Europe drafted and ratified the Protocol No. 11 to the European Convention on Human Rights. The purposes of this protocol were to simplify the structure of EctHR, to shorten the proceedings and, at the same time, to strengthen the judicial nature of the system, making it compulsory and abolishing the decision-maker role of the Committee of Ministers of the Council of Europe. Under the Protocol No. 11 dated 1998, ECtHR became a permanent legal structure, with full-time judges and allowing direct access to the European citizens.

Organization

The permanent headquarters of ECtHR is at Strasbourg, France, in a building designed in 1994 by the

English architect Richard Rogers and completed in 1995. The Operating Rules of Court provide that some of the meetings can take place in the Member States of the Council.

ECtHR is composed of 47 judges, with no conditions of nationality imposed on them. The judges are selected by the Parliamentary Assembly for a 6-year mandate; they exercise their duties ex officio on an individual basis, without representing any country. The 47 judges are assigned across into the five sections of the Court. Each section has a president, as well as the court. Two of the five presidents of the sections also serve as vice presidents of the Court. All of these functions are assigned for a period of 3 years. Each section chooses a Chamber which consists of the Chairman and six members by rotation. The Court has a Grand Chamber, composed of 17 members: president, vice presidents, presidents of the sections, and judges of the sections, the latter being selected every 9 months.

On June 23, 2008, ECtHR adopted the Resolution on Judicial Ethics, a document stating the principles that must be followed by judges to ensure clarity and transparency of their work: independence from any external authority or influence, impartiality and avoidance of conflicts of interest, integrity (high moral character), diligence and competence, confidentiality and privacy of Court deliberations, freedom of expression of their views, lack of involvement in additional activities (except when they can remain impartial and independent and when their schedule is not affected), rejection of any benefits, gifts, decorations or honors that might affect their independence and impartiality.

Procedural Issues

ECtHR judges individual complaints or complaints of the Member States of the Council of Europe, on violations of the civil and political rights stipulated in the European Convention on Human Rights. The official working languages are English and French.

ECtHR procedure is structured on three levels:

1. The Committees composed of three judges, each elected for 12 months within each section, charged with sorting claims in order to reject them if unfounded
2. The Chambers, consisting of seven judges, who are responsible for rendering decisions on the complaints admitted as founded by the committees
3. The Great Chamber, which consists of 17 judges, who judge the most important complaints

ECtHR decisions are made by the majority of judges present. The Committee of Ministers oversees the compliance of the states and the enforcement of ECtHR decisions. The most serious sanction that can be imposed on a State for the violation of a Court decision is exclusion from the Council of Europe.

In recent years, due to the increased awareness of citizens about their rights, an increased number of complaints have been lodged with the EctHR, leading to an unprecedented overload of cases and delayed decisions. For example, on January 1, 2010, the number of pending applications was 119,300, with 23% more than on January 1, 2009. The number of cases allocated to a judicial formation of the Court (Committee or Chamber) increased by 15% in 2009 compared to 2008 (from 49,850 cases in 2008 to 57,100 cases in 2009).

In 2004, Protocol No. 14 to the European Convention on Human Rights was issued in an attempt to simplify and accelerate the work pace of ECtHR. This Protocol instituted a number of procedural changes, such as:

- The initial selection of cases by a single judge and acceptance only if it finds that plaintiff has suffered “significant disadvantage”
- The analysis of cases for similarity to other cases judged before by ECtHR and their motivation by the failure of a Member State to comply with the ECtHR decision
- The assignment of only three judges to a case
- The potential to bring a member State of the Council of Europe before the ECtHR by the Committee of Ministers if the State fails to comply with the Court’s decision
- The provision by ECtHR of an interpretation of its verdict in order to maximize the likelihood that the State will respect its decision

The European Convention on Human Rights and Fundamental Freedom contains provisions on civil and political rights without stipulating the right to health of citizens. However, the Court has overcome this obstacle by considering the right to health as part of other civil and political rights stipulated by the Convention.

Article 3 of the Convention that prohibits torture or inhumane or degrading treatment or punishment may protect immigrants against expulsion to countries where there is a real risk that they will undergo treatments that could be considered torture or inhumane or degrading treatment or punishment, irrespective of the individual immigration history or her/his criminal record.

The European Court of Human Rights has examined over time a number of cases in which immigrants complained that although they were sick, they were expelled from the host country to their origin country where they could not receive proper medical care. Article 3 in these cases has been tempered in the sense that deportation of a person from a country where he or she could not receive adequate medical treatment was considered violation of the Convention. This issue was raised for the first time in 2004, in *D. v. the United Kingdom*, where the Court ruled that the deportation of a man suffering from end stage AIDS to St. Kitts, where he could not receive proper medical treatment or social support, represents a violation of the Article 3 of the Convention. However, a violation of the Article 3 of the Convention was not found in the case involving the deportation of a person suffering from a nonterminal disease who could benefit from proper medical care in the deportation country.

In *Hukić v. Sweden* (2005), the members of an immigrant family complained about their deportation to Bosnia-Herzegovina because their 5 years old son suffering from Down syndrome could not enjoy the same standard of medical care as in Sweden. The Court decided that "aliens who are deported can not claim the right to remain in a State signatory to the Convention to continue to receive medical, social or other forms of assistance provided by deporting State." This decision took into account the fact that the child's condition was not a fatal one and specialized care, appropriate to that case, was available in Bosnia-Herzegovina.

In *Ndangoya v. Sweden* and in *Amegnigan v. the Netherlands* (2004), the applicants, who were suffering from AIDS, challenged their deportation to their origin countries, Tanzania and Togo, respectively. In these cases, deportation was not considered a breach of Article 3 of the Convention because the disease was not in an advanced stage and the applicants were not deprived of medical care or family support in their countries of origin. Although the circumstances in their countries of origin were not as favorable as those in Sweden and the Netherlands, respectively, this was not decisive to the Court's decision.

Related Topics

- ▶ Access to care
- ▶ Asylum
- ▶ Convention Against Torture
- ▶ Convention on the Prevention and Punishment of the Crime of Genocide
- ▶ Discrimination
- ▶ Genocide
- ▶ Human rights
- ▶ Racism
- ▶ Refugee
- ▶ Torture
- ▶ Trafficking
- ▶ Universal Declaration of Human Rights
- ▶ Vulnerable populations

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European Union

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The European Union is an economic and political union between 27 member countries located primarily in Europe. The European Union was officially formed on November 1, 1993, by the Maastricht Treaty. In 2002, Euro notes and coins replaced national currencies in 12 of the member states. At this time, the Euro was used in 16 countries. The 27 member countries that compose the European Union are: Austria, Belgium, Bulgaria, Cyprus, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Ireland, Italy, Latvia, Lithuania, Luxembourg, Malta, Netherlands, Poland, Portugal, Romania, Slovakia, Slovenia, Spain, Sweden, and the United Kingdom. There are currently three official candidate countries: Croatia, Macedonia, and Turkey. Albania, Bosnia and Herzegovina, Iceland, Montenegro, and Serbia are officially recognized as potential candidate countries. Kosovo is also listed as a potential candidate, but the European Union does not list it as an independent country because not all member states recognize it as separate from Serbia.

Each European Union country is free to decide on the health policies best suited to national circumstances and traditions, but they all share common values. These include the right of everyone to the same high standards of public health and equity in access to quality health care. Joint action of the European Union countries adds value when facing potential threats such as epidemics and bioterrorism. The European Union has common standards for safe food and nutrition labeling, the safety of medical equipment, blood products and organs, and the quality of air and water.

The European Union is investing to improve health security of its citizens, promote good health, reduce inequalities, and provide more information and knowledge on health. This money is spent on a wide range of issues, including planning for health emergencies, patient safety, and reducing injuries and accidents. The European Union is also funding to promote better nutrition, safe consumption of alcohol, healthy lifestyles, and healthy aging to combat consumption of tobacco and drugs, to prevent major diseases including HIV/AIDS and tuberculosis, and to exchange knowledge in areas such as gender issues, children's health, and rare diseases.

The European Union determined that improving the environment will improve the health of its citizens. Environmental factors, largely pollution, cause between one quarter and one-third of illness and disease in industrial countries. A strategy within the European Commission's Environment and Health Action Plan is to tackle the links between environmental factors and conditions such as asthma, allergies, respiratory diseases, cancer, and neurodevelopmental disorders, such as autism and speech problems.

The European Union is improving health through research. The European Union is spending six billion euros on health research between 2007 and 2013 under the Seventh Framework Programme for Research and Technological Development (FP7). The money funds research in improvements in health and boosts competitiveness and innovative capacity of Europe's health-related industries and business. The emphasis is on translating basic discoveries into clinical applications, and developing and validating new therapies, as well as health promotion and prevention strategies, better diagnostic tools and medical technologies, and sustainable and efficient health care systems. Priority diseases include those that are cancerous, cardiovascular, infectious, mental and neurological, and specifically those linked to aging.

One of the hallmarks of the European Union health care system is providing access to medical treatment everywhere. European Union citizens can obtain health care wherever they go within the European Union. The European Health Insurance Card makes it easier for travelers to claim their right to health care. This card is available to citizens from the 27 member states, plus citizens of Iceland, Liechtenstein, Norway, and Switzerland. European Union citizens are able to obtain health care if they become ill in another member state, and in some cases, other European countries. With the European health insurance card, European Union citizens have the same access to care in the public sector (doctor, pharmacy, hospital, or clinic) that the inhabitants of the country the individual is visiting receive. If the individual receives care in a country where they are charged for the treatment, the individual will receive compensation after they return to their homeland. Additionally, in certain circumstances, a European Union citizen may obtain treatment in any European Union country of their choice, even if they are not on holiday in that country.

The single European emergency phone number is 112. This phone number can be used in any European Union country to connect to any emergency service. This service can be accessed from fixed phones, including pay phones and mobile phones and is provided by the European Union free of charge. When an individual calls 112, a specially trained operator will answer his or her call. The operator will handle the request directly or connect the individual to the appropriate emergency service. Operators are increasingly able to answer 112 calls in more than one language, which is helpful for individuals calling 112 while abroad.

The presence of illegal immigrants in European Union countries is increasing despite considerable immigration policy efforts over the last years. European Union Member States have responded by strengthening their fight against illegal immigration, with different multilevel measures that include the curtailment or denial of social security rights such as access to publicly funded health care. Access to health care for illegal immigrants is generally limited to situations that are life-threatening or pose a risk to the public health.

Related Topics

- ► Access to care
- ► Health care utilization
- ► Health insurance
- ► Illegal immigration
- ► Public health insurance

Suggested Readings

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Evil Eye

► Mal de ojo

Exclusion

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The Universal Declaration of Human Rights (1948, Article 25) states that “everyone has the right to a standard of living adequate for the health and well-being of himself and of his family.” In its broadest sense, health exclusion denotes a situation in which a person or a group persistently fails to attain access to this essential living standard. Two elements are fundamental to the notion of exclusion and its relationship with immigration.

First, the concept has a multidimensional nature. Numerous basic economic, social, cultural, and political factors make up people’s health and well-being, such as housing, education, information, leisure, food, clothing, pollution, and health care. (Effort has been devoted, especially within the European social policy framework, to identify indicators suitable for measuring exclusion.) As a consequence, many features of the integration process of immigrants in the host country can affect their probability of being excluded. One prominent aspect is their success in the labor market and, more generally, the incidence of financial barriers relative to the native population, since income has an enormous influence on life standards.

Second, individuals or groups can be declared excluded only compared to other members of the specific society in which they hold membership. Because exclusion is a relative concept, the notion of exclusion varies across time and place and depends, among other things, on the level of development, culture, and the prevailing institutional arrangements and social policies. For example, in countries where most people lack water sanitation services, lack of access to clean water is not evidence of exclusion.

Consideration of these two elements together (multidimensionality and relativity) produces a very complex picture of the concept of exclusion. Here, the scope of the analysis is restricted by focusing on a specific dimension (access to health care) and a restricted set of countries (advanced economies). Broadly speaking, developed countries are equipped with welfare state institutional arrangements, which explicitly deal with social exclusion in general and, in particular, guarantee coverage against specific health care needs. These public programs encompass both in-kind provision of health care (as in most European countries) and monetary transfers to support private expenditures in health care (either out-of-pocket payments or the purchase of private health insurance, as in the U.S.). For migrants, barriers to accessing public health programs represent a complex picture, where both eligibility criteria and differential take-up rates are relevant.

In general, countries do not intentionally discriminate against naturalized immigrants in their entitlements to access public social programs. In some countries, the eligibility of noncitizens for such benefits is conditioned on the length and category of their residence in that country and on their legal status (documented vs. undocumented). An example of the former type of limitation is the U.S. 1996 Personal Responsibility and Work Opportunity Reconciliation Act, which prohibited the receipt by most noncitizens of most types of public assistance, including Medicaid, during the first 5 years after arrival. The period of residence is relevant to the receipt of benefits in some European countries as well, such as Finland. Most countries prohibit access by undocumented immigrants to most, if not all, types of medical assistance. For example, in the U.S., undocumented immigrants cannot enroll in Medicaid and SCHIP; limitations differ across E.U. countries. However, emergency care and medically necessary health care are often permitted to them. In general, the residence permit/citizenship requirements represent implicit obstacles to access medical care. Often, people living in temporary detention centers face important access problems, too. Rules can also differ for refugees and asylum seekers.

Even if immigrants are eligible for public health care programs, they may be effectively excluded from participation in these programs due to low application rates. Potential barriers that could reduce immigrants' participation in the programs include: lack of information, e.g., knowledge about the availability of the program, application procedures, and other relevant institutional details; language difficulties; geographic barriers; administrative and bureaucratic factors, such as unintended administrative complexities; and differences in culture and social norms, which affect health behaviors. These barriers add to the other possible dimensions of relative deprivation of immigrants, such as poverty, inadequate housing, insecure working conditions, etc.

The above discussion on eligibility criteria and benefit application rates highlights a useful distinction between active and passive exclusion. Some rules, notably immigrants' eligibility restrictions, intentionally exclude a particular group of people from accessing public health assistance. In some cases, such as when administrative complexities exist, the potential exclusionary outcomes are accidental. Because of the interplay between the various dimensions of exclusion, active or passive exclusion in one particular area can bring about unintended and even unforeseeable exclusionary consequences in access to health care. As an example, undocumented immigrants often refrain from contacting authorities due to fear of being reported or arrested. This may increase the informational and bureaucratic barriers they face and reduce their access to hospitals. In this sense, strict rules against illegal immigration can unintentionally reduce undocumented immigrants' application rates for health-related benefits.

Several studies show that inequalities between immigrants and natives and across immigrants from different national origins in both eligibility criteria and application rates negatively affect immigrants' health care utilization, particularly access to prevention programs and delayed care, and health outcomes. Moreover, inequalities in health care utilization tend to persist over time and across generations, even after explicit barriers are removed. This last feature is crucial, as it causes sizeable persistent differences in access to health care across national minorities (ethnic, racial, linguistic).

These facts raise clear equity issues and can undermine social cohesion over time. From a public policy perspective, lack of health care utilization by immigrants can impact the community health, as might occur through increased exposure of citizens to transmissible diseases, and the increased costs associated with delayed interventions or unnecessary presentation for emergency services when regular care cannot be accessed.

Countries can try to address the public health concerns associated with migration inflows by enforcing selection rules on applicant migrants as well. In fact, while the previous discussion focuses on the potential barriers to accessing health care for immigrants already settled in the receiving country, another relevant form of exclusion occurs if potential migrants are precluded from entering into a country on the basis of health-related grounds (as, for example, in Canada). In general, the avowed aim of this kind of selection rules is to prevent the entry into the country of specific communicable disease (the screening procedures may differ across countries of origin) and/or persons likely to become an excessive charge on the public health care system (or, in general, on the welfare system). Both motivations were present, for example, in the U.S. Immigration Act of 1891 and continue to be reflected in current law.

Related Topics

▶ Access to care
▶ Assimilation
▶ Barriers to care
▶ Discrimination
▶ Health services utilization
▶ Illegal immigration
▶ Illegal Immigration Reform and Immigrant Responsibility Act of 1996 (U.S.)
▶ Irregular immigration
▶ Poverty
▶ Racial disparities
▶ Social integration
▶ Universal Declaration of Human Rights

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Explanatory Model of Illness

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The definition of the term explanatory model of illness underscores the non-universal nature of the manner in which illness is defined and experienced bringing to bear the thesis that illness is a socially constructed experience and not solely the result of purely biological factors. Studies on this topic began with the seminal work of medical anthropologist Arthur Kleinman. The term "explanatory model of illness" attempts to capture the idea that factors outside of the individual, such as culture, influence the way illness is conceptualized and experienced.

In certain societies, medical research and practice has been primarily influenced by germ theory which emphasizes pathogens as causes of disease. Germ theory gave rise to the biomedical model which conceptualizes individuals as physical and chemical beings. The term explanatory model of illness was developed to understand the way disease is experienced in individuals who do not endorse the biomedical model and thus, to quantify the illness experience of individuals who endorse more contextual explanations of disease rather than a purely biological one.

The predominant model of illness in a society influences an individual's disease causal attribution. Certain cultures emphasize social factors such as social stress and interpersonal conflict over etiological agents such as bacteria as causes of disease. For example, individuals from certain rural communities in Latin American prefer folk belief-shaped theories about body functioning. Moreover, some members of highly traditional Asian societies emphasize the role of non-somatic related phenomena such as depletion of energy, socially caused stress, such as disharmony between kin members, or physically caused stress, such as overwork, and disruption of temperature homeostasis, also known as sudden "enfriamiento" or "cooling," in illness manifestation.

Empirical evidence suggests that cross-cultural differences exist in the explanatory models of illness preferred by ethnic minority groups residing in multicultural societies. For example, a study investigated the importance given to various causes of illness by Black, Latino, Asian/Pacific Islander, and non-Hispanic White males and females with an age range of 16–81 years, residing in the United States. Results indicated that members of the minority groups sampled emphasized the importance of supernatural and interpersonal causes as disease explanations when compared to non-Hispanic Whites. Research with older Hispanic adults residing in the United States indicates that the health beliefs of certain members of this population can be described as a complex belief system. For example, health is conceptualized as a state of harmony between three entities: (1) the individual, (2) nature and cosmos, and (3) society. Moreover, experts have termed this complex health belief system Curanderismo. Curanderismo refers to the health practices that exemplify this historically influenced world view about the sources of illness. A study was carried out to investigate the use of folk medicine such as Curanderismo in Mexican-American women, 20–47 years, living in the United States. Findings suggest that 84% had personally received the services of an indigenous/folk/spiritual healer.

Immigrants' preferred way of explaining illness may come in conflict with the way health practitioners of the receiving community explain and treat illness. A lack of appreciation by health care practitioners of the way sociocultural aspects influence illness causal attributions can lead to ethnic health disparities by impacting important predictors of disease outcomes such as adherence to prescribed treatment regimen. In other words, an emphasis on chemical agents as cures may lead health care practitioners of the receiving community to neglect psychosocial and contextual/cultural aspects as potentially curative. A study conducted to investigate the preferred modes of treatment by physicians in a highly Westernized society revealed that biomedical variables alone predicted prescribed treatment regimens in 53% of cases. Experts agree that health care practitioners need to be aware of the potential diversity in explanatory models of illness especially in immigrants from cultures that are far removed from societies that emphasize a purely pharmacological disease treatment. Failure to inquire about disease conceptualization and attribution could negatively impact diagnosis accuracy and treatment effectiveness. Thus, it is recommended that health care practitioners probe the concept of explanatory model of illness in their culturally diverse patient population.

Researchers use different ways to assess cultural differences in preferred explanatory models of illness. For example, qualitative research methods are particularly useful to elicit cultural differences in Illness Representation Models (IRM). An IRM captures the following domains in illness cognitions: (1) the characteristics of the illness and their effect on identity, (2) the causes of the disease, (3) disease duration, (4) disease consequences, and (5) disease chronicity. Research suggests that the various domains of the IRM are influenced by culture and predict the manner in which individuals conceptualize a disease and the strategies used to control and adapt to such illness. An IRM is related to symptom experience, treatment seeking and adherence, and to the general psychological adaptation to the disease. For example, an emphasis on somatic disease attributions, at the expense of other potential environmental or contextual causes, leads to worse symptom management, and ultimately worse disability. On the other hand, emphasis on contextual disease attributions may lead to lower treatment adherence.

An individual's preferred explanatory model of illness has important implications for the adoption of health protective behaviors. Experts suggest that cultural health beliefs about factors that cause illness directly influence the actions that people take to prevent disease. Researchers urge multicultural societies to consider potential diversity in the health beliefs and practices of their population while planning and implementing health care services as certain population segments may embrace alternative health models. Failure to take into account existing cultural differences in illness explanatory models may result in the alienation of those individuals whose explanatory model of illness may differ from the predominant forms of prevention and treatment.

Multicultural communities are unique environments characterized by a continuing renewal of cultural patterns. Such dynamic cultural patterns interact with individual level, social, and geopolitical factors affecting societies at large. Thus, explanatory models of illness may be dynamic too and in constant fluctuation. The different conceptual systems of health illness beliefs influence an individual's exposure to risk, prevention, and care and as such can be important domains for assessing the relationship between cultural adaptation, well-being, and vulnerability to disease. Thus, it becomes important to investigate the extent to which indigenous health cognitions change and how they shape the adoption of health protective behaviors, access, and utilization of health care services.

The preferred explanatory model of illness has implications for the design and delivery of health promotion interventions aimed at culturally diverse individuals residing in multicultural societies. Research suggests that subjective culture influences the communication preferences of individuals regarding message content, source of communication, and channels used in public health interventions. Thus, it becomes important to investigate the influence of culture on explanatory models of illness and its subsequent effect on the communication preferences of culturally diverse individuals regarding preferred messages, sources, and channels for message delivery in health promotion interventions.

Related Topics

- ► Cultural background
- ► Curandero
- ► Ethnic minority group
- ► Health beliefs
- ► Health disparities
- ► Hispanics
- ► Latinos
- ► Methodological issues in immigrant health research

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Extended Family

- ► Compadrazgo
- ► Familismo
- ► Family
- ► Family reunification
- ► Hijos de crianza

F

Falls

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A fall is an event that results in an individual coming to rest unintentionally on a lower level. Fall-related injuries can be fatal or nonfatal; however, most are nonfatal. A recent study of childhood falls in the People's Republic of China, for example, reported that for every death due to a fall, there are 4 cases of permanent disability, 13 cases that require hospitalization for more than 10 days, 24 cases that require hospitalization for 1–9 days, and 690 cases that require medical care or that result in missed school or work.

Falls are a chief public health concern worldwide. The World Health Organization (WHO) estimates that 424,000 fatal falls occur each year; falls rank second only to road traffic injuries as the leading cause of unintentional injury death. Notably, 80% of fall-related fatalities occur in low- and middle-income countries; regions of the Western Pacific and Southeast Asia account for more than two-thirds of these deaths; and death rates due to falls are highest among adults over 60 years.

Each year, there are approximately 37.3 million nonfatal falls that are severe enough to require medical attention, resulting in greater than 17 million disability-adjusted life years (DALYs). Originally developed by the WHO, DALY is a measure of overall disease burden. It is expressed as the number of years lost due to ill-health, disability, or early death. Concerning severe yet nonfatal falls, the largest morbidity occurs in the following groups: persons aged 65 years or older, young adults aged 15–29 years, and children aged 15 years or younger. Another potential consequence of a fall, particularly for older people, is the risk for subsequent long-term care and institutionalization.

Risk

Age, gender, and health of the individual can affect the type and severity of injury. Age is a key risk factor for falls. Older people have the highest risk of death or serious injury from a fall, and the risk increases with age. In the United States, for example, 20–30% of older people who fall suffer moderate to severe injuries. Another high-risk group is children. Childhood falls occur largely as a result of their evolving developmental stages, innate curiosity of their surroundings, and increasing levels of independence that coincide with more challenging risk-taking behaviors. The circumstances surrounding a fall are often complex, interacting with poverty, sole parenthood, and particularly hazardous environments.

Both genders are at risk of falls; however, in some countries, it has been noted that males are more likely to die from a fall, while females are more likely to suffer more nonfatal falls. Older women and younger children are more likely to experience a fall and are at increased risk for severe injury. Worldwide, males consistently sustain higher death rates and DALYs lost; possible explanations may include higher levels of risk-taking behaviors and hazards within occupations.

Prevention

It is suggested that fall prevention strategies be comprehensive and multifaceted, where research and public health initiatives are prioritized, variable risk factors are explored, and effective prevention strategies are utilized. Effective fall prevention programs aim to (a) reduce the number of people who fall, (b) reduce the rate of falls, and (c) reduce the severity of injury should a fall occur. For older individuals, fall prevention programs frequently include a number of components to

Sana Loue & Martha Sajatovic (eds.), *Encyclopedia of Immigrant Health*, DOI 10.1007/978-1-4419-5659-0,

identify and modify risk, such as screening within living environments for risks for falls; providing clinical interventions to identify risk factors, such as medication review and modification, treatment of low blood pressure, vitamin D and calcium supplementation, treatment of correctable visual impairment; home assessment and environmental modification for those with known risk factors or a history of falling; prescription of appropriate assistive devices to address physical and sensory impairments; muscle strengthening and balance retraining prescribed by a trained health professional; community-based group programs which may incorporate fall prevention education and Tai Chi-type exercises or dynamic balance and strength training; use of hip protectors for those at risk of a hip fracture due to a fall. Experts suggest that effective interventions for children should include multifaceted community programs; engineering modifications of nursery furniture, playground equipment, and other products; and legislation for the use of window guards. Other promising prevention strategies include use of guard rails/gates, home visitation programs, mass public education campaigns, and training of individuals and communities in appropriate acute pediatric medical care should a fall occur.

Related Topics

- ► Health outcomes
- ► Life expectancy

Suggested Readings

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Suggested Resources

Centers for Disease Control and Prevention. (2009). *Preventing falls: What works a CDC compendium of effective community-based interventions from around the world.* http://www.cdc.gov/HomeandRecreationalSafety/Falls/preventfalls.htm

For information from the American Academy of Orthopedic Surgeons. http://orthoinfo.aaos.org/topic.cfm?topic=A00118

For information from the Centers for Disease Control and Prevention. http://www.cdc.gov/

For information from the National Institute for Occupational Safety and Health (NIOSH). http://www.cdc.gov/niosh/about.html

Familismo

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A quality that has come to characterize Hispanics/Latinos across the hemisphere is the notion of *familismo* (familism), defined as a strong orientation and commitment toward the family. *Familismo* is also connected to a high value on marriage, childbearing, and responsibility toward siblings. Family duties, loyalty, and interconnection to family members in both nuclear and extended families are also qualities that accompany the notion of *familismo*. The ideology of familism extends beyond blood kin to include extended families of several generations and godparents (*compadres*), another important cultural practice found among Latino families. Interviews conducted by the National Research Council offer some evidence as to how *familismo* is defined by immigrants and their children. A Mexican immigrant in Raleigh, North Carolina observes "that sometimes families here, White families, are not as united as Hispanics families... We're always famous for having aunts and uncles and relatives .. . ." In contrast, a third-generation Hispanic in Houston, Texas adds "[t]ypically, we have close families. Family is a really big part of our culture." These two quotes point out two critical issues underlying what we know about familismo: It is a quality that distinguishes Hispanic/Latino families from other groups, most principally Whites, and it tends to be passed down from generation to generation.

Historians trace the centrality of the family and its accompanying ideology of familism to the colonization of the Americas by the Spanish and Portuguese. In particular, the institution of marriage created alliances between families to further extend kin interests. In the USA, the development of large extended households is connected to the social and economic conditions that prevailed among Mexican American families in the Southwest before and after the end of the Mexican–American war in 1848. The large extended family offered stability and support in particular for poor and young men and women. In the Southwest, families expanded and contracted baffling census takers through the nineteenth and early decades of the twentieth century.

Familismo is a gendered ideology that helps organize the roles and responsibilities that men and women have toward each other and toward other family members. For example, among many immigrant families in the USA, children are not encouraged to leave the house until they are married. Once grown and married, they are encouraged to live close to parents so that everyone in the family lives close by. Even when children are married, some parents encourage the newly married couple to move in as a strategy to save money and maintain family ties. The notion of *familismo* as a defining quality of Latino families has been inscribed in popular culture by films such as: Gregory Nava's, *My Family* (starring Jimmy Smits, Edward James Olmos, Esai Morales, and Jennifer Morales) from 1995 and the more recent, *Nothing Like the Holidays* from 2008, produced by Alfredo De Villa, starring John Leguizamo, Alfred Molina, Luis Guzman, and other Latino actors.

Research has sought to link the notion of *familismo* to school failure and lack of assimilation among Latino immigrants and their children. Some associate the strong family orientation among Latino immigrants as an impediment to developing and assimilating an ideology based on the needs and desires of the individual. The argument is that strong family ties prevent Latino immigrants from developing individualistic and self-oriented goals needed for success in school. Others have used *familismo* as a cultural practice impeding full acculturation of men and women and therefore a cultural explanation for the high rates of isolation and poverty among Latinos. A distorted notion of *familismo* as applied to men and women posits that Latino families are characterized by strong-minded macho men and submissive and passive women tied together by notions of obligation to each other. The trope of *familismo* has become a convenient label to dehumanize, demonize, and cast off Latino immigrants as culturally incompatible with modernity and post-industrial societies.

Research has also offered alternative ways to understanding how *familismo* becomes a resource for immigrant families across mainland Latino communities. There is evidence that extended-family households continue to prevail among immigrant communities because of different life-course needs. Immigrant families often contain aging parents, children, and other family members in different stages of family formation. Psychologists have found Mexican American and Puerto Rican children are more likely to live with grandparents, thereby providing working parents some reprieve from the huge costs of child care. A question that concerns researchers is: if familism protects children, could low-economic status offset the benefits of living in a large extended family? Evidence suggests that two-parent homes with extended kin often provide resources (emotional, economic, and cultural) that offset the socioeconomic instability found among working class and poor immigrant families. The consensus emerging from some of the research suggests that familism is a value worth keeping, even in the name of rapid acculturation processes among second- and third-generation Hispanic/Latino youths.

If Hispanics/Latinos continue in the path of assimilation and acculturation similar to the one used by European American groups, some researchers suggest that this could place the value of familism in jeopardy. To what extent does the socio-economic mobility and adoption of US cultural norms erode *familismo* as a cultural characteristic of Hispanic/Latino families? Researchers suggest that trends in intermarriage, cohabitation, and divorce rates vary a great deal among the many nationality groups that represent the larger community popularly known as Hispanics/Latinos. Mexicans, for example, tend to have larger families and have been found to be more familistic than other groups. It has been suggested that this is due to the high levels of immigration and residential concentration, factors that help maintain in-group marriage and familism.

Migration is also another factor that could seriously erode notions of familism among some Hispanic/Latino groups. The growing number of immigrant working mothers who leave children in their countries of origin in the care of grandparents and other relatives has raised concerns about the future viability of these transnational families. Transnational mothers are caught in the struggle to survive produced by globalization processes, thereby throwing into relief deeply cherished notions of *familismo*. Further, in the USA, the implementation of more restrictive immigration laws and the recent increase in deportation of men and women without proper documentation foster conditions that threaten immigrant family relations, bonding, and responsibilities.

Related Topics

- ► Acculturation
- ► Compadrazgo
- ► Family
- ► Family reunification
- ► Gender
- ► Marriage
- ► Transnational community

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Family

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Family as it relates to immigrant health refers to a unit of biologically related individuals in a variety of scenarios: the members of this unit may immigrate to a receiving country together, they may be separated from each other by some members' decision to immigrate to a new country, they may be separated physically but maintain strong ties emotionally or financially. Each of these experiences has different repercussions for the "family" involved. There are many reasons behind family decisions to migrate, including: poverty, war and other destructive situations, oppression and prejudice, or a desire for freedoms not available in the sending country. A common factor in immigration for many families is to provide better lives and more opportunities for their children. Children are usually aware of this motivation, which carries with it expectations for them. Immigrant families often differ from other families in receiving countries: structurally, relationally, and financially. There are many factors that influence outcomes for families following immigration. It is important to consider characteristics of both sending and receiving countries when working with immigrant families, and to look at the interactions between families and the systems of the receiving country, as well as the nature of the family's exit from the sending country.

A structural and relational difference between immigrant and native families, especially in the USA, is that immigrant families are more likely to include extended family members, and have different expectations for family members than native-born families in receiving countries. Immigrant families are likely to have a two-parent household, and often include grandparents or aunts/uncles/cousins or others. Living with extended family members may be a temporary arrangement following immigration, allowing for support during transition, but changing as the family adjusts. In industrialized countries, native-born families are more likely to be "nuclear" families consisting of only parents and children, and may have only a single parent. Extended family members often constitute an important social support for immigrant families, whether they live in the household or in the neighborhood, providing child care, social support, job opportunities, language translation, and financial support. Children and adolescents in immigrant families tend to have significant responsibilities, contributing to the family and home in a multitude of ways. Immigrant families often expected siblings to be caretakers prior to migration, and continue the practice following migration. Sibling caretaking is perceived by immigrant families to have many positives for all involved: children who are caretakers like the authority and responsibility, children who receive care see their older siblings in a positive way, and parents feel that they can trust the care that is being provided, as well as seeing an economic benefit. However, sibling caretaking conflicts with the cultural expectations of most receiving countries, where children are seen as dependents and are not given such high levels of responsibility. In some receiving countries this can lead to allegations of neglect, or cause immigrant families to have punitive interactions with government systems (educational or child protection). It is important to look at the risks and benefits for each family, and to recognize the cultural norms and values that shape the practice.

While extended family provides support, the larger ethnic community of other immigrants from the same sending country also creates networks of resources. When families either immigrate with or find a community of compatriots from their sending country, the network of compatriots supports the family in maintaining its values, structure, and traditions. The network helps to socialize children and reinforce cultural norms. The ethnic community can provide jobs or knowledge about opportunities in the receiving country, help the family to navigate the educational and social support systems, and generally facilitate the family's transition. The experiences of immigrant families that have this extended support are very different from those of families who immigrate without it. Immigrant families are more likely to adopt the language and cultural practices of the receiving country if they are isolated from the support of their ethnic community. But some of these immigrant families will adhere to the culture of their sending country despite their isolation, maintaining the familiar through all the transitions.

It is important to consider how connections to family members in the sending country are maintained for an immigrant family. Most immigrants will have ties to family members that were left behind, often sending money or resources. They may travel between the receiving and sending countries on a regular basis. They may even maintain a residence in their sending country, intending to eventually return. These transnational patterns are becoming more common as it becomes easier for families to travel and migrate. Sometimes parents migrate prior to the immigration of other family members in order to prepare a home for the family in the receiving country. This separation has ramifications for family relationships, as some children feel loss and resentment as a result, even if they cognitively understand the reasons for the parent's absence. During the separation, children may be given more power in the family, causing conflict if the parents attempt to reassert their roles. If there is a marital separation as part of migration, it may cause stress on the marriage. These strains will need to be addressed following reunification. The consequences of these separations and their effects on different populations remain unclear; research continues in this area.

The losses accompanying separations are one form of loss that immigrants experience. Other forms of loss may be pre-, post-, and part of the immigration process. They include traumas and separations prior to immigration, often due to war or oppressive regimes in the sending country; separation from family members and loss of familiar settings, resources, climate, and cultural opportunities due to immigration; and separations that occur following immigration, as well as losses due to adaptation and acculturation to the receiving country. Traumas and separations prior to immigration influence the family's exit from the sending country, as the family may feel compelled to exit, may leave as refugees, or may have to use subterfuge to exit. These affect the resources that the family will have in the receiving country, which affects the overall transition process. The family may worry about family members left behind with no way to maintain contact or be sure of their continued safety. This can consume family members' energy, making it more difficult for them to adjust, and may contribute to differential adjustment within the family. Depending on how trauma is experienced by different family members, this may also contribute to differential adjustment to the receiving country. Families that do not have trauma prior to immigration will still experience the loss of their familiar milieu, and will need to learn which of their skills and assets will be useful in their new setting. Adaptation, acculturation, and assimilation are further losses that impact immigrant families. Because different family members may change at different rates, conflicts may arise as a result of these differences. Some family members may perceive the losses related to adaptation as positive, where others see it as threatening, and others become depressed.

One way that many immigrant families tend to differ from native families is the value placed on collectivism or individualism. Families tend to emigrate from sending countries, such as India, China, or nations in the Middle East or Africa, where collectivism and interdependence are valued. For many there is a cultural conflict between the values of the sending country and those of the receiving countries, such as members of the European Union and North American countries, which often emphasize individualism and autonomy. Collectivism and interdependence stress the importance of social relationships and connections to family members. Many immigrant families are able to support their members in maintaining connections while developing the autonomy that is expected in most receiving countries. Some immigrant families see autonomy as a threat to these relationships; when this happens it can lead to conflict and division within the family. The prioritizing of interdependence is more commonly seen in immigrant families than native families. In addition to these umbrella values, there are specific cultural heritages that influence how family members are socialized and further shape family relationships and dynamics.

Sending and receiving countries often hold differing values with respect to gender roles. Women often gain status and power following immigration, and men may lose power and status if they are unable to work at a level commensurate with their previous status. A specific immigrant group in which the dynamics relating to changes in gender and families have been explored is that of Somali immigrants to the USA. Traditionally Somali families are patriarchal and headed by men, but 25% of Somali families who have immigrated to the USA are headed by women. Extended family support is very important in Somalia, but because these ties have been disrupted by immigration, new networks have been created with other nonfamilial refugees while others struggle in isolation. While extended family provided support premigration, it also was a source of social control, especially for women. In the USA, social control comes from other sources in the community, and is more directed at men. Somali women tend to view the changes in power dynamics more positively than Somali men do, but both are aware that there is an increased strain on marriages.

Despite all of the associated stress, immigration is often seen as a protective factor. Families who immigrate tend to have family members who overcome many obstacles and who are resilient in response to risks that cause problems for nonimmigrants. These protective factors usually do not extend beyond the first or the 1.5 generation, which suggests that the protective factors are related to the experience of immigration. There also appears to be an interaction between the cultures of the sending and receiving countries that affects this protective factor. The children who are most successful following immigration tend to be those who are able to use the resources of both the sending and receiving countries.

Each family needs to be seen in light of all the different resources and experiences they bring to the immigrant transition. Resources include family and community relationships, finances, education, skills, and language. Experiences include traumas and losses, as well as the culture and history of the sending country and reasons for immigration. The systems of the receiving country create the space where all these resources and experiences are used, and depending on how the systems work and what is valued, the family's transition will be more or less successful.

Related Topics

- ► Ambiguous loss
- ► Ethnic enclaves
- ► Family reunification
- ► Social integration
- ► Social networking
- ► Transnational community
- ► Trauma

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Suggested Resources

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Family Planning

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Family planning in the developing world and with immigrant and minority populations in the United States, has a mired history of opposing goals and competing factions. Research physicians defied the Declaration of Helsinki as recently as 1971 in their conduct of experiments with hormonal contraception on unsuspecting women. The Catholic and Evangelical churches have rejected all family planning except periodic abstinence, also known as the rhythm method, and only for married couples. Government agencies have focused on population control while simultaneously expressing concern about women's health, particularly maternal mortality. Women's desires, needs, and rights have rarely been a family planning priority. This has led to inconsistent contraception use, unwanted pregnancies, and clandestine abortions. Populations most affected are those without the resources necessary to access health care services.

Since the latter part of the twentieth century, Hispanics have had the highest fertility in the United States. On average, according to Census data, Hispanic women have 2.3 children compared to 1.8 for non-Hispanic White women and 2.0 for African American women. Hispanic fertility in the Unites States is higher than in various Latin American countries. In the latter, largely due to local government concerns and foreign aids, family planning programs have been aggressive. Hispanic-origin women residing in the United States face multiple obstacles to accessing health care and, as a result, to family planning.

The National Family Planning Program, also known as Title X, was created in 1970 during the Nixon administration. The Title X Family Planning program is administered within the Office of Public Health and Science, Office of Population Affairs (OPA) by the Office of Family Planning (OFP). It is the only federal program in the United States dedicated exclusively to the provision of family planning and related preventive health care. The most recent Title X annual report explains that immigrant populations fear Title X providers will turn them over to (immigration) authorities and, therefore, underutilize available services.

Hispanics are less likely to be privately insured than their non-Hispanic White and African American counterparts. Undocumented Hispanics have very limited access to public insurance. The Personal Responsibility and Work Opportunity Act of 1996 limited federal Medicaid coverage to citizens and legal immigrants. Additionally, in order to qualify for coverage, legal immigrants must have arrived in the United States before 1996 or have resided in the United States for at least 5 years. Hospitals, however, are required to provide emergency medical services to the undocumented, including labor and delivery services. The 2005 Deficit Reduction Act codified new regulations requiring proof of citizenship as a condition for Medicaid eligibility. The one exception applies to low-income women during pregnancy even when they are undocumented.

Beyond regulatory barriers, disparities in family planning mirror disparities in other health services. Discrimination and distrust have affected the relationship between communities and family planning providers. The first large-scale clinical trial of oral contraceptives, or the Pill, was conducted in Puerto Rico in 1956. By 1957, Mexico and Haiti were also testing the Pill. The Food and Drug Administration (FDA) approved the Pill in the United States in 1960, but reports of side effects prompted pharmaceuticals to further fine-tune the Pill's hormonal composition. In 1971, a San Antonio doctor set out to test whether the Pill's side effects were psychological or real.

Mexican women in San Antonio attending a clinic to obtain oral contraceptives were, without their consent, entered into a crossover clinical trial. Half were given placebos and the other half were put on the Pill. In the middle of the trial, the experimental group crossed over to being the control group. Eleven out of 76 women became pregnant and sued the doctor for child support. They lost. The researcher said he had instructed the unsuspecting study participants to use vaginal spermicides to prevent pregnancy if the Pill did not. Vaginal spermicides have a substantial failure rate when used alone (without a condom or diaphragm). The researcher also claimed the subjects would not have been able to understand his study design, thereby excusing his failure to secure their consent.

As early as 1949, just under one fifth, or approximately 20%, of all deliveries in Puerto Rico were followed by sterilization. Currently, Hispanic women are far more likely to be counseled on sterilization than their non-Hispanic White counterparts and sterilization rates reflect this disparity. Recent data indicate that 20% of Hispanic women in their childbearing years are sterilized compared to 16% of non-Hispanic White women.

In the United States, the largest repository of information on family planning is the Centers for Disease Control's National Survey of Family Growth (NSFG). It is a household survey, which has been translated into Spanish. The NSFG attempts to explain trends and group differences in birth rates, contraception, infertility, sexual activity, and marriage. In the first 5 cycles of the survey – 1973, 1976, 1982, 1988, and 1995 – the NSFG was based on samples of women 15–44 years of age. In 2002, the survey was expanded to include a national sample of 4,928 men. Response rates have been approximately 80% in every cycle. NSFG survey results report Hispanic women are more likely to use 3-month injections (Depo Provera) than the Pill compared to non-Hispanic White women, 24% and 69% versus 14% and 87%, respectively. The NSFG documents that Hispanic women are more likely to obtain their birth control from clinics than from private providers. Also, Hispanic women were far more likely to be counseled on family planning when this was not the focus of a medical visit.

One topic not currently discussed in the literature on Hispanics and fertility that has been investigated in anthropology involves the menstrual cycle and what is normal. Research conducted with African Dogon women in Mali in the 1980s found that women had far fewer menstrual cycles than American women did. This is because these women, during their fertile years, were either pregnant or lactating, which was a fairly typical pattern in preindustrialized agrarian societies. Breastfeeding was, and in some areas still is, used for child spacing. However, women must breast-feed between eight and ten times a day to suppress ovulation. This mechanism also suppresses menstrual bleeding. The NSFG documented Hispanic Americans' preference for Depo Provera, which has been associated with decreased menstrual bleeding; this preference may be related to what Hispanic immigrant women or their relatives have experienced as "normal" menstrual cycles. On the other hand, the choice of a quarterly injection over a daily pill may have been influenced by providers who believe Depo Provera is a better choice, that is,, more reliable, for certain populations. Indeed Depo Provera is more reliable than the Pill, and becoming pregnant after stopping Depo Provera takes longer than becoming pregnant after stopping oral contraceptives.

Additional research on Hispanics and family planning was available for approximately the past 50 years. Sociologists and economists have developed theoretical models. They have attempted to explain the Hispanic fertility differential using various hypotheses, which address a wide range of topics from cultural preferences for larger families to the impact of women's work on family planning and fertility. Hospital data, from various Latin American countries, demonstrate women are being hospitalized for complications of induced clandestine abortions as abortion is largely illegal across Latin America. These data contradict the belief that Hispanic women's reproductive choices are affected by either cultural norms or religiosity. Recent applied studies on Hispanics and family planning have been done in health services research. However, much of the applied family planning research on Hispanics has used small clinic samples and, therefore, has studied predominately lower socioeconomic status women. Some of the recent clinic studies have also revealed Hispanic-American women are doing their own abortions.

Much of the early theoretical research on Hispanic fertility focused on Mexican origin individuals as they were the first large Hispanic immigrant subgroup in the United States. The early research on Mexican (and minority) fertility attempted to contrast economic and cultural models to accept one view by ruling out the other. In the 1960s, the work of Goldscheider and Uhlenberg incorporated both economic and cultural components in their Minority Status Hypothesis. This model posits that being a minority has an independent effect on fertility. That is, some "minority" individuals will have fertility levels different from the majority population for no other reason beyond their minority status. This hypothesis does not suggest a direction. Exposure to the majority society, they state, can depress or increase fertility.

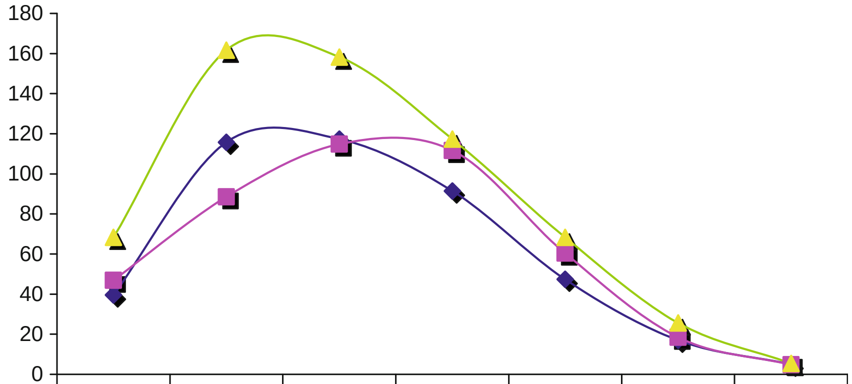
Two decades later, Bean and Swicegood explained that three broad approaches to the study of minority fertility emerged from the work of Goldscheider and Uhlenberg. These are the comparative, the intragroup, and the contextual studies. The comparative studies examine minority to majority fertility levels after matching for socioeconomic variables. According to this view, perceptions of discrimination or marginality will not surface until the minority group has become acculturated and partially assimilated. Intragroup studies do not study minority group status directly. They focus on the internal heterogeneity of racial and ethnic groups with regard to individual acculturation and assimilation. This approach intends to tap into dimensions of ethnicity not measured by socioeconomic status. Contextual approaches usually take residential and occupational segregation to be indicators of acculturation and assimilation. These may vary independently of individual socioeconomic characteristics but still affect fertility behavior. For example, a Hispanic-origin individual with a college degree living in a largely Hispanic enclave will keep the traditions and practices of the ethnic enclave. This view contradicts economic models, which suggest upward mobility is associated with taking on the values and norms of the host society.

The value of children, according to economic theory, can be measured by the amount of children – quantity, or by resource intensity – quality. Thus, children are seen as human capital. In agrarian societies, child quantity was more important than child quality. As populations become urban, this tendency is reversed. Economists see children as home-produced assets. “Production” will be affected both directly and indirectly by the wife’s time and the (cost of) available market goods and services. All this is contingent on the level of education of both parents. The more valuable a parent’s time is, as measured by salary for work outside the home, the more expensive a child becomes. This theory may work well for nuclear families and less so for cultures that benefit from the social support (for childcare) made possible by extended families, albeit sometimes non-blood kinships.

Recent research examining fertility and maternal earnings across racial groups found that family size is detrimental to non-Hispanic White women’s earning but not to Hispanic women. These researchers also report that early onset of childbearing was detrimental to Hispanic women’s future earnings but not to their non-Hispanic White counterparts. They attribute this, in part, to the fact that Hispanic women have a high gender ideology and, therefore, are less likely to seek work that does not conform to (Hispanic) female gender roles. This type of work pays less. To their credit, they do discuss the role of discrimination in preventing access to better jobs. However, they did not examine ethnic subgroups of Hispanic immigrant women. There is a vast body of research going back to pre-Colombian times addressing gender roles in Latin America and how these vary by geographic area. Moreover, gender roles are fluid. Aztec deities had the ability to change genders. Recent ethnographic research done in Mexico documents that, among poor and lower socioeconomic families, husbands help with childcare and chores when women work outside the home for paid wages.

Current Census data support both social and economic fertility models. Comparing immigration status, both native-born women and naturalized citizens have lower fertility than noncitizens. Later generation Hispanic women have birth rates similar to their non-Hispanic White counterparts. As Hispanic women acculturate and attain more formal schooling, fertility decreases (Fig. 1).

Fertility and family planning studies that include measures of religiosity tend to use small samples either from surveys or focus groups. Findings have not been consistent. Abortion is illegal in most Latin American countries (Cuba and Puerto Rico are the exceptions) and, although most of Latin America subscribes to Catholicism, this does not seem to deter abortion rates. Hospital data from across Latin America detail complications of clandestine abortions. However, restricting abortion estimates to hospital data overlooks the women who die before accessing medical care. According to the Alan Guttmacher Institute, an estimated 5,000 women die every year as a result of clandestine abortions in Latin America; an estimated 800,000 are hospitalized due to abortion complications. Approximately 1 out of every 30 (3%) women in Colombia, Brazil, and the Dominican Republic has had an abortion; in Mexico the rate is 2.5%, and in the United States, the abortion rate is 1.9% (reported as 19/1,000). The Centers for Disease Control (CDC) compiles data in the United States but only for legal abortions. The national (reported) abortion rate for



	15 to19	20 to 24	25 to 29	30 to 34	35 to 39	40 to 44	45 to 50
◆ Native born	39.6	115.7	117.4	91.5	47.4	17	5.1
■ Naturalized	46.8	88.5	114.8	111.7	60.4	18.4	4.8
▲ Not a citizen	68.4	161.7	158.2	117.4	68.3	25.6	5.5

Family Planning. Fig. 1 Births in the last 12 months per 1,000 Hispanic women by citizenship and age. Source: US Census Bureau, American Community Survey, 2006. See detailed Table 9 www.census.gov/population/www/socdemo/fertility.html

Hispanic women in the United States is 1.6%. This is probably underestimated given that, during focus groups, women report bringing pregnancy termination methods from their home countries.

A very popular abortifacient in Latin America is a prostaglandin sold as Cyotec, also known as Misoprostol. In most of Latin America, it is available over the counter for the treatment of peptic ulcers. For pregnancy termination, it may either be taken orally or inserted into the vagina. In 2000, researchers at three obstetrics and gynecology clinics in New York noted that low-income immigrant women were already using Misoprostol as an alternative to going to an abortion clinic, because it was easier and less expensive. It was available for approximately $2 a pill compared to hundreds of dollars for a medical abortion. Immigrant women reported getting this pill from doctors, pharmacies, relatives, and from contacts in other countries. In 2009, the *New York Times* reported its use in immigrant Dominican neighborhoods.

Clinic-based studies attempting to obtain information on values affecting family planning beliefs and practices have often been contradictory and ambiguous. Still, some of the qualitative research has captured information not discernible from survey data. For example, the National Council of La Raza recently conducted multiethnic focus groups across several cities and discovered that, among their sample, Hispanic Americans receive their birth control from trusted sources in their home countries, suggesting it is easier to obtain there than in the United States. Moreover, some participants in their Bronx sample reported not only buying birth control at Latino-owned stores known as “bodegas,” but also receiving contraceptive injections at these locations.

The role of Hispanic men in family planning has received less attention but does merit discussion. Hispanic men, in popular culture, have long been portrayed as hypersexual. The myth of the womanizing Don Juan can be traced to the Golden Age of Spain and continues in Latin America as a manifestation of machismo. A great deal has been written about both the positive and negative qualities of machismo. Across research on machismo, a man’s ability to seduce (many) women is a revered trait. In the 1950s, research conducted in Puerto Rico reported that men use condoms to prevent sexually transmitted infections and less so for birth control. They used condoms with women other than their primary partners. Although the NCLR multiethnic sample found men did report condom use, most of which were purchased at gas stations, they felt their primary partners would suspect that they were being unfaithful if they suggested condom use. The NCLR male sample reported not liking the condoms they received for free because these allowed for less pleasure than condoms they bought. Currently, the only other reliable family planning available to men is vasectomy, a surgical procedure which prohibits the sperm from entering the semen and renders the man sterile, and which can only rarely be reversed successfully. According to data from the NSFG, Hispanic men are approximately half as likely to obtain a vasectomy as their non-Hispanic White counterparts.

Finally, very little has been written about barrier methods such as the diaphragm or sponge. The general consensus is that Hispanic women feel uncomfortable touching their genitals. Because much of the qualitative research has been done with lower socioeconomic subjects, it is not clear that more educated, later generation women would have the same perceived discomfort using vaginal barrier methods.

In summary, national data in the United States reveal that the top two family planning methods used by Hispanic women are sterilization and Depo Provera. It is not clear whether they elect these or whether family planning providers feel low-literacy, low-income groups are best managed with these methods. Hispanic women are likely to receive family planning services at clinics as opposed to from private providers. This may be attributable to lower levels of health insurance. They also receive family planning methods from their home countries as well as through community networks that, it may be argued, are not qualified to be dispensing medical contraception. An example of these providers is Hispanic grocery stores, also known as bodegas. More alarming is that these same sources supply immigrant women with pregnancy termination methods that may pose substantial risk to the user.

Related Topics

- ▶ Access to care
- ▶ Acculturation
- ▶ Alternative and complementary medicine
- ▶ Barriers to care
- ▶ Gender role
- ▶ Health determinants
- ▶ Machismo/Macho

Suggested Readings

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Family Reunification

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Family reunification occurs when families join each other in a new locale after separation. There are different reasons that families become separated, such as forced displacement because of war and a search for employment in another country in order to send money home to family.

Once immigrants are settled in a new country, they often start the process of sponsoring the migration of other family members to join them. Most countries allow their permanent residents or naturalized citizens to sponsor the migration of relatives. Policies and procedures on family migration vary from country to country. For example, in the USA, there are no restrictions on the number of visas provided for the migration of spouses, dependent children, and parents of US citizens. However, permanent residents are limited in number of spouse and children visas issued. In Australia and Canada, there is no difference between citizens and permanent residents in terms of sponsorship of immediate relatives for migration. Also, adult children and siblings must meet English language and skills requirements to relocate to Australia.

Families often experience a great deal of stress as a result of separation, regardless of the reason, and the fact that reunification can take several years. In the case of war, families may have been separated by force and sent to different refugee camps. Family members in such situations will often send letters to villages where they used to live in an attempt to locate each other as well as asking new arrivals to the refugee camp if they can identify the location of others' family members. For example, the Lost Boys of Sudan were often unaware if family members were still alive. This sense of not knowing the fate of family members caused a great deal of stress. In the case of a family member leaving the nuclear family by choice to seek work in another country, the remaining family members left at home also experience stress even if they are monetarily benefitting from the money sent home by the absent parent. Children often feel abandoned by the parent who left and if it is years before family reunification takes place, children and parents frequently report that they feel like strangers to each other when reunified.

Related Topics

- ► Ambiguous loss
- ► Immigrant visa status
- ► Stress
- ► Unaccompanied minors

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Family Violence

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Family violence, also known as domestic violence, includes physical and sexual violence of a family member. That family member may be a parent, a spouse or partner, or child, or other member of the family who is residing in the household. These physical forms of violence may be accompanied by intimidation; verbal and emotional abuse; financial abuse; isolation of the victim from family and friends; and deprivation of or control over essential elements of living, such as transportation, clothing, and access to the telephone.

The actual prevalence and incidence of family violence are generally impossible to determine. Various studies suggest that between 10% and 52% of women are abused by an intimate partner at some time during their lives and between 10% and 27% of women are sexually abused, either as children or as adults. The estimates vary depending upon the design of the study and the way violence is measured and defined. Worldwide, it has been estimated that approximately 40 million children are abused each year and that at least 4% of children in industrialized countries are physically abused each year.

Many cases of family violence remain unreported. Many persons are abused in the course of a longer period of time and at the same time they are trapped in hopeless situations. These cases may include relationships in which the victim is financially dependent; in which the victim fears that he or she may lose their children, discredit their family, or be ostracized by the other members of the family; and those in which the victim sees no alternative.

Women may be vulnerable to victimization because of their physical size. However, men may also be victims of abuse by their female partner. It may be difficult in some circumstances to determine if a partner is inflicting violence in an attempt to defend him- or herself from the abuse, if the individual is instigating the violence, or if it is a case of mutual battering. It is important to remember that domestic violence may also occur in the context of same-sex relationships.

Parents who are violent with their own children may consider this behavior normal and natural in order to impose certain norms of their family. Their aggressive behavior is facilitated by the fact that usually young children cannot defend or seek for medical care by themselves. Besides the physical trauma, the abused children frequently suffer from long-term psychological effects. The abused child lives under the uncertainty and the anxiety of more abuse. They may later abuse their life partners, children, or parents.

There is a growing awareness of the occurrence of violence against elderly family members. Like other forms of family violence, elder violence may be physical or sexual in nature and may be accompanied by emotional and/or financial abuse. Elders are at increased risk of violence from family members in situations in which the elderly person has diminished capacity and needs assistance with the functions of daily living. There is also an increased risk in situations in which the elderly person is residing with an adult child who is abusing substances or is dependent on the elderly parent for housing.

Family violence is not restricted to one social class, but occurs across all social classes and income levels. Sociological studies have identified financial problems as being a primary trigger factor in many cases of family violence. Some studies have suggested that family violence occurs more frequently in urban areas partially due to the particular environmental conditions (noise, increased density of population, and people crowded in small spaces) which increase individuals' levels of aggression. However, other studies suggest that the incidence of family violence may be as high in rural areas, in part because of individuals' relative isolation.

Family violence is now recognized as a public health problem due to its high prevalence and serious health consequences. In addition to the physical injury suffered by victims, victims and witnesses to the violence may suffer severe emotional injury. A major consequence of the family violence is the psychological trauma suffered by the victims which can disturb their mental and relational balance. Victims begin to organize their lives around their trauma, experiencing their trauma and negative emotions repeatedly. Thus the victim progressively sets up an exaggerated type of behavior, dominated by intense negative emotions such as fear of the life partner, anxiety, worry, depression, sleep disturbances, marked irritability, disorder of concentration, etc. The victim may develop posttraumatic stress disorder or depression. In some cases, the family violence may lead the victim to attempt suicide. Children who are abused may run away in an attempt to escape the violence. Data suggest that children who witness violence inflicted by one parent against the other have an increased risk of later perpetrating family violence themselves or becoming a victim of family violence.

Various theories have been developed in an attempt to explain family violence. Explanations include an acceptance of the violence by the larger society; mental illness on the part of the perpetrator, the victim, or both; a desire for greater control and power by the perpetrator, perhaps due to his or her own insecurities; and difficulties coping with stress and frustration that may be caused by finances, conflicts over children, and other issues. The *general systems theory* suggests that family violence occurs as the result of a complex feedback system that exists at the individual, family, and societal levels. Societal level factors include the level of violence in a particular society, the extent to which a family is socialized to violence, the extent to which cultural norms are accepting of violence, and the organization of society. Family-level factors include the extent to which individuals ascribe to physical punishment for wrongdoings, the extent to which sibling violence is tolerated or encouraged, and the extent to which family members are socialized to violence. Individual level factors may include insecurity, jealousy, frustration over any number of issues, mental illness, substance abuse, and feelings of shame, among others.

Immigrant women and children may be at increased risk of family violence. In situations in which it occurs, they may be afraid to seek assistance from law enforcement authorities or other entities because the perpetrator of the violence may have threatened them with further violence or with the possibility of deportation from the country. They may also be afraid that health care personnel or the police will report them to the immigration authorities, particularly in situations in which the victim or a household member is present in the country illegally. There may be additional barriers to seeking assistance, such as isolation as the result of the perpetrator's abuse and inability to speak the language of the host country.

Related Topics

- ► Anger
- ► Anxiety
- ► Battered spouse
- ► Child abuse
- ► Child rearing
- ► Depression
- ► Drug abuse
- ► Family
- ► Posttraumatic stress disorder
- ► Rape
- ► Stress
- ► Violence

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Suggested Resources

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Farmworkers

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Migrant and seasonal farmworkers in the USA and in other nations provide the hand labor required for the production of many agricultural products including fruits, vegetables, mushrooms, Christmas trees, flowers, sod, and tobacco. In the USA and Canada, the migrant and seasonal farmworker population has become overwhelmingly Latino and immigrant. Agriculture remains an extremely dangerous industry. While providing an essential service to society, farmworkers are exposed to numerous occupational and environmental health risks that result in high rates of physical injury and illness. Farmworkers are also exposed to significant psychological stressors, including discrimination, separation from family, long work hours, and fear of unemployment and underemployment, which increase their risks for mental illness and substance abuse.

Farmworkers in the USA have few of the protections granted to other workers in modern industrial societies. Since the 1930s, agriculture as an industry and farmworkers as employees have been affected by "agricultural exceptionalism." This exceptionalism exempts the agricultural industry from most labor standards and safety regulations, such as the Fair Labor Standards Act. As employees, farmworkers are excluded from the protections of the National Labor Relations Act, which governs worker organizing and collective bargaining. The only national regulation that requires occupational safety training for farmworkers is the US Environmental Protection Agency's Worker Protection Standard (WPS) which focuses on pesticide safety. Two states, California and Washington, require that farmworkers receive safety training on heat stress. In addition to the limited requirements for farmworker occupational safety training, the Occupational Safety and Health Administration sets standards for field sanitation for all farmworkers and regulations for migrant farmworker housing. Health scientists and advocates have consistently documented the limited regulatory protection for farm labor. The situation of farmworkers was summarized in 1951 by President's Commission on Migratory Labor in stating "[the US] depend[s] on misfortune to build up our force of migratory workers and when the supply is low because there is not enough misfortune at home, we rely on misfortune abroad to replenish the supply." The circumstances for farmworkers have seen only limited improvement since 1951. Therefore, although their work is essential and their exposure to harm is high, farmworkers generally receive low wages, and they are seldom provided health benefits by their employers.

Farmworkers Defined

Who is considered a farmworker varies among analysts and for different programs and regulations. Factors included in defining farmworkers, and their eligibility for health, social, and educational services, include the different agricultural commodities (crops, dairy, poultry, livestock) and sectors (materials processing, fisheries, forestry) in which individuals work, their migration statuses, their ages, their incomes, and eligibility periods (e.g., employed in farm work in the last 24 months, or the last 36 months, or 12 of the last 24 months).

Farmworkers include individuals who work in agricultural production, with agricultural production including planting, cultivating, harvesting and processing crops for sale, and caring for animals. Agricultural crops include food commodities, such as fruits and vegetables, and non-food commodities such as flowers and ornamental plants, sod, Christmas trees, and tobacco. Agricultural production excludes manufacturing activities, such as preserving fruits and vegetables, working in grain storage, slaughtering or butchering of livestock and poultry, or making cheese and cooking food. Seasonal farmworkers are individuals whose principal employment is in agriculture on a seasonal basis rather than year round. Seasonal farmworkers do not change residence in order to work in agriculture. Migrant farmworkers are individuals whose principal employment is in agriculture on a seasonal basis, and who, for purposes of employment, establish a temporary home. The migration may be from place to place within a state, interstate, or international. Many definitions of migrant farmworkers include the family members who accompany them.

The National Agricultural Workers Survey (NAWS) differentiates six types of farmworkers: (1) non-migrant workers are equivalent to seasonal farmworkers (for 2002, the NAWS estimates that 57% of farmworkers were non-migrant), (2) foreign-born newcomer migrants are foreign-born farmworkers who have traveled to the USA for the first time, (3) international shuttle farmworkers travel from permanent homes in a foreign county to the USA for employment but work only within a 75-mile radius of that location, (4) domestic shuttle farmworkers have permanent residences in the USA but travel 75 miles or more to do farm work in a single location and work only within a 75-mile radius of that location, (5) international follow-the-crop farmworkers travel to multiple US farm locations for work from permanent homes in a foreign county, and (6) domestic follow-the-crop farmworkers travel to multiple US farm locations for work from permanent homes in the USA. For 2002, the NAWS estimated that 13% of farmworkers were foreign-born newcomers, 57% were non-migrant or settled, 8% were follow-the-crop migrants, and 18% were shuttle migrants.

Number and Demographic Characteristics of Farmworkers

Farmworkers are employed across the USA. Although the number of farmworkers in the USA is large, an accurate count of their numbers is difficult to establish. Much depends on how “farmworker” is defined. A national census of farmworkers has not been completed since the early 1990s; this census put the number of farmworkers plus family members at over three million. Estimates of farmworkers in the ten states with the largest farmworker populations were prepared for 2000. An analysis of the 2006 Current Population Survey produced an estimate of 1.01 million hired farmworkers in the USA. The 2007 US Census of Agriculture reports 2,636,509 agricultural workers employed on 482,186 farms. These included 911,439 workers who worked 150 days or more, and 1,725,070 workers who worked 150 days or less; 98,135 farms reported having only workers who worked at least 150 days, 280,894 farms reported having only workers who worked less than 150 days, and 103,157 farms reported having workers who worked both 150 or more days and less than 150 days. A total of 38,784 farms reported hiring migrant farm labor.

The farmworker population is ethnically diverse. It includes African Americans, American Indians, Asian immigrants, and Caribbean immigrants. However, since the early 1990s, the majority of migrant and seasonal farmworkers have been from Latin America, particularly from Mexico. The NAWS indicates that 84% of migrant and seasonal farmworkers in the US self-identify as Hispanics, with 75% of all farmworkers having been born in Mexico, 23% in the USA, 2% in Central America, and 1% in other countries. Mexican farmworkers are a diverse group, coming from urban as well as rural Mexico, with at least one-quarter being from native communities and speaking an indigenous language.

Two trends in the ethnic composition of the farmworker population are important to the health of farmworkers and to the provision of health care for farmworkers. The first is the growing number of farmworkers from Mexico and other Central American countries who speak an indigenous language. These farmworkers are from among the poorest communities in their nations, with the greatest health risks and the least health care. Providing health care and occupational safety and health training to these indigenous language speaking farmworkers is especially difficult due to the large number of indigenous languages spoken, the small number of farmworkers who speak each language, and that most of these languages are not written. The second trend in the ethnic composition of the farmworker population that is important to health and health care is the growing number of farmworkers from Southeast Asia and from Eastern Europe. The number of these new immigrant farmworkers remains small and the locations in which they work are limited, but if the numbers of these immigrants grow, training related to their language, health beliefs, and health histories will be required.

Farmworkers tend to be young, with most under age 35 (the NAWS reports that farmworkers have an average age of 33.6 years). The great majority of farmworkers are men. Most farmworkers have little education. The 2002 NAWS found that most farmworkers have less than a high school education. The 2006 Current Population Survey reports that 30.0% of agricultural workers have less than 9 years of education, and 24.5% have from 9 to 12 years of school. Farmworkers are poor; at least 30% of farmworkers have annual incomes below the federal poverty level.

Finally, about half of migrant and seasonal farmworkers in the USA are not documented. This places them at risk for deportation and limits their access to services. A temporary labor program is available to farmworkers through the H2A visa program. Although no annual limitations on the number of H2A visas are enforced, the US Department of Labor certification process requires employers to certify that US workers are not available before they may hire an immigrant worker with an H2A visa. For 2007, 50,791 H2A visas were issued for the entire USA; this was an increase from 37,149 H2A visas issued in 2006. An H2A visa allows an individual to enter the USA to work in agriculture for a specified period of time for a particular farmer, who is obligated to provide an average of 35 h of work per week, a specific hourly wage, inspected housing, and to meet all safety requirements.

Occupational Exposures and Injuries

The number of farmworkers in the USA is large, and their work, living arrangements, and migratory lifestyle expose these workers to numerous hazards. However, few data are available to document the number and types of occupational injuries and illnesses that farmworkers experience. National and state public health systems do not require the specific reporting of agricultural injuries and standard injury reporting systems have difficulty delineating agricultural injuries. With the lack of national, regional, or local surveillance data, information on the prevalence of injuries and illness among farmworkers is based on local observational studies or reports from farmworker health, service, and advocacy organizations. The observational studies generally have small samples, are focused on small areas, and they are limited in the health data they collect; an exception is the state-wide and comprehensive California Agricultural Workers Health Survey. Health data from health and service providers are limited to those farmworkers who present to obtain services. These study designs and data collection procedures limit the generalizability of these health data.

Even with the limited available information, it is still clear that immediate occupational injuries and illnesses common among farmworkers include musculoskeletal injuries, hearing loss, eye injuries and symptoms, skin disease, mental illness, heat stress, pesticide exposure and its sequelae, and green tobacco sickness. Long-term health outcomes from these occupational exposures include neurological disease and cancer. The nature of farm work, with significant distance between work sites, low income, and migratory nature, means injuries and illnesses resulting from lifestyle factors including transportation and housing hazards must also considered. Lifestyle related injuries and illnesses common among farmworkers include infectious diseases such as tuberculosis, HIV/AIDS, and sexually transmitted infections, alcohol abuse, and poor oral health.

Access to Health Care

Providing health services to farmworkers has been a concern for several decades. Farmworkers are overwhelmingly poor, they are seldom provided health insurance by their employers, and they are seldom provided paid sick leave when they need to obtain health care. These characteristics limit farm worker access to health care. Farmworkers experience other barriers to health services, including linguistic and cultural differences from the majority population, low educational attainment, mobility, inadequate transportation, lack of documentation, and a limited number of health care facilities. A final barrier to health services for farmworkers is the limited number of health care facilities provided for this population.

Several programs have been implemented by governmental agencies, as well as by nonprofit organizations, to address the health services needs of farmworkers and their families. Often, local health programs are provided by clinics, organizations, churches, and academic health programs (e.g., medical and nursing schools). The Bureau of Primary Health Care, Health Resources and Services Administration (HRSA), provides funds for migrant health clinics, and many states provide additional funds for these programs; however, the number of facilities, their locations, and their hours of operation cannot respond to the needs of the farmworker population. In addition to funding Migrant Health Centers and Community Health Centers, HRSA helps to address barriers to health services for farmworkers by funding nonprofit organizations that support the efforts of local clinics and service organizations. These "central grantees" each have a different focus. Farmworker Justice, Inc., focuses migrant health legislation and policy. The focus of Farmworker Health Services, Inc., is supporting outreach worker programs for Migrant and Community Health Centers by providing products, services, and activities that enable them to understand and effectively address farmworker health issues. Migrant Clinicians Network, Inc., works to strengthen the infrastructure for health care facilities serving farmworkers and other mobile poor populations. Migrant Health Promotion has developed six model outreach programs and provides training and support to organizations in the use of these programs. The National Center for Farmworker Health, Inc., provides information, services, and products to healthcare centers. National Association of Community Health Centers, Inc., serves as an informational resource for community-based health centers by providing education, training, technical assistance, and leadership development.

Directions

The number of farmworkers in the USA is large and they are employed in all regions of the nation. The occupational and environmental hazards to which farmworkers are exposed are many. The information documenting farmworker health is limited. Health services available for farmworkers are also limited. Accurate and current information on the number and characteristics of farmworkers is needed, as is a better surveillance system documenting the occupational injuries and illnesses experienced by farmworkers. More informed health and safety regulations that reflect the current industrial nature of agriculture are needed for farmworkers and all agricultural workers.

Finally, the system for providing health care to farmworkers needs to be expanded.

Related Topics

- ► Environmental exposure
- ► Environmental health
- ► Environmental justice
- ► Falls
- ► Food industry
- ► Hispanics
- ► Labor migration
- ► Language
- ► Latinos
- ► Migrant farmworkers
- ► Occupational and environmental health
- ► Occupational health
- ► Occupational injury
- ► Pesticides
- ► Tuberculosis

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Fatalism

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Fatalism refers to an attitude of perceiving the world in which everything is seen as ordained by fate. Individuals with a fatalistic viewpoint believe that all past, present, and future events (e.g., illness or death) have already been determined. Accordingly, future events are inevitable, and individuals are powerless to change their circumstances. Perceptions of what controls future events vary; it could be luck, destiny, or god. However, fatalism would be most likely to stem from ideas derived from theology or physics.

Fatalism influences health behaviors and outcomes. Fatalism has been reported as a psychological and socio-cultural barrier for the prevention and early detection of cancer among minority immigrants in multicultural societies. For example, an immigrant woman with a belief in fatalism might think that she will get cancer if she is destined to get it – regardless of her efforts to prevent it. In this context, fatalism would influence low cancer screening rates among minority immigrants.

Related Topics

- ► Cancer health disparities
- ► Cross-cultural health

Suggested Readings

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Female Genital Diseases

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Sexually Transmitted and Other Genital Infections

Sexually transmitted infections (STIs) are likely to be common among the immigrant population due to lack of access to health care, antibiotics, and condoms. Refugee populations and those fleeing war and abuse may also have been in situations in which sexually transmitted infections would be difficult to avoid. Certain STIs are rare in the United States but are more highly prevalent in developing countries. HIV (not included below) is not a female genital disease, but its presence makes the transmission or acquisition of other infections more likely; the reverse is also true. Two infections described below – bacterial vaginosis and vaginal yeast infections – are not transmitted sexually but are characterized by vaginal discharge and may be associated with HIV infection.

Other genital infections may be associated with poor hygiene or crowded living conditions. Immigrant females may have inadequate facilities for washing or may not have had proper instruction in female hygiene. Refugees may have been living in overcrowded camps, and recent immigrants may continue to live in overcrowded areas where proper hygiene is difficult.

Sexually Transmitted Infections

Chancroid

Chancroid is a painful genital ulcer caused by the bacterium *Haemophilus ducreyi*. This sexually transmitted infection is occasionally found in the United States but is more common in developing countries, including many parts of Africa. Chancroid increases the likelihood of transmitting and acquiring HIV. A health care provider must examine the genital ulcer to diagnose chancroid; cultures may be done. The infection can be treated with antibiotics. Condoms and avoidance of contact with ulcers can help to prevent transmission of chancroid.

Chlamydia

Chlamydia, caused by the bacterium *Chlamydia trachomatis*, is one of the most common sexually transmitted infections in adolescents and young adults. The infection is transmitted through vaginal, anal, or oral sex. Female genital symptoms include vaginal discharge, pelvic or abdominal pain, or pain with urination. The infection is diagnosed in females with either a urine or cervical sample and can be treated with oral antibiotics. Untreated, the infection may spread to the uterus and fallopian tubes and cause pelvic inflammatory disease (PID). PID is a serious infection that can result in chronic pelvic pain and infertility. The risk of transmitting or acquiring chlamydia can be decreased by condom use.

Genital Herpes

Genital herpes is a sexually transmitted infection caused by the herpes simplex virus (HSV); it can be caused by HSV type 1 or HSV type 2. Most people who carry the herpes simplex virus do not have any symptoms. Symptoms that do occur are usually most serious and severe during the first episode or outbreak of herpes; these symptoms include painful blisters, sores or ulcers, and fever. A health care provider may examine the genital sore and take a culture to diagnose genital herpes. Blood tests are available to check for antibodies to the herpes virus; however, these results are often difficult to interpret. Genital herpes cannot be cured. Additional outbreaks can be suppressed or shortened with antiviral medications. Condoms reduce the risk of transmitting or acquiring herpes.

Genital Warts

Genital warts are caused by the human papillomavirus (HPV) which is passed during sexual contact. There are about 40 types of HPV; only some cause genital warts. The warts are usually small bumps in the genital area. A health care provider must examine the genital area to diagnose genital warts. Topical treatments are available but may need to be repeated. For some people, genital warts go away without treatment; others need multiple courses of treatment. A vaccine is available to prevent most genital warts in males and females. The risk of HPV infection may be lowered through the use of condoms.

Gonorrhea

Gonorrhea is a sexually transmitted infection that is caused by the bacterium *Neisseria gonorrhoeae*. Symptoms of a genital infection in females include vaginal discharge, pelvic or abdominal pain, or pain with urination. Like chlamydia, the infection is diagnosed in females with either a urine or cervical sample and can be treated with oral antibiotics. Untreated, the infection may spread to the uterus and fallopian tubes and cause pelvic inflammatory disease (PID). PID is a serious infection that can result in chronic pelvic pain and infertility. Condoms decrease the risk of transmitting or acquiring gonorrhea.

Granuloma Inguinale (Donovanosis)

Granuloma inguinale is a sexually transmitted infection rarely found in the United States. Caused by the bacterium *Klebsiella granulomatis*, granuloma inguinale is characterized by painless, growing ulcers. A health care provider diagnoses the infection by examining a biopsy of the ulcer. Treatment is with antibiotics.

Lymphogranuloma Venereum

Lymphogranuloma venereum (LGV) is caused by a variant of *Chlamydia trachomatis* (serovars L1, L2, or L3). The infection rarely occurs in the United States. Most people with LGV have tender, persistent lymph nodes near their groin; they may have a small, transient ulcer. A health care provider must examine the area to diagnose LGV. Cultures and blood tests may be done. Treatment is with antibiotics.

Molluscum Contagiosum

Molluscum contagiosum presents as flesh-colored bumps on the skin. It is caused by a pox virus. The infection is common in childhood and is spread by skin-to-skin contact. It also can be spread by sexual contact and can be found in the genital area. The infection usually resolves on its own but can be treated with medication or by a health care provider. Treatment of genital lesions is generally recommended to prevent spreading the virus.

Syphilis

Syphilis is a sexually transmitted infection caused by a bacterium called *Treponema pallidum* that may initially present with a painless ulcer (called a chancre) in the vaginal area. After that primary stage, which will resolve without treatment, the secondary stage of syphilis is characterized by rash (particularly on the palms and soles), fever, swollen glands, and fatigue. If untreated, latent and late syphilis may occur, resulting in brain damage and dementia. Syphilis is diagnosed by blood tests and is treated with antibiotics. Condoms and avoidance of contact with ulcers can help to prevent transmission of syphilis.

Trichomoniasis

Trichomoniasis is caused by *Trichomonas vaginalis*, a protozoan parasite. A sexually transmitted infection, trichomoniasis has symptoms in females that include vaginal discharge, odor, pain with urination, and vaginal itching or burning. Trichomoniasis increases the risk of acquiring HIV if exposed during intercourse. A health care provider must examine the vagina and vaginal discharge to diagnose trichomoniasis. Treatment is with oral antibiotics. The chances of transmitting or acquiring trichomoniasis can be decreased by using condoms.

Nonsexually Transmitted Infections

Bacterial Vaginosis

Bacterial vaginosis is caused by an overgrowth of certain bacteria in the vagina; it is not a sexually transmitted infection. Common symptoms of bacterial vaginosis are vaginal discharge, odor, burning, or itching. Bacterial vaginosis increases the risk of acquiring HIV and other sexually transmitted infections. A health care provider must examine the vagina and vaginal discharge to diagnose bacterial vaginosis. Treatment is with oral or topical antibiotics.

Folliculitis

Folliculitis is a bacterial infection of the hair follicle. It is often found in the pubic area. Folliculitis often resolves without treatment, but it may require medication or other medical treatment.

Genital Tuberculosis

Genital tuberculosis is common in women in countries where tuberculosis, caused by *Mycobacterium tuberculosis*, is endemic. The infection spreads to the genital tract from the lungs or other nongenital area. Symptoms include vaginal bleeding and pelvic or abdominal pain. Women may also present with infertility. A health care provider makes the diagnosis with special x-ray and laboratory studies. Treatment is with medication.

Pediculosis Pubis

Pediculosis pubis is also known as pubic lice and is usually transmitted through sexual contact. The main symptom is severe itching around the pubic area; nits and lice may also be seen. Treatment is with topical pediculcides.

Streptococcal Vaginitis

Streptococcal vaginitis, caused by Group A Streptococci bacteria, is found mainly in prepubertal girls. Symptoms include vaginal discharge, redness, soreness, and irritation. A health care provider diagnoses the infection by examining the area and taking a bacterial culture. Treatment is with antibiotics.

Vaginal Yeast Infections

Vaginal yeast infections are typically caused by *Candida albicans*; they are not sexually transmitted. Symptoms include vaginal discharge and vaginal itching or irritation. Women who have recently taken antibiotics or oral steroids, women with elevated blood sugars (as in diabetes), and women with compromised immunity (HIV, chemotherapy) are at greater risk for developing yeast infections. A health care provider must examine the vagina and vaginal discharge to diagnose a vaginal yeast infection. Treatment is with oral or topical antifungal medications.

Genital Cancers

Many female genital cancers are preventable through regular screening which may not be available to the immigrant population. Quick access to treatment may also be unavailable.

Cervical Cancer

Cervical cancer is cancer of the cervix, the lower part of the uterus. The main cause of cervical cancer is human papillomavirus (HPV). A vaccine to prevent HPV is available. Regular PAP tests screen for changes in cervical cells that could progress to cervical cancer. When detected early, cervical cancer is treatable and recovery rates are high.

Ovarian Cancer

Ovarian cancer is most common in women over 40 years of age. It can cause symptoms such as abdominal pain, pelvic pain, or bloating. No simple screening test for ovarian cancer exists. Treatment is with medication and surgery

Uterine Cancer

Uterine cancer is found mainly in women who have gone through menopause. The most common symptom is vaginal bleeding. A health care provider makes the diagnosis by performing an endometrial biopsy – taking a piece of the inner lining of the uterus. Treatment, including medication and surgery, is most effective when the cancer is found early.

Menstrual Disorders

Immigrant adolescents and women may be more susceptible to menstrual disorders because of nutritional issues and lack of health care access. A few common menstrual disorders are described below.

Amenorrhea

Amenorrhea may be primary (no menstrual period) or secondary (no menstrual period within 6 months). Possible causes are numerous and include genetic abnormalities, excessive diet or exercise, chronic disease, thyroid problems, or pregnancy. A health care provider will examine for causes of amenorrhea and possibly do laboratory tests. Treatment is directed at the cause of amenorrhea.

Dysmenorrhea

Dysmenorrhea, or menstrual cramping, is common among women. Caused by a chemical released during menstruation, dysmenorrhea can result in cramping, nausea, vomiting, and diarrhea. Secondary causes of menstrual cramps include genital infections and abnormalities of the genital anatomy. Dysmenorrhea can be managed with nonsteroidal anti-inflammatory medications or other medications.

Endometriosis

Endometriosis is a condition in which uterine lining cells are present outside the uterus and cause pelvic pain and menstrual cramps. The condition tends to run in families. A health care provider makes the diagnosis, which may require surgery. Treatment is with medications.

Other Genital Diseases

Contact Dermatitis

Contact dermatitis is a skin rash caused by contact with an irritating substance. Soaps, cleansers, and chemicals are common irritants. Contact dermatitis can occur in the genital area and appears as a red, often itchy, sometimes painful rash. Treatment involves avoiding the irritant and topical medication.

Fibroids

Fibroids (leiomyomas) occur in up to 50% of women older than 35 years of age; they are a benign tumor of the uterus. Fibroids may be small or large, but are generally slow-growing. They are more common in overweight people and in people with certain ethnic backgrounds. Symptoms include heavy menstrual bleeding and abdominal pain. A health care provider makes the diagnosis by ultrasound or surgery. Treatment is with medication or surgery.

Lichen Sclerosus

Lichen sclerosus occurs on the labia and causes the skin to become thin and white. Other symptoms include itching and pain. The cause of lichen sclerosus is unknown. A health care provider diagnoses lichen sclerosus and treats the disease with medications.

Related Topics

- ► Human immunodeficiency virus
- ► Sexually transmitted diseases
- ► Syphilis
- ► Women

Suggested Readings

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Suggested Resources

Centers for Disease Control and Prevention. www.cdc.gov
World Health Organization. www.who.int/en/

Female Sex Workers

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Sex workers, more commonly referred to as prostitutes, work in the sex industry and trade in sex commercially. Sex work is legal in approximately 50% of countries around the world. Examples of countries in which sex work is illegal include the United States (except for 11 counties in the state of Nevada), China, India, the Philippines, Romania, Saudi Arabia, and Uganda.

In the case of migrant female sex workers, trafficking is a prevailing issue. Trafficking of humans, in conjunction with arms dealing, is the second largest criminal industry worldwide, followed by drug dealing, and the numbers are rising. In 2000, United Nations estimates were that 4 million women and children had been trafficked into the sex industry. From places such as Southeast Asia, Latin America, and Eastern Europe, up to 50,000 women and girls are trafficked annually – taken from developing and economically unstable countries and trafficked to countries that are more industrialized and economically stable. The United Nations estimates that sex trafficking generates 5–7 billion dollars annually.

Many migrant female sex workers, especially those who are trafficked, are forced to work in prostitution and/or in the sex entertainment industry. Typically they do not know how to get out of this situation or where to turn to for help. Fear of deportation, lack of language skills, and other cultural barriers in the new home country create further obstacles to freedom and alternative employment. Frequently traffickers and pimps use oppressive techniques to maintain the sex workers' dependence. Common techniques include debt bondage, isolation, confiscation of legal documents such as passports and visas, threats of violence, imprisonment and/or deportation, and controlling the sex workers' finances. Shame and fear of stigmatization add to female sex workers remaining hidden victims.

Over the last several years, many governments have engaged in efforts to combat trafficking through prevention, protection, and prosecution. However, because the crime of human trafficking is highly clandestine, most cases continue unreported, and traffickers remain at large. Frequently traffickers are associated with international criminal organizations, which make them highly mobile and difficult to prosecute.

Often traffickers use deception to lure women into believing they will obtain legitimate work or to convince them to become mail order brides. Some women agree to engage in sex work, or are already sex workers in their countries of origin. However, they are not usually aware, nor do they expect that they will be forced into financial bondage to their traffickers, working in squalid, isolated, and confined conditions. Until their debts to the traffickers are paid off, the sex workers will likely have to engage in sex work every day, several hours per day, sometimes for years. In addition, frequently they are moved from one location to another, and with each move they become indebted further to the trafficker, thereby becoming "sex slaves."

Sometimes traffickers use elaborate schemes to convince women to go willingly or even to force them to migrate. Regularly, for example, trafficked female sex workers from the Ukraine are offered work abroad as models. To lure the women, traffickers set up bogus modeling schools, use phony contracts, and employ the use of elaborate, yet fake, photo sessions – being careful to attend to critical details. These elements serve to instill trust among the women themselves. The concept of "trust" is very important in this scenario, and most Ukrainian traffickers are women themselves. Although Ukrainian women are trafficked as sex workers throughout the world, their primary destinations are the former Soviet states, Europe, Canada, and the United States.

Female sex workers from Nigeria have been working along roadsides in Italy for decades. Most are lured with promises of well-paying jobs in factories, offices, and on farms. The majority of these women come from rural areas and have little or no education. Routinely, once they arrive in Italy, they are placed with a Nigerian madam, usually a former prostitute, and are indebted instantly to her. Often those trafficked are made to undergo religious rites that involve swearing never to reveal the identity of their traffickers and madams to the police and to pay off their debts. These rites have significant implications for the trafficked women, because they believe strongly that if they do not do as they are told, they risk harm to themselves and their families. They are required to pay their debts in a few months time, in addition to paying monthly rent for their roadside spot, which is where they solicit sex from paying clients. In order to earn enough money, they must work continuously, servicing a high number of clients every day. This has significant consequences for the health status of these women. In addition to the stress and harsh living conditions, they face social and cultural stigma from their countries of origin where prostitution is looked down upon. However, extreme poverty and the promise of easy earnings outside of their country often create situations for trafficked women in which they are encouraged by their own family members, even husbands, to accept sex work abroad.

Prior to 1949, there were no migratory restrictions to Hong Kong from mainland China. Since Hong Kong's transformation into a fast-growing manufacturing economy, numerous factory workers were needed, and mainland Chinese immigrants provided an abundant workforce. Since the 1980s, however, there has been a gradual tightening of border controls, with immigration laws strictly enforced, and routine repatriation of undocumented Chinese immigrants. The sex industry in Hong Kong is dominated by Chinese migrant female sex workers. Sex work is a tolerated choice for these women for whom it appears to be the best available option to support their families. But, given their immigration status and the general stigma attached to Chinese immigrants by Hong Kong nationals, these sex workers are relegated to the lower end of the local sex market. They work in places such as massage parlors, saunas, motels, and one-woman brothels, which are concentrated in the older, overcrowded, working-class, residential districts that are frequented by local clients. They are highly visible at the street level, as opposed to other sex workers who provide sex labor in night clubs or through escort services. In addition, since the Hong Kong government began tightening border controls, Chinese migrant sex workers have become an easy target for law enforcement officials, and they now account for a significant portion of the female prison population in Hong Kong. They are prosecuted primarily for working without a visa, because sex work itself is not illegal. In fact, sex work in Hong Kong is typically accepted as "immigrant work." However, since mainland Chinese immigrants are considered an "undesirable burden," they are subject to mass arrests and imprisonment. Currently, Hong Kong has the highest proportion of female prisoners in the world: about 22% of the total prison population, compared with the global averages of between 2% and 9%. In 2004, mainland Chinese immigration violators made up approximately 60% of the women in prison.

Primarily, migrant female sex workers in the United States (US) are from Southeast Asia, Latin America, and Eastern Europe. Research on the trafficking of women to the US, however, has been less well documented than in other countries. In 1998, one of the first cases surfaced in the media and illuminated this issue for many Americans. The trafficked women were scattered across 14 states, but Atlanta, Georgia, was discovered to be the base of operations for the network. Incidentally, most were minors. A significant portion of the US sex industry operates behind legitimate businesses that act as fronts for prostitution; examples include: restaurants, night clubs, health clubs, saunas, escort services, strip clubs, pornography emporiums, peep shows, and massage parlors. Although large trafficking rings and criminal organizations are involved in much of the trafficking of women to the US, there are also many smaller operations.

Most of the research available regarding the health status and health issues faced by migrant female sex workers focuses on sexually transmitted diseases (STDs) and HIV/AIDS. Instead of emphasizing the worker's vulnerability to acquiring sexually transmitted diseases from numerous sex clients who often prefer, and, in some cases, demand not to use condoms, often female sex workers are regarded as the vectors of these diseases. Although research of the specific health issues women face as a result of sex work is limited, the repercussions of sex work on women's physical and psychological well being is extensive.

A study of 68 local female sex workers in St. Paul and Minneapolis, Minnesota revealed significant health problems as a result of engaging in sex work. For example, high rates of STDs, such as Chlamydia, gonorrhea, syphilis, genital herpes, and warts; pregnancies with low rates of prenatal care, frequently resulting in low birth weight or premature births (migrant female sex workers report being subjected to forced abortions); and drug use, including crack cocaine and alcohol. Many female sex workers, including migrants, report the use of drugs and/or alcohol as a way to cope with engaging in sex work.

Violence is a constant presence in the lives of most female sex workers. Often reported are rape and assault, which frequently lead to broken bones, head injuries, and many types of internal injuries. Other major health issues include stress-related difficulties such as sleep disorders, flashbacks, and depression – all symptoms of Post Traumatic Stress Disorder (PTSD). High rates of self-destructive behavior, including attempted suicide and cutting are frequently cited. Furthermore, 76% of the women in the Minnesota study reported difficulty establishing intimate relationships outside of prostitution, which they attributed to an inability to separate feelings of fear, disgust, and an emotionally distanced attitude developed in prostitution. Although the Twin Cities women reported having good access to health care, only 35% revealed their experiences as prostitutes to their primary health care providers. Many female sex workers, including migrants, keep this crucial information from their health care providers, listing the primary reasons for their silence as (1) the illegality of their work, (2) the illegality of their immigration status – thus, fear of arrest, prosecution, and deportation, and (3) the social stigma and cultural barriers associated with sex work.

In 2002, a comprehensive study highlighting the health issues faced by migrant female sex workers in Indonesia, the Philippines, Thailand, Venezuela, and the US, shed a rare light on both the physical and psychological health challenges for these women. Although this research revealed similar health problems as those found in the women in the Minnesota study, migrant female sex workers cope with additional issues related to their cultural, ethnic, and religious backgrounds; the physical demands of the migration process; and frequent relocation from one place to another. An inability to speak the native language, discrimination, illegal immigration status, lack of access to health care, and often being confined or limited in their ability to leave their work locations further compound their overall health problems. Furthermore, if they are in a country illegally, health care access can be self-restricted by fear of deportation. Even where sex work is legal, it is still stigmatized, and migrant female sex workers, who face more cultural, racial, and ethnic barriers to care, are hampered further by feelings of shame when discussing their health problems as a consequence of sex work activity.

The five-country study reveals the health problems of migrant female sex workers which most commonly include pulmonary tuberculosis, anemia, hepatitis-B, and STDs – including chronic syphilis, gonorrhea, and herpes. They suffer pelvic inflammatory disease, inflammation of the uterus, vaginal irritation, bleeding caused by multiple and violent sex partners, general pain and soreness of the vaginal area, perforated anal and vaginal walls, peritonitis, mutilation, chronic choking from gonorrheal tonsillitis, and asphyxiation from oral penetration. Often younger girls who become pregnant are unable to sustain the pregnancy. Furthermore, they are more susceptible to STDs and to HIV infections, due to a thinner genital tract mucous membrane that offers a less effective barrier to viruses. Although migrant female sex workers are forced by their pimps or madams to use contraception at times, many do become pregnant, only to be forced to have abortions. This can causes extreme difficulty, especially for those who have strong emotional and/or religious convictions regarding abortion. Migrant female sex workers have reported undergoing self-induced abortions using abortifacients or by physically stomping on or punching their own stomachs. Whether or not a condom is used is ordinarily dictated by the client, and usage rates vary from 30% to 80%.

Physical injuries are a large extent of the health problems suffered by migrant female sex workers. These injuries are sustained primarily as a result of violence, including physical and sexual assault (rape). Injuries include bruises from being hit and beaten; vaginal and rectal bleeding as a result of violent intercourse; head trauma; mouth injuries and broken teeth; broken bones; ruptured blood vessels in the eyes and nose from being choked; bleeding all over the body – including the face and lips from being bitten; broken and bruised ribs; and stomach, head, back, throat, and face pain. All of the women surveyed in the 2002 five-country study reported high rates and frequency of violence, some reporting experiencing violence 100% of the time.

Emotional, behavioral, and psychological effects of sex work, and the violence that accompanies it, significantly impact the health of migrant female sex workers. Women most report feeling depressed, guilty, self-blame, numb, hopeless, anger, and rage, while additional complaints include difficulty sleeping, an exaggerated startle response, feeling on guard, loss of appetite, engaging in self injury, and having suicidal thoughts.

Even when sex work is legalized, as in many parts of Europe, and primarily due to their immigration status, migrant female sex workers remain outside established legal, social, and medical structures – even though on average they outnumber local sex workers. Many involved in the sex industry do not identify themselves as sex workers and consider their work to be temporary. However, the reality is that impoverishment; victimization by traffickers, pimps, and madams; illegal immigration status; and language and cultural barriers often trap them as sex workers. Recommendations for helping migrant sex workers to improve their health status include using direct field work programs to teach sex workers about disease and injury prevention; using cultural mediators of the same nationality and cultural background to communicate directly with or between the sex worker and health care providers and educators; and training former sex workers to be peer educators and supporters. Ideally, migrant female sex workers from different cultural, racial, and religious backgrounds would have access to health services and health information that is culturally relevant and appropriate.

Individuals and organizations who advocate on behalf of sex workers have major philosophical differences concerning the legalization and regulation of the sex industry. On the one hand, legalization and regulation have been promoted as ways to eliminate trafficking, violence and abuse, and to assure that sex workers have access to health care and other essential services. Proponents also argue that it would help stem the tide of sex trafficking of women and girls, even though there is some evidence to contradict this claim. Those who oppose the legalization of sex work argue that all sex work is a form of oppression and violence, rarely do those who engage in sex work do so by choice, and sex workers are victims of poverty and exploitation.

Related Topics

- ► Access to care
- ► Health care utilization
- ► Health services utilization
- ► Posttraumatic stress disorder
- ► Prostitution
- ► Rape
- ► Religion, religiosity, and spirituality
- ► Sex work and sex workers
- ► Sexually transmitted diseases
- ► Slavery
- ► Stigma
- ► Trafficking
- ► Violence

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Fertility

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Introduction

The forces influencing population growth differ dramatically across the world's major regions. For example, as compared to developed countries, the current annual rate of growth in nondeveloped countries is increasing nearly six times as fast. Certainly, migration is not a new phenomenon; it is responsible for the base population of many current industrialized nations. Experts suggest, however, that the current dynamic of population growth differs from that of earlier periods due to increased pressures to migrate to more developed countries – pressures caused mainly by the comparatively high rate of population growth and widening economic disparities. The manner in which the developed countries respond to the growth of immigration pressures will have a major impact on their demographic and economic futures.

Migration

Migration, either voluntary or forced, is prompted often by social choice or by economic necessity. Current worldwide immigration patterns reflect a flow of people from poor countries to those with more developed economies, especially to those industrialized countries with aging workforces. The swell of immigrants is changing the composition of populations; for example, 7% of Britain and France's populations is now foreign-born, while immigrants comprise nearly 10% of Germany's population and 17% of the Canadian populace.

In comparison to other countries, historically the USA has had a welcoming immigration policy, periods of restriction and bias notwithstanding. Since the mid-1960s, there has been an increase in immigration to the USA, particularly from countries in Latin America and Asia. Over the past decade, the USA has seen unprecedented numbers of immigrants. The 2000 Census reflected the trend, as 10% of America's residents were born in other countries, the highest percentage since 1930, and the largest number in the country's history. Furthermore, never before has there been such a marked shift in the locations from which immigrants originate. Due to quotas favoring northern Europeans, before 1965 more than three-fourths of all immigrants to the USA came from Europe.

Immigration and Fertility

Total fertility is the number of children the average woman in a given population is likely to have throughout her lifetime; the figure is based on current birth rates. The number ranges from more than seven children in developing countries in Africa, to around one child per woman in Eastern European and highly developed Asian countries. Associated with total fertility rate is *replacement rate*. The *replacement rate* is the number of children each woman needs to have to maintain the current population levels of a given population – known as zero population growth.

Replacement occurs when a child matures and has an offspring. In developed countries, the necessary replacement rate is about 2.1. The need for the extra 0.1 child per woman is due to the potential for death and to account for those who choose or are unable to have children. In less developed countries, due to higher childhood and adult death rates, the replacement rate is around 2.3. Used to give a more accurate measure of population trends, *population growth rate* is calculated as birth rate − death rate + net migration rate.

Total Fertility Rates, Immigration, and Strength of the Economy

Many economists contend that total fertility rates are closely tied to growth rates for countries and can be an excellent indicator of future population growth or decline for a country or for a particular population. As modern societies became more productive, fertility rates began declining. Because rising life expectancy kept populations expanding, the trend went unnoticed. By the 1960s and 1970s, however, more countries started seeing their birthrates sink beneath replacement levels. Today, women in more than 60 countries do not bear enough children to keep the population growing. Even in less developed countries, the trend toward a lower birth rate is apparent. Over the last few decades, Mexico's rate went from nearly seven children per woman to 2.3.

Outcomes of a Declining Birth Rate

Across Europe, birth rates are falling; the total fertility rate is less than two children per woman in every member nation of the European Union. As a result, European populations are either growing very slowly or beginning to decrease. At the same time, low fertility is accelerating the aging of the populations. As a region, Europe in 2000 had the highest percentage of people age 65 or older – 15%, a figure that is expected to double by 2050. These trends indicate difficult times ahead for European economies. For example, a shrinking workforce can reduce productivity. At the same time, the growing ratio of elderly individuals threatens the solvency of pension and social insurance systems that would assist in caring for the elderly. As household sizes decrease, the ability to care for the elderly diminishes, even as elderly people face growing health care needs and costs.

Economic growth depends strongly on an expanding population. Until the 1960s, neoclassical economists believed that population growth reduced a society's standard of living by dividing up the same "pie" of available resources into smaller and smaller slices. Economists have come to understand gradually, however, that in industrialized countries, due to economies of scale and specialization of labor, population growth drives productivity growth.

US Fertility

The USA has the highest population growth rate of all industrialized countries. There are approximately four million births and 2.4 million deaths annually in the USA, with growth due to natural increase at 1.6 million per year. However, when factoring in immigration totals, the US population is growing by 3.3 million per year.

US Population Growth: Immigrants and Rate of Fertility

As compared to women in their home countries, analysis of data collected by the Census Bureau in 2002 shows that women from the top 10 immigrant-sending countries living in the USA collectively tend to have higher fertility. As a group, immigrants from these countries have 23% more children than women in their home countries. Among Mexican immigrants in the USA, for example, fertility averages 3.5 children per woman compared to 2.4 children per woman in Mexico, and among Chinese immigrants, fertility is 2.3 in the USA compared to 1.7 in China. Exceptions to this trend include immigrants from three countries: India, Vietnam, and the Philippines – immigrant fertility is lower in the USA than in their home countries. When education level is controlled for, the disparity in fertility rate is even greater between the USA and the home country. Given the education level of immigrants and the fertility of similarly educated women in their home countries, one would expect immigrants from the top sending countries to have 2.15 children on average in the USA, not the 2.9 they actually have.

Related Topics

- ► Childhood injuries
- ► Family
- ► Family planning
- ► Infant mortality
- ► Reproductive characteristics
- ► Reproductive health
- ► Women

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Filipinos

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Filipinos are individuals with origins from the country of the Philippines, a consortium of islands off the southeastern coast of the main Asian continent. While Pilipino/Tagalog is the national language, often English is widely spoken in addition to other regional languages besides Tagalog and/or the hybrid of Tagalog/English, otherwise known as “Tag-Lish.” A primary motivation for immigration among Filipinos is the pursuit of economic opportunities as a means to financially support immediate family members and/or extended kin who remain in residence in the Philippines. Filipino immigrants reflect ethnolinguistic, demographic, and socioeconomic diversity. In the context of immigrant health, there is limited information concerning the health issues of Filipino immigrants. In health studies, Filipinos are either underrepresented or merged with other Asian groups, e.g., Asian Americans. Also, few studies distinguish between first generation immigrants born in the Philippines and subsequent generations who were born in the host countries. Some reasons for the limited attention to Filipino immigrants in health research may result from a relatively seamless assimilation into the host countries and the challenges associated with finding representative samples of Filipinos. Furthermore, possible factors considered to contribute to the Filipino immigrants’ seemingly rapid integration into host countries like the United States compared to other immigrant populations are that many Filipino immigrants choose to marry non-Filipinos and Filipino immigrants are already familiar with American culture before immigrating to the United States because the Philippines used to be an American territory. Within the Filipino American community, dialogs regarding cultural identity and activism for social change aimed to minimize discrimination, injustice, and economic exploitation shifted self-identification from “Filipino” to “Pilipino” in the 1960s. Currently, both labels are recognized and preference is determined by individual choice.

Immigration Patterns

In the early 1900s, Filipino immigrants were mainly composed of male laborers from rural areas. After World War II (WWII), families immigrated to the United States as military dependents. Post-1960s, many Filipinos immigrating, predominately to the United States, have been well-educated and demonstrate high levels of English proficiency. Also, increasing numbers are migrating to the Middle East, Europe, and Australia for employment. A significant proportion of these immigrants are professionals, mainly physicians, nurses, dentists, teachers, lawyers, and engineers. The majority of Filipino immigrants are college graduates. While the first wave of immigrants resettled in rural communities, the second wave of immigrants chose urban centers and suburban areas reflecting changes in socioeconomic status and demographics. The 1965 Family Reunification Act and the 1990 Amendment to the Immigration and Naturalization Act allowed grandparents and aging WWII veterans to enter the United States. With the 1990 amendment, WWII veterans were granted American citizenship, but were not given service-related compensation such as healthcare benefits.

Labor emigration has a long history in the Philippines and active support from the government. The Philippines Overseas Employment Administration (POEA) regulates the recruitment of laborers for contract work in different countries. Also, the Philippines is one of the largest exporters of physicians and nurses – approximately one third are women and a majority are individuals under 40 years of age. Despite the large numbers of Filipino immigrants with the professional qualifications and technical requirements to be competitive, many individuals have difficulty obtaining jobs that match their education and training experience. Currently, poor treatment and cases of infringement of human rights among overseas Filipino workers (OFWs) have received political attention, resulting in the push for the POEA to take a more active policy in protecting the welfare and ensuring the rights of OFWs in contractual agreements with overseas employers. Temporary OFWs are contract workers intending to return to the Philippines. These individuals are recruited through private organizations to be employed as laborers in factories, domestic homes, retail and construction in the Middle East. Generally, Filipino immigrants moving to North America or Europe have procured permanent employment opportunities and do not intend to return to the Philippines. These individuals are often employed as healthcare professionals.

In 1983, Filipinos in the United States represented the largest population among Asian Americans in the Western region (including Alaska and Hawaii). In 2000, there were over 1.8 million Filipinos living in the United States; Filipinos comprised the second largest Asian group. In addition, there were approximately three million OFWs with official temporary contracts More than eight million Filipinos are estimated to live outside the Philippines. The strength in these numbers generate vast revenue for the Philippines. Remittances recorded between 1990 and 2001 for money Filipino immigrants were sending back to the Philippines through official channels accounted for 5% of the GNP of the Philippines. In 2001, over 6 billion USD were sent home.

The Principle of Balance (Timbang)

Among Filipino immigrants, health and illness result from maintaining or losing balance. One of the underlying beliefs behind this concept is that rapid changes from “hot” to “cold” and vice versa will cause illness, while optimal health is maintained by staying “warm.” Bathing is one of the strategies used to maintain the body’s balance. Beliefs relating to hot and cold also include environmental changes that affect the body. Drastic changes in temperature can upset the balance of the body and cause illness, for example. One woman in Becker’s study of chronic illness among elderly Filipino Americans living in San Francisco claimed that the heart condition she developed in the United States was caused by the cold climate in contrast to the humid climate of the Philippines that allows the body to perspire. Within this hot-cold system, perspiring allows the body to maintain balance. Balance can also be altered by specific food and drinks. Illness can also result from emotional and social stress. This concept of balance is expressed in social interactions through reciprocity. Social and emotional distress, and consequently ill health, can result from difficulty in maintaining family obligations and social responsibility. Furthermore, specific so-called culture-bound syndromes observed among Filipino immigrants such as *amok*, *mali-mali*, and *lanti* are described as “loss of equilibrium.”

Health Issues

Studies on health issues of Filipino immigrants, mostly from Filipino immigrants living in the United States, primarily attribute health problems to life-style and cultural changes. Compared to individuals living in the Philippines, Filipino immigrants are at greater risk for developing chronic conditions. Higher prevalence rates of hypertension are observed in Filipinos living in the US compared to those living in the Philippines among those aged 65 and older. Compared to Filipinos in the Philippines, Filipino immigrants between 55 and 65 years old in Hawaii are at higher risk for coronary heart disease. High prevalence rates of hyperuricemia and gout among Filipino men have been reported in Seattle and Hawaii. These medical conditions may relate to the increased intake of high-protein foods. Anderson suggested that some Filipinos may have difficulty processing foods with higher purine loads resulting from these dietary changes post-immigration. Also, studies show high incidence of tuberculosis among Filipino immigrants. Filipinos are three times more likely to be diagnosed with diabetes compared to Caucasians. While Filipino men are reported to be at greater risk for liver cancer and lymphoma, the cancer rates overall among Filipino immigrants are the lowest compared to other ethnic groups. Filipino children show similar patterns of risk for diabetes, hypertension, and metabolic syndrome.

In terms of mental health, effects of perceived discrimination on health may include symptoms of depression, increased substance abuse, and chronic conditions. The large scale epidemiological survey of mental health among 2,095 Asian American immigrants, the National Latino and Asian American Study (NLAAS), was conducted in 2002–2003 and targeted three nationalities: Chinese, Filipino (n = 508), and Vietnamese. Filipino immigrants reported the highest levels of everyday discrimination, stating physical appearance such as height or weight as reasons for discrimination rather than income or education, compared to other Asian groups. Perceived discrimination was a significant predictor for cardiovascular conditions and associated with increased risk for respiratory and pain conditions such as frequent headaches, ulcers, nausea, and chronic back problems. These chronic somatic problems have been associated with increased use of pain medications. A moderate incidence was found for clinically diagnosed schizophrenia among Filipino immigrants living in Hawaii compared to other immigrant groups. Later age diagnoses and a high mortality ratio for women were reflected. In San Francisco between 1968 and 1972, 57% of female Filipino immigrants were admitted into psychiatric facilities. Most of the cases involved major life events strongly linked to loss of status and feelings of shame. Thus, some doctors questioned whether some of these cases were truly severe mental illnesses or were only temporary disturbances during a readjustment period. Furthermore, compared to other Asian groups, incidence of suicide was low, but diagnoses of clinical depression were often triggered by emotional stress related to family obligations and social responsibility. While the "family" can offer sources of care and support enhancing mental well-being, it can also be a source of stress especially for the children of Filipino immigrants caught between different generations and perspectives. Although often portraying successful assimilation stories, studies of Filipino immigrant youth reflect internal conflicts and emotional struggles potentially placing these individuals at increased risk for attempted suicides and clinical depression.

Related Topics

- ► Acculturation
- ► Asian Americans
- ► Health care

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Finland

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Finland is a nation of approximately 5.2 million people located in the far northern regions of Europe.

Despite a unique language, spoken by only 23 million people worldwide, and a homogenous religious population with 90% Lutheran, the people of Finland represent a diverse group. The majority are Finns who speak Finnish, though 6% of the population are Finland-Swedes who speak Swedish; smaller portions of the population are composed of Gypsies (5,500) and Sami (4,400) who speak Lappish. Over the past 15 years, the population of Finland has changed with a surge of immigrants. Due in part to the fall of the Soviet Union and to Finland joining the European Union in 1995, the number of foreigners permanently living in Finland has dramatically increased from 26,300 in 1990 to 155,660 in 2009. Foreigners residing in Finland in 2009 were from 175 different countries, with 2,435 from the USA. In addition, the number of foreign-born Finnish citizens has doubled over the past 15 years. Immigrants now comprise 6% of Finland's population, representing a much larger portion than prior to 1990. Finland continues to grant citizenship to 2,000–3,000 immigrants annually.

Immigration from Finland to the USA primarily took place from 1864–1924, though there have been smaller trends of migration over the years. The Finns settled across the northern tier of the USA with concentrations in Massachusetts, New York City, Michigan, Wisconsin, Minnesota, Oregon, Washington, and Colorado. The 1990 Census registered 658,870 US residents claiming Finland ancestry with the highest concentration in Michigan, representing 1.2% of the state's population. Historically, assimilation of the Finnish Americans has been difficult due to language barriers and cultural differences. They were quick to adapt to American culture, though privately maintained their own cultural traditions, including cuisine, holidays, religion, and language. The immigrants banded together in small communities to provide support to each other as well as provide support to their country of origin when needed. Finnish Americans are typically politically active and fought for fair wages and working conditions, organizing strikes and protests. This led to the development of a reputation as "troublemakers" in the early twentieth century. The backlash of persecution that followed created tension and caused Finnish Americans to blend more among other European Americans for fear discrimination. They continued to maintain Finnish traditions behind closed doors and passed on their culture to their descendents.

One aspect of Finland's culture is their belief in natural medicine, including massage, cupping (bloodletting), and sauna. Immigrants in the nineteenth and twentieth centuries continued these practices, though today, sauna is the primary retained health practice. Sauna is an historic part of healing rituals; when the Finns get sick, they make a sauna. Sauna can help with respiratory and circulation problems, relax stiff muscles, and relieve aches and pains. There is a Finnish proverb that says if sauna, whiskey, and tar salve don't make you well, death is imminent. Modern immigrants employ sauna, chiropractors, acupuncture, and alternative medicine for relief of ailments.

Despite the emphasis on natural and alternative medicine, Finnish immigrants have a high incidence of heart disease, respiratory illness, high cholesterol, lactose intolerance, stroke, alcoholism, and depression. It is speculated that the increased rate of heart disease is partly due to the traditional Finnish diet, which is high in fat. Respiratory illness is directly related to tobacco smoking, common among native Finns and Finnish immigrants. The use of modern medicine, improved preventive health care, and health education would be helpful in this population to address these common medical problems.

Related Topics

- ► Acupuncture
- ► Alternative and complementary medicine
- ► Cardiovascular risk factors
- ► Depression
- ► Tobacco
- ► Tobacco use

Suggested Readings

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Suggested Resources

Finland Health Statistics. http://www.nationmaster.com. Accessed March 11, 2010.

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First Generation Immigrants

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Introduction

Nearly every American can trace his or her family history to one or more ancestors who entered the USA as an immigrant. From 1607 to the present, it is estimated that the total number of immigrants to the USA is between 35 and 50 million. As immigrants adjust to life in a new country, predictably they face a variety of challenges. In recent decades, researchers have sought to define those challenges and to determine their unique affects on each immigrant generation. In this context, first generation immigrant will refer to the first generation to immigrate to the USA, rather than the immigrants' children – the first generation born in the USA. This is an important distinction, as even within various social sciences, often the terms *first*, *second*, and *third generationimmigrants* are defined divergently across studies.

First Generation Immigrants and Health Care

Compared to their US-born counterparts, on average, first generation immigrants disproportionately lack health coverage and receive fewer health services. These findings hold constant even when factors are controlled for, including sociodemographic status, socioeconomic status, and lifestyle. For example, a 2003 Kaiser Foundation study reported that low-income first generation immigrants were nearly two times as likely to be uninsured as low-income native-born persons. Furthermore, first generation immigrants are approximately twice as likely as citizens not to receive health services. Factors that limit their access to quality health care include: a reduction in available programs for noncitizens, confusion over program eligibility, concerns that enrollment will jeopardize one's immigration status, and language barriers.

As compared to US-born citizens, there are significant differences in the physical and mental health status measures among first generation immigrants to the USA. Considering that they lack health coverage disproportionately and receive fewer health services, it is surprising that first generation immigrant adults enjoy some advantages over their US-born counterparts for certain health measures. Researchers have suggested that the length of stay in the USA is a key factor in health status – noting that, in general, the trend is the longer the first generation immigrant stays in the USA, the more likely it is that a decrease will be seen in the aforementioned health measures.

First Generation Immigrants and Religion

Churches and religious organizations help to create for the immigrant a sense of community in the new country, and frequently they are a major source of assistance for those in need – spiritually, socially, economically, etc. Relationships among congregants of ethnic churches are reinforced with traditional foods and other familiar traditions. American places of religious worship have a centuries-long tradition of service to those who are in need most. Spiritual support delivered in a familiar cultural context, combined with material assistance, increases the appeal of church membership and participation for first generation immigrants to the USA. In fact, participation and commitment by the immigrant in the US setting may often be greater than what was exhibited in the country of origin.

Another notable aspect of the social dynamics of immigration is the relationship between immigrant religions and new American-born religious movements. In the 1960s, a trend began to emerge in which native-born spiritual seekers sometimes gravitated toward immigrant religions, centers, and teachers. One example popular in the New York City area is joining a Faulun Gong group that blends traditional Chinese religious and health practices.

Law, Politics, and Policy

Through legal means, thousands of immigrants enter the USA each year. In 2004, almost a million people legally immigrated to the USA under qualifying categories. These categories include: employment-based preference, family preference, immediate relatives of US citizens, diversity, and refugees/asylees. Recent legislation has authorized the category, diversity, which allows a limited number of individuals to immigrate based on past underrepresentation in the immigrant population.

Many in the USA are concerned about illegal immigration, and proposed policies are discussed and drafted frequently as potential solutions. Bills have been introduced to resolve the immigration controversy, such as the one rejected in 2007. The authors of that bill proposed to allow illegal immigrants to obtain a renewable visa if they were present on January 1, 2007. The bill was defeated eventually due largely to growing debate and disagreement over how to handle the massive illegal immigration to the USA over the past 15 years.

Some policies have been aimed at both legal and illegal immigrants. Federal policy and law relative to first generation immigrants has been shaped by numerous key legislative events. Often first generation immigrants are limited in their English proficiency, the three hallmark legislative events that impact upon that particular aspect of their transition into a new culture include: Title VI of The Civil Rights Act (1964), Lau *v.* Nichols (1974), and Executive Order 13166 (2000). The most recent event, EO 13166 in 2000, has resulted in each federal agency being charged with taking reasonable steps to provide meaningful access to its own federally conducted activities. The Order was designed to provide persons who are limited in their English proficiency with greater access to federally conducted and federally assisted programs and activities.

Related Topics

- ► Access to care
- ► Border health
- ► Cultural adaptation resources
- ► Emigration
- ► Foreign-born
- ► Health care utilization
- ► Immigrant visa status
- ► Immigration status
- ► Immigration and Naturalization Service
- ► Limited English proficiency
- ► Religion, religiosity, and spirituality

Suggested Readings

Fremstad, S., & Cox, L. (2004). *Covering new Americans: A review of federal and state policies related to immigrants' eligibility and access to publicly funded health insurance reviews significant declines in health coverage for legal immigrants after the enactment of the 1996 welfare law.* Washington, DC: Kaiser Commission on Medicaid and the Uninsured.

Pellegrino, E. D., & Mazzarella, P. (1993). *Transcultural dimensions in medical ethics.* Hagerstown, MD: University Publishing Group.

Portes, A., & Rumbaut, R. (2006). *Immigrant America: A portrait* (3rd ed.). Berkeley, CA: University of California Press.

Suggested Resources

For information on an historical look at U.S. immigration policy. http://web.missouri.edu/∼brente/immigr.htm

For information on immigration policy. http://www.immigrationpolicy.org/

For information on the U.S. Bureau of Citizenship and Immigration Services. http://www.uscis.gov/portal/site/uscis

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Fitness

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Introduction

Fitness is the quality of life characterized by how effectively the body can meet ordinary physical demands, as well as those demands that are unexpected and more challenging. Physical fitness is the capacity to perform normal daily activities with little effort, while being able to perform more difficult activities with increased effort and without significant fatigue. On the other hand, low physical fitness leads to significant fatigue even with light activity. Fitness levels differ among individuals and can be improved by engaging in physical activity, but can be worsened through physical inactivity.

Widespread acceptance exists of three physical fitness classifications related to skill, health, and physiology. Skill-related fitness is composed of agility, balance, coordination, speed, power, and reaction time. This class is the most advanced level of fitness and is associated mostly with sport and motor-skills performance; therefore, it is not necessary to master to achieve optimal health. Health-related physical fitness is associated with optimal health and directly impacts the risks associated with the premature development of diseases and adverse health conditions. The components of health-related fitness are cardiorespiratory endurance, muscular strength, muscular endurance, flexibility, and body composition. Since each of these components affects the body's ability to function, regular physical activity is required to achieve optimal health-related fitness. Finally, physiologic fitness relates to the health status of biological systems that have been influenced by regular physical activity. The components of physiologic fitness are metabolism, morphology (or fat content and distribution), and bone integrity. Since improvement of health-related fitness is positively correlated with improvement in physiologic fitness, both categories are closely related to health promotion and disease prevention.

The Components of Physical Fitness

Physical fitness is comprised of five components: cardiorespiratory endurance, muscular strength, muscular endurance, flexibility, and body composition. Each component affects the overall physical capacity and health status of individuals.

Cardiorespiratory endurance is the capacity to perform activities at moderate to high levels of intensity for a prolonged period of time. Though there are several ways to gauge intensity, a basic way to determine intensity level is to monitor an individual's ability to speak while performing physical activity. Moderate intensity physical activity causes the breathing rate to increase but does not restrict the individual's ability to carry conversation. High intensity physical activity, on the other hand, causes such an increase in breathing rate that conversation becomes difficult or impossible. Intensity levels are the same for everyone, but fit individuals have the capacity to perform more movement before reaching high levels of intensity, while unfit individuals experience high levels of intensity with less movement.

Muscular strength is the body's capacity to exert quick episodes of physical force at high intensity levels. Maximum strength is only achieved briefly because fatigue develops quickly, while lack of strength limits the amount of force one can exert.

Muscular endurance is the body's capacity to exert physical force over an extended period of time. Muscular endurance enables the body to delay the onset of fatigue while performing continuous moderate to high physical activity. Fatigue develops more quickly at higher intensity levels.

Flexibility is the body's capacity to perform movements through the full range-of-motion around single or multiple joints by stretching the muscles that stabilize those joints. More flexible individuals are able to perform more movements through the full range-of-motion and are at lower risk of incurring muscle, bone, or joint injuries. On the other hand, lack of flexibility restricts the range-of-motion of movements and may cause injury by stretching the muscles beyond comfort.

Body composition is the total makeup of the body as it pertains to lean body mass (primarily bone and muscle) and body fat. In general, there is a direct relationship between body composition and overall health. Higher body fat percentage increases the risk of developing several diseases and adverse conditions, such as cardiovascular and metabolic diseases. Also, the capacity to perform physical activity lowers with higher body fat percentages. Conversely, lower body fat percentages help to prevent the onset of diseases and conditions and increase the capacity to perform physical activity.

How to Improve Fitness

Regular physical activity is required to improve physical fitness. Exercise programs help, especially if a structured routine is needed, but are not essential. The body responds to any frequent physical activity by adapting at the cellular level, though more specific results are reached by following exercise programs. Physical activity is bodily movement produced by the contraction of skeletal muscles. Exercise, on the other hand, is planned, structured, and repetitive physical activity performed with a specific purpose, usually to improve one or more components of physical fitness. In general, the more physically active individuals are, the more fit they become. However, too much physical activity can lead to overuse injuries and should be avoided. Recommendations vary concerning the minimum amount needed of daily physical activity; however, in general, 60 minutes of moderate to high intensity activity is recommended with 20–30 minute concentration on cardiorespiratory endurance.

Fitness can be improved by following a few simple principles. First, the FITT (Frequency Intensity Type Time) principle allows individuals to track the amount of daily physical activity. Frequency refers to how often physical activity is performed during the course of one week, while intensity refers to the difficulty of the activities. Type refers to the type of the activity performed to improve one of the fitness components. Most activities only improve certain components, so individuals should engage in a variety of activities to maximize their physical fitness. Finally, time refers to the duration the activity is performed during one session or over one day. Physical activity does not have to be performed in one continuous session; intermittent activity also improves physical fitness. In fact, some argue that intermittent activity may be more advantageous than activity confined to one session since engagement in physical activity is spread out throughout the entire day and not confined to only one period of the day.

Other principles that may improve physical fitness are overload, specificity, adaptability, stimulation, and reversibility. Overload refers to exerting enough effort during physical activity to cause at least slight discomfort, but not exhaustion or injury. In other words, in order for fitness to improve, individuals should push themselves to at least a moderate level of intensity. Specificity occurs when the performance of a specific activity is improved by continually engaging in that activity only. According to this principle, frequent jogging will improve a person’s ability to jog, or frequent gardening will improve gardening, and so on. Adaptability refers to the body’s response to frequent physical activity. As one engages in activity, eventually the body becomes more efficient and performance improves. Fit persons must then exert more effort to reach moderate and high levels of intensity because the body has become more able to meet the demands of physical activity. Related to adaptability is the principle of stimulation in which the body must be stimulated continually in order to improve fitness. Otherwise, adaptation can inhibit further improvements if the intensity level is not increased. Finally, when physical activity is discontinued, even for brief periods of time, fitness levels begin to diminish. This is the principle of reversibility. These principles apply to any amount or type of physical activity or exercise program.

Benefits of Physical Fitness

Frequent physical activity is beneficial to overall health as it may serve to delay or prevent the onset of many diseases and adverse health conditions. Most benefits are achieved by engaging in frequent cardiorespiratory activities (e.g., brisk walking, jogging, biking, swimming, household chores, and aerobics classes). The body becomes more efficient at utilizing body fat as an energy source, which leads to body fat reduction and energy increase. Also, cardiorespiratory endurance is associated with a reduction in blood pressure and stress levels, and is associated with an increase in heart function, blood capillary density, work capacity, and blood sugar use for energy. These outcomes decrease the likelihood of developing obesity, diabetes, cancer, and cardiovascular disease. Adaptations occur at various lengths of time, from 6 weeks to 6 months, depending on the time and frequency an individual engages in cardiorespiratory activities. Many experts recommend 20–30 min of cardiorespiratory activity most days of the week, but more activity leads to quicker results, and some activity is better than not engaging in activity at all.

Several health benefits are associated with muscular strength and endurance. Since strength building activities promote increases in bone density, one of the most important benefits is the prevention of osteoporosis. Muscular strength and endurance activities such as lifting or moving heavy objects, walking upstairs, and weight training lead to increases in muscular size, strength, and stamina. Also, by increasing the strength of opposing muscles that work on the joints, these activities lead to improvements in joint stabilization and posture.

Flexibility may be the most neglected component of physical fitness, but can still affect health outcomes. A lack of flexibility is associated with adverse conditions of the muscles, bones, and joints and should be a focus in achieving optimal fitness. Engaging in flexibility activities such as stretching, yoga, and activities involving the full range-of-motion assists with maintaining or improving range-of-motion through physical activity and helps to maintain muscle elasticity. As a result, injuries caused by movements beyond the range-of-motion are not as likely to occur nor tend to be as severe as those occurring in inflexible individuals. Finally, since muscle elasticity decreases with age, flexibility is more crucial for older individuals.

Diseases and conditions associated with body composition have been presented previously. In general, higher body fat percentages increase the risk of developing several chronic diseases. Engaging in cardiorespiratory activities is the most effective way to decrease body fat since the body becomes more effective at fat utilization. However, to decrease body fat percentage, muscular strength and endurance activities should be performed also. Therefore, frequent cardiorespiratory activity coupled with muscular strength and endurance activities influence body composition toward more lean body mass and less fat mass.

Summary

Physical fitness determines how effectively and efficiently the body handles the demands of daily life, both those that are ordinary in nature and the demands that are more challenging. The level of physical fitness is different for all individuals, but optimal physical fitness is achieved only by engaging in frequent and intense physical activity. By focusing on the five components of physical activity, individuals may optimize their health and may delay or prevent the onset of debilitating diseases.

Related Topics

- ► Cardiovascular disease
- ► Chronic disease
- ► Diabetes mellitus
- ► Disease prevention
- ► Health promotion
- ► Hypertension
- ► Obesity

Suggested Readings

American College of Sports Medicine. (2006). *ACSM's guidelines for exercise testing and prescription* (7th ed.). New York: Lippincott Williams & Wilkins.

Beaulieu, N. P. (2008). *Physical activity and children: New research.* New York: Nova Science.

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Morris, M., & Schoo, A. (2004). *Optimizing exercise and physical activity in older people.* New York: Butterworth-Heinemann.

Nash, R. (2003). *Total stretch.* San Diego: Thunder Bay Press.

Suggested Resources

United States Department of Health and Human Services (2008). *Physical activity guidelines for Americans.* Retrieved from http://www.health.gov/paguidelines/guidelines/chapter2.aspx

United States Department of Health and Human Services (2010). *The President's Council on physical fitness and sport.* Retrieved from http://www.fitness.gov/digest_mar2000.htm

Five-Year Bar

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Individuals who violate certain provisions of the Immigration and Nationality Act may be barred from returning to the United States for a 5-year period. Individuals who violate the terms of an F (student) visa cannot return for 5 years after their last departure after the violation. More generally, however, people speak of the 5-year bar that comes from an order of expedited removal.

Normally, an individual wishing to come to the United States applies for admission at a Port of Entry, which includes international airports. That individual is inspected and, if the Customs and Border Protection (CBP) officer is satisfied, the individual is admitted. If the officer is not satisfied with the documentation, the officer may allow the individual to withdraw his/her application for admission. In that case, there are no legal bars to the person reapplying for admission in the future.

However, a CBP officer can also issue an "expedited removal" order against the individual if fraud or misrepresentation was involved with the attempted entry. Individuals illegally in the United States found within 100 miles of a land border and who cannot establish that they have been in the United States for a 2-year period are also subject to expedited removal, although enforcement of this provision is not consistent. The individual expeditiously removed is then barred for 5 years from returning to the United States. A waiver is available, but only a small percentage of applications are approved.

Many individuals who receive expedited removal orders do not understand what the consequences are. They believe that they have simply been turned away. Unfortunately, many of these individuals then proceed to try again. An individual with a second removal order faces a 20-year bar to returning to the United States, and the chances of getting a waiver are significantly reduced.

Many of the individuals expeditiously removed have used false documents to attempt to enter the United States. If that document is a United States passport or other citizenship document, the individual may be found to have made a false claim to United States citizenship. There is no waiver for a false claim charge, meaning that the person is permanently barred from immigrating to the United States.

Individuals can be held by CBP officers for several hours, while their application for admission is reviewed and validated. CBP guidelines provide that an individual must have access to necessary medicines, food, and water if held for an extensive period of time. However, anecdotal evidence suggests that this does not always occur. Individuals with chronic health conditions such as diabetes report that they have been unable to take insulin shots or other necessary medications.

CBP officers are also responsible for the enforcement of customs laws, including those related to the importation of medicines and other pharmacological substances. Generally, importation of prescription medicines from abroad (including Mexico and Canada) is prohibited. Individuals importing less than a 3-month supply for personal use can, in limited circumstances, and in the discretion of the CBP officer, bring their medicine into the United States. However, the medicine must be declared and other requirements exist, including that the medicine not violate United States drug laws.

Related Topics

- ► Immigrant visa status
- ► Immigration status

Suggested Resources

Website for United States Customs and Border Protection. http://www.cbp.gov

FMGs

- ► Foreign medical graduates

Focus Groups

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Focus group is a term used to better understand how a group of people having something in common might feel, perceive, or understand an issue – getting people together to ask questions that hopefully will shed more light on why they feel the way they do. This is essentially what a focus group is.

Focus group as a concept began as a marketing research tool in which a small group of people (about eight to ten individuals) sit at a roundtable discussing a selected topic of interest in an informal setting. As a marketing tool, the discussion could be about a particular product, for example, and the participants are asked their opinion about the product. This information becomes useful to the product managers and market researchers in deciding if their product is appealing to the group, if it needs improvement, and ultimately if it would be purchased by the targeted population group.

Applications

In the example above, the information gathered in the focus group helps to tell the product manager and marketing researcher more about the consumer's habits, who and how they might use the product and what they would expect of the product. For example, if the product is a shaving cream for men or a hair product for women, the focus group participants would reflect the population that the researcher believes might use the product. Feedback from the participants will let the researcher know if the product is appealing to that particular demographic group.

Focus groups can also be used to better understand individuals' perception of health-related issues. For example, if a researcher is interested in what people understand about their illness, the care they receive, or how they feel the care could be improved, using the focus group format may provide the answers.

Characteristics

Focus group participants are usually selected based on a set of predetermined criteria. Depending on the purpose of the focus group, one key factor in the success is selection of the participants based upon specific characteristics or demographics, for example, the participants' age, gender, education, race, or ethnicity. Participants in a focus group are generally selected based on their use of and knowledge, attitudes, or feelings about a product, service, or concept. The participants should be prepared to discuss the topics at hand and provide quality input about that topic.

There is no ideal number of participants for a focus group, although eight to ten participants are the norm. Often, the size of the group is dependent on the comfort level of the moderator/facilitator. The moderator/facilitator has to make sure that one or two participants do not take over the discussion, making it difficult for everyone else to share their thoughts. Groups of more than ten are more difficult for the moderator/facilitator to control.

Moderators

A moderator or facilitator directs or guides the discussion – they are seen as discussion leaders – to make sure the opinions or reactions of all the participants in the group are heard. They try to stimulate the discussion within the group yet saying or adding as little as possible. They usually work from a guide that directs them with a plan about the topics to cover and questions to ask to stimulate the discussions. The moderator tries to include everyone in the discussion and allow time for all the topics to be covered.

Sessions

When planning a focus group session, the physical location of the session is very important. The location should encourage relaxed participation and informal, spontaneous comments. It must be of an adequate size and have comfortable seating and ventilation. Most importantly, the location must be geographically convenient for the participants. Focus group discussions are usually tape-recorded or video-taped to ensure that everything being said is captured. The facility should be relatively soundproof to minimize outside noises and distractions. Depending on the organization requesting the focus group, one-way mirrors may also be used to observe the group without intrusion.

Once the location, moderator, and participants are selected, the moderator begins with an introduction. The introduction includes welcoming the participants, informing them of what will take place during the session, sets up ground rules for how the discussion will follow. The participants are asked to introduce themselves to the group as a way to help them be at ease. Following the outlined plan, the moderator starts with general topic discussions and gradually moves to more specific ones. Once the specific topics are discussed, the moderator will move the discussion into a wrap-up phase.

At the conclusion of the focus group, the moderator may prepare a report for the researcher that includes a written summary of the results of the session as interpreted by the moderator and an analysis of the tape-recorded discussions.

Finally, the use of focus groups is a valuable tool for communities to have their voices heard about issues important to them such as the design of health-related programs that respond to their particular needs and practices.

Related Topics

- ► Community-based participatory research
- ► Community programs
- ► Explanatory model of illness
- ► Health beliefs
- ► Methodological issues in immigrant health research
- ► Mixed methods

Suggested Readings

Fern, E. F. (2001). *Advanced Focus Group research*. London: Sage.

Greenbaum, T. L. (1998). *The handbook for Focus Group research* (2nd ed.). Thousand Oaks: Sage.

Suggested Resources

www.Answers.com

Food

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Food is the source of how humans and animals obtain nutrients required to sustain life. It is composed of carbohydrates, proteins, fats, and water. We eat or drink food on a regular basis to maintain health.

Across the world, food intake is a common thread that connects people not only locally but also across nations and continents. It must be consumed on a daily basis but in the right proportions to prevent disease. As man has evolved so has his obtainment, preparation, storage, and sharing of food. In earlier years, our predecessors were hunters and gatherers of food. Farming then became a major source of getting food followed by mass processing of food items. Food that once was cooked over an outdoor flame can now be prepared indoors enclosed in an oven or in a fraction of the time in a microwave oven. Electricity and its various offspring, including refrigerators and freezers, help keep food unspoiled for longer amounts of time. Meats are no longer cured with salt and dried for preservation regularly, but instead can be frozen for consumption in the months ahead. This is important especially in climates that experience harsh winter weather making growing food or food attainment physically difficult. Sharing food has become easier with transport from one corner of the world to another occurring regularly on a daily basis.

Although we all need food, obtaining it, preparation, and presentation vary in many parts of the world. For example, a fish caught in Tokyo, Japan, is more likely to be served raw as sushi versus one caught in Louisiana, United States, where frying in oil is more accepted. Food may also have different meanings to people of different backgrounds. While pork for a person of the Protestant faith may carry no significance, a Muslim follower may see it as unclean and therefore not fit for consumption. We must be cognizant and sensitive to location, culture, and personal background even as they pertain to food. Today's world focuses on how food elements such as agriculture are grown or meat sources such as chickens are raised. According to the United States Department of Agriculture, organic foods, including organic meat, eggs, and dairy products, come from animals that are given no antibiotics or growth hormones and are produced without using most conventional pesticides, bioengineering, or ionizing radiation. They are thought to be more beneficial for our bodies and have become popularly sought out in today's culture.

For some populations, food variety is of lower importance than availability. Worldwide agriculture produces enough food to provide each person with over 2,500 kcal/day. This is more than enough to meet the energy requirements of each of the nearly 7 billion persons on earth assuming equal distribution. Unfortunately, there are still about 854 million people who are classified as food insecure. Food insecurity is when a person does not have enough food to maintain an active and healthy life. Obtaining knowledge regarding household size, food availability is essential to ensure food security. Food security means that the food needs are met all the time in a household. Food insecure households should be referred to the appropriate social programs that can assist where available. There are social programs to help such as 'Women, Infants and Children' in the United States. It focuses on providing support for supplemental foods for low-income pregnant, breastfeeding, and non-breastfeeding postpartum women, and to infants and children up to age five who are at risk nutritionally.

Another recent concern regarding food availability are food deserts. This is defined as large areas such as urban neighborhoods where major grocery stores are not located, leaving the inhabitants with resources limited to fast foods and no access to healthier, affordable options. There is more focus to this problem to improve food access for those affected.

While food items are important, water is also considered food that is paramount to survival. Worldwide access to clean water is a major concern. Water is a clear, tasteless, odorless fluid with natural supplies coming from the oceans. Our bodies require a minimum amount daily. It contributes to health as well as disease if it is not sanitary. Contaminated drinking water is a major cause of disease in developing countries worldwide. Around 1.1 billion people globally do not have access to improved water supply sources, whereas 2.4 billion people do not have access to any type of improved sanitation facility. The World Health Organization has a number of programs and projects focused on improving water sanitation worldwide. Improvement in water quality and access will lead to fewer deaths related to water-borne diseases and relief of dehydration that contributes to malnutrition worldwide.

While it is important to remember the necessity of food, it is also very desirous. Its consumption is also for pleasure, celebration, religious expressions, comfort, and countless other uses. Food stimulates all of our senses: sight – the bright colors of the variety of fruits and vegetables; sound – popping corn; smell – a freshly baked cake; texture – the ridges of a potato chip; and of course, taste – such as contrasting salty and sweet flavors of chocolate covered pretzels. The balance for the need and the love of food keeps our bodies in harmony. In all parts of the world, we must maintain this balance to keep fighting illness, prevent disease, and remain healthy for long and fulfilling lives.

Related Topics

- ► Celiac disease
- ► Dietary patterns
- ► Food insecurity
- ► Kwashiorkor
- ► Nutrient intake
- ► Nutrition
- ► Nutrition programs

Suggested Readings

Byrd-Bredbenner, C. (2009). *Wardlaw's perspectives in nutrition* (8th ed.). New York: McGraw-Hill.

Suggested Resources

http://www.cdc.gov/nccdphp/dnpao/
http://www.who.int/nutrition/en/
http://www.foodtimeline.org/
http://www.nutritiondata.com/
http://www.mypyramid.gov/
http://www.who.int/topics/water/en/

Food Industry

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The food industry is a collective of diverse businesses that supply much of the food energy consumed by the world population. The food industry includes a variety of business categories such as regulation (policies and regulations for food production and sale), education (academic, vocational, and consultancy), research and development, financial services (insurance and credit), manufacturing (agrichemicals, seed, farm machinery, agricultural construction, etc.), agriculture, food processing, marketing, and wholesale and distribution.

There has been an increased focus recently on the relationship between the food industry in developed countries and immigrants. Much of the debate centers on the agricultural aspect of the food industry. Immigrants, especially those who are in a country illegally, are among the most vulnerable workers in a society. Most developed countries require workers to have proper documentation. In theory, this functions as a deterrent to the employment of unauthorized immigrants. As in the case of the United States, however, the penalties against employers are relatively small, while the acceptable identification requirements are ill-defined and lack oversight. These factors combine to make it easy for employers to hire unauthorized labor – a marginalized group who likely will not report abuses to authorities. These jobs may be more attractive to immigrants because often the minimum wages in one country can be several times the prevailing wage in the immigrant's country of birth.

There are two chief arguments concerning the relationship between the food industry in developed countries and immigrants. One position holds that the relationship is a win–win – the overall quality of life is improved for the immigrants, while the demand is filled for workers in these hard to fill positions. Furthermore, although foreign-born workers are likely to earn substantially less than native-born workers during their careers, the disparity is much smaller for foreign-born workers' children. The other position holds that the relationship is a win–lose proposition, with immigrants being exploited, while powerful business owners in the food industry gain significantly. The argument has intensified as the economies have flagged in developed countries. As jobs have grown scarce, many citizens have grown to resent immigrants, seeing them as taking up part of the available resources and as a threat to their financial security.

There is disagreement among economists as to whether immigration policy should exclude persons who are less educated in terms of a formal education. One camp of economists contends that there is value to the economy overall as a sector of the job market is not being disrupted owing to labor shortages – as the positions in the food industry are less glamorous and frequently involve long hours in less than ideal conditions. Still, other economists disagree and contend that immigration policy should be shaped by the desire to attract only highly skilled individuals with skill sets more appropriate for employment in sectors of the labor market that will enable a nation to compete better globally. As this debate unfolds and immigration policies are reshaped, persons continue to migrate. Research indicates frequently they will work in some capacity in the food industry.

Calls for Further Research, Policy Reform, and Oversight

Research such as the Southern Policy Law Center's recent report, *Injustice on Our Plates*, details the need for policy reform to protect immigrants working in the food industry. The latest literature outlines frequent abuses to immigrants who are marginalized frequently and who have little power to protect themselves.

Immigration to the United States is at an all-time high. In 1994, one in ten persons in the US labor force was born elsewhere, but in 2009, one in seven was foreign born. Giving consideration to the bills and laws being discussed in Congress regarding immigration reform, researchers in the growing field of agriculture and applied economics have called for research that considers the economic impacts of reducing the availability of immigrant workers in the various sectors of the food industry.

Related Topics

- ► Employment
- ► Farmworkers
- ► Labor migration
- ► Occupational and environmental health
- ► Occupational health
- ► Occupational integration
- ► Poverty

Suggested Readings

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Suggested Resources

For information on civil rights and the Southern Policy Law Center. http://www.splcenter.org/

For information on the American Journal of Agricultural Economics. http://ajae.oxfordjournals.org/

For information on the Food and Agriculture Organization of the United Nations. http://www.fao.org/

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Food Insecurity

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A population is defined as food-secure when all people, at all times, have physical and economic access to sufficient, safe, and nutritious food to meet their dietary needs and food preferences for an active and healthy life. Food insecurity, by contrast, is a state in which individuals or families have limited or uncertain ability to acquire, in a socially acceptable manner, nutritionally adequate and safe foods sufficient for an active and healthy life for all members of the household. Although the subjective experience of hunger and the objective physiologic and anthropometric changes of malnutrition may follow from food insecurity, these findings are not required for an individual or family to be considered food-insecure. Rather, food insecurity can stem from difficulties with any of three general aspects of food security: availability, access, or utilization. For people to be considered food-secure, the quantity of food available to them must be adequate to meet their caloric needs, they must have access to a reasonable range of food choices they can obtain in a socially acceptable manner, and they must be able to utilize the food resources they have in a way that leads to a nutritionally appropriate intake.

A variety of definitions and approaches have been used to measure food insecurity at the individual, family, and national levels. In some assessments of food insecurity in the developing world, an estimate of total calories available per capita, based on local food production and food importation, is used as a proxy for the availability aspect of food insecurity. In this approach, an individual is defined as food-insecure if he or she consumes less than a nutritional target, expressed in calories per day. This method allows for comparisons between countries in terms of the sufficiency of the total amount of food available, but is not as useful for capturing and analyzing variability in access and utilization that may lead to individual or household-level food insecurity.

Much of the research on food insecurity in the medical and social science literature, by contrast, is based on a more detailed, qualitative assessment of food insecurity. There have been a number of questionnaires developed and standardized to allow researchers to determine family or individual food security status based on brief interviews. These include the Radimer/Cornell hunger and food insecurity survey items, the United States Department of Agriculture, Current Population Survey food security questionnaire, and the Household Food Insecurity Access Scale. These scales all include items that assess feelings of uncertainty or anxiety about the subject's ability to obtain food, perceptions of insufficient quantity or quality of food, and reductions in food intake due to economic constraints. They also include questions that directly address limitations in the ability to provide appropriate food for the children in the household. These questionnaires have been widely adapted and validated for use in both developing and developed countries. Scoring of responses allows classification of the individual or household as food-secure or food-insecure. In some cases, food-insecure respondents can be further subdivided into those with low food security, those with very low food security, and those with very low food security among household children.

Research using these and other measurement schemes has found evidence of significant food insecurity even in developed nations. In the United States in 2008, it was estimated that 15% of households were food-insecure at least some time during the year. Although a large proportion of published research on food insecurity in developed nations is focused on the United States, similar studies have been conducted in a variety of settings. Recent large surveys from both Canada and Australia have found 7% of respondents in those nations met criteria for food insecurity. Within developed nations, there are subsets of the population who have much higher rates of food insecurity. In a small sample of inner city London residents in 2003, 20% were found to be food-insecure. In the 2008 US survey, 23% of children were estimated to reside in food-insecure households and 37% of households headed by single women met criteria for food insecurity. In Toronto, one survey focused on high-poverty neighborhoods found that approximately two-thirds of families in those neighborhoods were food-insecure.

Correlations have been found between food insecurity and a number of adverse health effects. Despite the fact that adults have been shown to act to shield children from the worst effects of household food insecurity, children from food-insecure households have been found to have higher rates of undernutrition, poorer physical function, poorer health status, increased rates of acute and chronic illness, more depression and suicidality, more behavior and emotional problems, and higher developmental risk. In adults, food insecurity has been linked to a wide variety of chronic diseases and overall poorer health status. The relationship between food insecurity and obesity has been widely studied, but has yielded conflicting results.

In a number of studies, immigrants have been found to have higher rates of food insecurity and associated health problems. A survey of Mexican immigrants in New York City in 2004, using a single-item measure, found 28% of respondents reported they had felt hungry in the past 6 months but could not afford to obtain food. Report of hunger in this population was higher among men, those who had worked as day laborers, and those who received no public assistance. Hunger was also associated with more reported days of poor physical and mental health. Individuals who reported sending money to friends and family in their home countries were also more likely to report hunger. This is noteworthy because many developing countries, particularly those in Central America and the Caribbean, are highly dependent on such remittances to offset local food insecurity.

Food insecurity among immigrants is also associated with poor dietary habits. A small survey of Colombian immigrants using a food bank in London, Ontario, Canada, was conducted in 2005. This was a highly educated sample, with 64% having completed a college or university degree. Although previous studies have found that not all food bank users meet criteria for food insecurity, in this sample all respondents reported at least household-level food insecurity. Forty-four percent reported food insecurity with individual hunger, and 39% reported the most severe degree of food insecurity, that with hunger among children. High proportions of this sample reported lower than optimal intakes of fruits, vegetables, and dairy products, and significant majorities reported lower intake of fruits, vegetables, meats, and dairy while in Canada than when they were in Colombia. Sixty-five percent said they consumed more grain products since coming to Canada, and 56% were overweight or obese.

Several studies have found increased risk of food insecurity among immigrants and their children, even when compared to comparably low-income native-born families. In an evaluation of about 6,000 low-income families from a nationally representative sample of US families with children, 20% of all foreign-born children as well as 20% of native-born children with two foreign-born parents and noncitizen mothers lived in households that met criteria for food insecurity. This proportion was cut in half, to 10%, if both parents were foreign-born but the mother was a US citizen, and was 8% in families where both parents were US born. In another large US sample focused on mothers with children aged 3 and under, the rate of household food insecurity for immigrant mothers was found to be over twice that of US-born mothers, 35% vs. 16%. In addition, this study found a small but statistically significant difference in report of fair or poor child health, reported by 14% of immigrant mothers and 12% of native-born mothers. These findings were despite significant differences in some factors that should have been protective in the immigrant families, notably a markedly higher rate of breastfeeding (82% vs. 37%) and a lower rate of low birth weight children (10% vs. 15%). Even immigrant families that had been in the United States for 11 or more years continued to have an elevated rate of food insecurity, at 25%.

In the United States, food-insecure immigrants have been found to have relatively low participation in public assistance programs, even when they are apparently eligible. In one study of 630 legal immigrants in California, Texas, and Illinois, only 20% of responding households were found to be fully food-secure. Forty-one percent met criteria for food insecurity with moderate or severe hunger, and 7.5% reported that their children, at times, did not eat for a whole day because there was no money to buy food. Even in this highly food-insecure sample, 40% were not participating in any public assistance programs. Although the study did not systematically investigate the reasons for low participation in public assistance, some immigrants commented in interviews that they were concerned that accepting public assistance would adversely affect their ability to become naturalized citizens or would place them at risk for deportation. An additional finding of that study was that Latino immigrants were at higher risk of food insecurity than Asian immigrants to the same area, indicating that varying cultural practices and attitudes may lead to differing risk levels for food insecurity.

The higher prevalence of food insecurity in immigrant populations as well as the documented associations between household food insecurity and adverse health effects indicate the need for professionals, researchers, and advocates working with immigrant populations to consider the possibility of food insecurity, even in developed nations. Although food insecurity, as defined by qualitative survey methodologies, may not be associated with objective findings of hunger or malnutrition, it remains an important consideration for the medical and psychosocial well-being of families.

Related Topics

- ► Dietary patterns
- ► Food
- ► Food stamps
- ► Maternal dietary intake
- ► Nutrition
- ► Poverty

Suggested Readings

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Food Stamps

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The Food Stamp Program, also known as Supplemental Nutrition Assistance Program (SNAP), is a Federal program administered by the US Department of Agriculture that provides assistance to low-income and no-income people and families living in the USA.

In response to the Great Depression, the first food stamp program was initiated in 1939. Participants in that first FSP program were required to buy coupons to purchase their groceries. For each such coupon purchased, the participant received a different coupon that could be used to purchase surplus foods. That FSP program only lasted until 1943. The next such program, called the Pilot Food Stamp Program, was initiated in 1961 by President John F. Kennedy. The Pilot FSP lasted until 1964, when the Food Stamp Act was passed, and brought about the system of food stamps that prevailed until the SNAP program came into existence in 2008.

In the past, the Food Stamp Program used paper coupons or stamps that were worth various denominations and were color coded. Brown-colored coupons represented $1.00, blue-colored coupons represented $5.00, and green-colored coupons represented $10.00. Today, SNAP benefits are available through an Electronic Benefits Transfer (EBT) card, which operates much like a debit or prepaid credit card. The transition from stamps and coupons to EBT cards was authorized by the Food, Conservation, and Energy Act of 2008 on June 18, 2008, which was enacted over President George W. Bush's veto. Some of the benefits to using the EBT system over paper food stamps are that there are no minimum dollar amounts per transaction, fraud prevention, personal security, and increased privacy.

SNAP benefits can be used to buy breads, cereals, fruits, vegetables, meats, and dairy products. SNAP benefits may be used to purchase seeds and plants which produce food for the household to eat. In certain locations, some restaurants are authorized to accept SNAP benefits from qualified homeless, elderly, or disabled people. SNAP benefits cannot be used to buy alcohol of any kind, nonfood items, or hot foods.

The number of Americans receiving food stamps reached 39.68 million in February 2010, the highest number since the program's inception in 1962. In 2006, an average of 37 million individuals were eligible for food stamp benefits each month, and 25 million received them. From 2005 to 2007, Arkansas, Illinois, Kentucky, Maine, Missouri, Oregon, Tennessee, and West Virginia had significantly higher participation rates than two-thirds of the States; and California, Colorado, Kansas, Nevada, and Wyoming had significantly lower rates than two-thirds of the States in all 3 fiscal years. The rate of SNAP participation appears to correlate to the rate of poverty. Those areas with the highest concentration of persons below the federal poverty guidelines are the areas that have the highest participation.

To receive food stamps, everyone in the household must meet certain income requirements, have or apply for a Social Security number, and be either a US citizen, US national, or have status as a qualified alien. Most able-bodied people between the ages of 18 and 60 must register for work to participate in an employment or training program to qualify for food stamps. Some college students also may be eligible.

To meet the income requirements, the entire household cannot have more than $2,000 in resources. However, if the household includes a person older than 60 years of age or who is disabled, the resource limit is $3,000. Supplemental Security Income (SSI) or benefits under the Temporary Assistance for Needy Families (TANF) program are not counted as income for food stamp purposes. Financial resources include cash, bank accounts, real estate, vehicles, and other property.

Some exceptions to financial limitations exist. For example, an applicant's primary home and the land it sits on are not considered resources when determining food stamp eligibility. Most states now use TANF rules on vehicles. Licensed vehicles are not counted if they are used for income-producing purposes, needed for long distance travel for work (other than daily commute), used as the home, needed to transport a physically disabled household member, needed to carry most of the household's fuel or water, or if the household has little equity in the vehicle (less than $1,500, if sold). If a vehicle has a fair market value or equity value more than $4,650.00, it is counted as a resource. The applicant may qualify for other income exclusions if it includes a person age 60 or older or disabled. The income limits are different for different household sizes and may change each year.

Some non-US citizens are eligible for food stamps without a waiting period. Those "qualified aliens," as they are termed in the legislation, include legal immigrant children under the age of 18; blind or disabled legal immigrants who receive disability benefits; individuals born on or before August 22, 1931, and who legally resided in the USA on August 22, 1996; lawful permanent residents who are active duty members or veterans of the US armed forces or a spouse or a child of a veteran or active duty service member; certain refugees; certain asylees; certain deportees; Cuban or Haitian entrants under §501(e) of the Refugee Education Assistance Act of 1980; and Amerasian immigrants under §584 of the Foreign Operations, Export Financing and Related Programs Appropriations Act of 1988.

The following legal non-US citizens are eligible for SNAP, even though they are not qualified aliens: Hmong or Highland Laotian tribal members and their spouses and children who helped the US military during the Vietnam era; American Indians born in Canada; and members of Indian tribes under §4(e) of the Indian Self-Determination and Education Assistance Act.

Certain qualified aliens are eligible only if they have lived in the USA for 5 years in qualified status. These individuals include lawful permanent residents; parolees who have been paroled for at least 1 year under §212(d)(5) of the Immigration and Nationality Act (INA); conditional entrants under §203(a)(7) of INA in effect prior to April 1, 1980; and battered spouses, children, or the parent or child of battered persons with a petition pending under §204(a)(1)(A) or (B) or §244(a)(3) of INA. (In this context, the term "parolee" refers to a category of individuals under the US immigration law, not someone who has been paroled from prison.)

During the SNAP application process, an applicant should provide identification: proof of income, proof of living expenses (such as child care; rent receipts or mortgage payments, and utility bills), any medical bills for household members who are aged 60 or older, and, if applicable, government payments such as Social Security or SSI for household members who are disabled.

Even though SNAP is a Federal program, SNAP is administered at state and local levels. An applicant can apply at any Social Security office if the applicant is currently receiving SSI benefits and if there is a food stamp representative at that office. Otherwise, an applicant must apply in person at one of the state offices. Currently, there are a few states that allow applicants to apply for SNAP benefits online.

The number of SNAP recipients has increased each year since 2000. The number of children receiving SNAP benefits rose from approximately 8.7 million in

2000 to 12.6 million in 2007. The number of children receiving SNAP benefits rose from approximately 8.7 million in 2000 to 12.6 million in 2007. Congress allocated $54 billion for the SNAP program in 2009, a marked increase from the $39 billion in 2008. Currently, the SNAP program feeds approximately one in eight adults and one in four children. So long as poverty continues to increase in the USA, the need for programs such as SNAP will remain.

Related Topics

- ► Food
- ► Food insecurity
- ► Nutrition

Suggested Resources

Cunnyngham, K.E., & Castner, L.A. (2009) *Reaching those in need: State Supplemental Nutrition Assistance Program participation rates in 2007*. Prepared by Mathematica Policy Research for the U.S. Department of Agriculture, Alexandria, VA: Food and Nutrition Service, USDA. Retrieved on March 5, 2010, from www.fns.usda.gov/ora

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Foreign Medical Graduates

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International medical graduates are a growing category of highly educated immigrants spread all over the world. Some of them study abroad and come back to their country of origin; some go to another country, eventually pass the license exam, and try to find a job position in the host country. Both situations are challenging in terms of professional performance, social adjustment, personal fulfillment, and well-being.

It is well acknowledged that there are psychological and emotional problems confronting graduate medical students and doctors in general, whether they are immigrants or not. The prevalence of psychological distress exceeds that of general population. Moreover, the psychological distress of these students in low-income countries appears to be higher than in Western countries. For international medical graduates, these issues are even more sensitive. It is inevitable that becoming an international student is a transition that will challenge an individual and his or her sense of well-being. Some of these students tend to suffer from poor health during their overseas stay.

Many of their concerns are traditionally overlooked. For international students, an unfortunate aspect of living and studying overseas can be the experience of perceived abuse or exclusion from involvement in activity or interaction with others. When abuse occurs, it is most likely to be verbal abuse or feeling excluded. One concern is whether the abuse experienced by international students is culturally motivated. Students who have reported abuse have had significantly stronger perceptions of being treated differently in the host country because of their cultural background than those who did not.

There is some evidence that international students are at high risk of psychological problems. A study of international medical graduates in a large Australian university found that there are some changes in health and risk behavior. About one-third of the students evaluated their health as being only fair, almost one-fifth reported a considerable or strong adverse effect of their health on work, and about 10% had entertained suicidal thoughts. A small but worrying minority had begun using hard drugs, gambling, or smoking, and one quarter had increased their drinking, some to a considerable degree. In a large Finnish study of international medical graduates, one-third of medical students and young doctors reported mental health problems that required treatment.

Loneliness, tiredness, sadness, and worrying are reported as a frequent source of problems. Even more, some of them may develop elevated levels of depression, anxiety, and stress, as well as a rise in the occurrence of syndrome-like tendencies resembling paranoia, anxiety, depression, and somatic complaints. Given the conceptual basis of the anxiety scale – a prolonged period of coping with demands for high achievement that are extremely important for the person to meet if self-esteem is to be maintained – it is not surprising that international students have reported higher than average levels of anxiety. Local students on the whole tend to have better mental health than students from the other countries. Despite an increased need for treatment, there is no corresponding increase in care-seeking, most of the evidence showing an inappropriate health care use among international medical graduates. One reason for this may be the stigma attached to having a mental disorder. Studies have found that the more symptoms of serious personality problems reported by individuals, the less likely they were to seek help. Other reasons for these tendencies were attributed to certain psychosocial factors such as information received regarding study opportunities, social contacts with other tenants, and future job opportunities.

Among the factors that influence well-being in a new culture are similarities between the culture of origin and the host culture (with greater differences suggesting increased difficulty in adjustment), gender, age, and situational variables such as length of stay. Age and gender are two key factors identified in the research literature but have not been consistently found in research studies. In general, female students have shown greater levels of psychological distress than male students and have experienced a higher rate of physical abuse and sexual harassment than male students, thus indicating lower levels of safety, greater experience of bad treatment, and more instances of self-harm or ideation among female students. Female students have reported more diagnoses of sexually transmitted diseases. These changes may be due to some changes in patterns of sexual activity, especially for those whose home country had strict cultural constraints on sexual interaction, especially for young females. There is some evidence for initiation of sexual activity in Australia, with the change more apparent for female than male students.

It is generally thought that the longer international students spend in the host country, the greater their adaptation. On the other side, while sociocultural adjustment relates to length of stay, psychological adjustment does not.

There is a growing recognition that students' academic performance is related to their health and social and psychological well-being. Poor health can make it difficult to maintain the energy and focus on study and work. Occupational status is believed to be particularly important for the psychological well-being of the future immigrant physician, because – more than for other occupational groups – their work role is one that that shapes strongly their self-identity. Immigrant medical students who passed the licensure examination and already obtained a job in their profession have been found to have significantly higher scores on measures of work satisfaction, mood, self-assessed health, self-esteem, and general satisfaction with life than those who did not pass the medical examinations and did not have yet the chance to work as physicians.

For immigrant medical graduate students, obtaining a medical license and finding appropriate professional employment are the first two stages in the process of integration into the medical care system. Success in these two tasks means not only that the immigrants can continue to view themselves as physicians, but also that their self-identity has been socially legitimized by the host society.

Related Topics

- ► Culture shock
- ► Depression

Suggested Readings

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Foreign Nurses

- ► Nurse/Nurse practitioner
- ► Nursing shortage

Foreign-Born

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The term *foreign-born*, also called non-native, describes persons who are born outside of the country in which they reside currently. Frequently, they are not citizens of their current country of residence. The term *foreign-born* can be used to describe persons who are immigrants or persons who are expatriates. Immigrants are foreign-born people and their families who enter the USA and settle. This is a generic phrase that includes everyone from the US-born children of foreigners, to naturalized citizens, to the undocumented.

Foreign-born residents can, under certain circumstances, change their status and become citizens through naturalization. For example, foreign-born, like immigrants, can make a commitment to live in a country permanently; or, like expatriates, they can live abroad in another country for an extended period of time with a plan to return to their birth country.

In terms of citizenship, the status of those who are foreign-born differs depending on the country to which one emigrated. There are countries, such as Germany and Japan, where it is very difficult, if not impossible, for the foreign-born to become citizens. In countries such as Canada and the USA, foreign-born can become citizens.

The foreign-born living in the USA include immigrants (legal permanent residents), temporary migrants (e.g., students), humanitarian migrants (e.g., refugees), and unauthorized migrants (people illegally residing in the USA). Foreign-born immigrants (legal permanent residents) or nonnatives in the USA cannot vote, although they may work, pay taxes, send their children to school, and serve in the military – much like the citizens of the country in which they reside.

This gap between the voting public and the total population raises important issues about government accountability to residents who cannot vote, and the civic responsibilities newcomers are expected to assume within their communities. In response, several communities across the USA are seeking to grant noncitizen residents the right to vote in municipal and/or school board elections. Today, the practice of noncitizen voting has spread to more than 20 countries around the world, to include communities in New Zealand, Chile, Israel, and all Member States of the European Union. A recent report by the Center for Immigration Studies indicates there are now 35.2 million foreign-born people living in the USA, an estimated 12.1% of the population. With the number of voters potentially hanging in the balance, the result of the proposed legislation to afford the right to vote on local issues will be especially important for many US communities and for those interested in voting as a tool for political incorporation.

Foreign-born immigrants are entitled to the same rights as citizens, although they cannot vote or hold political office. Approximately 40% of immigrants become citizens through the naturalization process. To become naturalized, with some exceptions, foreign-born immigrants must reside in the USA for 5 years and demonstrate a level of English proficiency and knowledge of US history and government.

Related Topics

- ► Immigration in the global context
- ► Labor migration
- ► Legal services
- ► Migrant day laborers
- ► Migrant farmworkers

Suggested Readings

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Former Soviet Union

► Russia

France

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Location

France, currently the 20th most populous country in the world – population 65.8 million, is a nation located in the western region of the continent of Europe. It is bordered by Belgium and Luxembourg to the northeast, Germany and Switzerland to the east, Italy to the southeast, and Spain to the southwest. It is bordered by or contains also several key bodies of water including the Mediterranean Sea that lies to south of France, where the Principality of Monaco forms a small enclave; the coastline of the Atlantic Ocean that runs along the country's west side; and the English Channel to the north, across which is situated the country's last neighbor, England.

History

Historical records indicate that France has been inhabited since the Neolithic period, while written history begins in France with its invasion by the Romans between 118 and 50 B.C. The Roman legacy is apparent, particularly in the southern part of the country, where Roman circuses are still used for bullfights and music productions. Furthermore, some of the nation's main roads still follow the routes used originally 2,000 years ago. A chief legacy of the Roman Empire is the Catholic Church that still holds great influence in the region.

Charlemagne became emperor of the Roman Empire in 800, and with his rule, society began to shift toward feudalism. The era of the Middle Ages, while characterized frequently as a period of stagnation or decline, can be described also as a complex mix of economic and cultural developments; examples include the music and poems of the Troubadours and the love lyrics of the Trouveres of northern France; the building of Gothic cathedrals; and, economically, recessions owing to pandemic disease and wars.

The start of the sixteenth century marks the end of the feudal system, and France began to emerge as a modern state. Louis XIV, who was king from 1643 to 1715, was a powerful monarch. During his tenure, French influence extended deep into Western Europe. In fact, the French language was used in the European courts and France's culture was exported all over Europe. From Louis XIV's reign through the next century, France expanded to other continents, and a series of French wars developed with England and Spain over control of North America.

The French Revolution began in 1789 and lead to the creation of the Republic. While Napoléon reunited the country and his ambition paved the way for him to rule most of Western Europe, ultimately, that very ambition was his downfall. He was defeated in 1815 by British and Prussian forces; however, he is still revered in some Eastern European countries. Following Napoleon's defeat, France returned to a monarchy and underwent another revolution in 1848, which allowed Napoleon's nephew to be elected president and become emperor. The close of the nineteenth century marked the start of the industrialization of the country, the development of its railways, and the bitter wars with Prussia and Germany.

The separation of the Church from the State, confirmed in France in 1905, was a traumatic process for the nation, particularly in rural areas. Today, the French state is careful to avoid any religious alliance. Under a "don't ask, don't tell" policy, the law forbids French students and civil servants from displaying any sign explicitly revealing their religious allegiance. The mandate applies to such symbols as the Christian cross and the head covering traditionally worn by Muslim women, the hijab. The policy has been copied recently in other countries such as Tunisia and Turkey.

After two world wars in which France lost a large percentage of the male workforce to injury or death, and during which a significant portion of its industry was destroyed, France went through a period of reconstruction, development, and prosperity. France and Germany were at the start of the Treaties that grew eventually into the European Union.

Geography

Metropolitan France is located in Western Europe; in addition to this primary land holding, the country possesses several territories in North America, the Caribbean, South America, the southern Indian Ocean, the Pacific Ocean, and Antarctica. Metropolitan France covers 547,030 km^2, the largest area among European Union (EU) nations; it is approximately 80% the size of the United States' state of Texas. France features a varied terrain, from coastal plains in the north and west to the mountainous Alps in the southeast, the Massif Central in the south-central, and the Pyrenees in the southwest. France also has extensive river systems such as the Seine, the Loire, the Garonne, and the Rhone. Three of the streams flow from east to west, the Seine into the English Channel, the Loire into the Atlantic, and the Garonne into the Bay of Biscay, while the Rhône flows from north to south into the Mediterranean. Excepting the utmost north region, France may be described geographically as four river basins and a plateau.

Including its overseas departments and territories, excluding Adélie Land, France's total land area is 674,843 km^2. France enjoys the second-largest Exclusive Economic Zone (EEZ) in the world; it covers 11,035,000 km^2. An EEZ is a sea zone over which a state has special rights over the exploration and use of marine resources; an EEZ stretches 200 nautical miles from the coast to the seaward edge of the state's territorial sea.

The north and northwest regions of France feature a temperate climate, while the interplay between maritime influences and latitude and altitude produce a varied climate throughout the remainder of the country. A Mediterranean climate prevails in the southeast; in the west, the climate is predominantly oceanic, with a high level of rainfall, mild winters, and cool-to-warm summers; in the Alps and mountainous regions a mainly alpine climate is found, with an average of more than 150 days per year with temperatures below freezing point and snow cover lasting for up to 6 months. At 4,810 m, Western Europe's highest point, Mont Blanc, is located in the Alps, near the Italian and Swiss borders.

Ecology

A study in 2010 by Yale and Columbia Universities ranked France the most environmentally conscious nation of the G-20. By percentage of land area, it is the second most wooded of all EU nations, as forests account for 27–28% of the land. French forests, such as the heavily wooded Vosges Mountains in the northeast and the Pyrenees Mountains in the southwest, are among the most diversified woodlands of Europe, featuring more than 140 varieties of trees. Presently, France has nine national parks, 46 natural parks, and a goal of converting by 2020, 20% of its EEZ into a Marine Protected Area.

An Environmental Charter was included in the French Constitution in 2004. For many decades, France has had as part of the government's cabinet, a member whose function is organized around environmental concerns. Today, the full title of the position is *Minister of Ecology, Sustainable Development, Transport, and Housing*. The current title reflects the influence of the Green party and the pro-environmental movement in French politics over the past decade. The Ministry is responsible for policy on the State Environment, Transportation, Sea, and Housing.

Demographics, People, and Culture

France, the 20th most populous country in the world, has a population estimated in January 2011 at 65.8 million people, of whom 63,136,180 live in metropolitan France, whereas 2,685,705 live in the French overseas departments and territories. In 2003, the nation's natural population growth – the difference of births minus deaths, excluding immigration factors – accounted nearly for all of the natural population growth in the entire EU; the rate rose in 2006 to its highest since the end of the baby boom in 1973.

The French language derives from the Latin dialect spoken by the Romans in Gaul, and includes also many Celtic and Germanic words. Today, French remains one of six official languages at the United Nations and has been a unifying factor in Africa, Asia, the Pacific, and the Caribbean.

A law with origins in France's 1789 Revolution and reaffirmed in the Constitution of 1958 prohibits the French state from collecting data on ethnicity and race. Devoid of official data on the country's ethnic minorities, it has been estimated that 40% of the French population overall is descended at least partially from the waves of immigrants the country has received. Additionally, it is estimated that between three million and six million residents are of North African ancestry, 2.5 million are of Black African ancestry, and five million are of Italian ancestry. Due to more recent immigration, it is estimated that there are presently five million Arab-Berber people and approximately 500,000 Turks living in France.

With a rich culture, diverse geography, and a plentitude of attractions, France has been the world's most popular tourist destination for over 20 years, hosting 81.9 million tourists in 2007. Notable cultural attractions include Paris; the French Riviera; the Atlantic beaches; the resorts of the French Alps; castles of the Loire Valley, Brittany, and Normandy; and world-renowned food and fashion. Just a few of the country's notable landmarks are the Arc de Triomphe, an iconic triumphal arch in Paris; the Calanques, a series of miniature fjords to the south of Marseille; the Chateau de Versailles, France's most exquisite chateau; the Eiffel Tower, a symbol of Paris; and the Notre Dame Cathedral, the landmark cathedral of Gothic architecture.

Education

France has a public education system that is highly centralized, free for children beginning at age 2, and is compulsory between ages 6 and 16. Private education is primarily Roman Catholic. Higher education in France began with the founding of the University of Paris in 1,150 and now consists of 91 public universities and 175 professional schools, including the post-graduate Grandes Ecoles. Private, college-level institutions have been growing in recent years, which feature curriculums structured on the American system of credits and semesters.

Government and Politics

The French Republic is a unitary semi-presidential republic with strong democratic traditions. The constitution of the Fifth Republic was approved by referendum in September 1958, and it strengthened the authority of the executive in relation to the French parliament. France's executive branch has two leaders: the President of the Republic, who is the head of state and is elected directly by universal adult suffrage for a 5-year term; and the Government, led by the president-appointed Prime Minister.

The French parliament has two chambers or houses, a bicameral legislature, comprised of a National Assembly and a Senate. The National Assembly deputies represent local constituencies and are elected directly for 5-year terms. As the Assembly has the capacity to dismiss the cabinet, the majority in the Assembly determines the choice of government. Senators are chosen by an electoral college for 6-year terms; beginning in September 2008, now half of the seats are submitted to election every 3 years. In the event of disagreement between the two chambers, the National Assembly has the final say. The government has a strong influence in shaping the agenda of Parliament.

Economy

Characterized by substantial agricultural resources, a large industrial base, and a highly skilled work force, France has the world's fifth-largest economy. In recent years, the services sector has been increasingly vital to the country's economic activity and has been a critical factor in nearly all job creation. The French government's economic policies are targeted at investment and domestic growth, achieving and maintaining a stable fiscal environment, creating jobs, and reducing the high unemployment rate.

In January 1999, France joined ten other EU countries in adopting as its currency the Euro. Subsequently, monetary policy has been set by the European Central Bank, and on January 1, 2002, France, along with the other EU countries, dropped the national currency in favor of Euro bills and coins. Despite significant reform and privatization over the past 15 years, however, the French government continues to control a large share of economic activity. Government spending, for example, was 55.6% of GDP in 2009, ranking among the highest in the G-7. Furthermore, the government continues to own shares in corporations in a range of sectors, including banking, energy production and distribution, automobiles, transportation, and telecommunications.

France has been highly successful in developing dynamic telecommunications, aerospace, and weapons sectors. It has virtually no domestic oil production and has relied heavily on the development of nuclear power, which now accounts for approximately 80% of the country's electricity production. Agriculture is important also to the French economy. France is the world's second-largest agricultural producer, after the United States. Approximately 17% of all agricultural land within the EU-27 is located in France; France is the EU's leading agricultural exporter. Although the country is expanding its forestry and fishery industries, France remains cautious regarding the cultivation of genetically modified (GM) plants at the domestic and EU levels. The nation is a proponent of the European preference principle and is attentive to protecting its interests in further agricultural trade liberalization at the EU and World Trade Organization (WTO) levels.

Health

France has a universal health care system that is financed largely by the government through a national health insurance system. The World Health Organization noted in its 2000 assessment of world health care systems that France provides the "best overall health care" in the world. In 2005, France spent 11.2% of GDP on health care, a figure much higher than the average spent by countries in Europe. Approximately 77% of health expenditures are covered by the government.

Most general physicians in France are in private practice, although they draw their income from the publicly funded insurance funds. The French government has assumed responsibility for the financial and operational management of health insurance, doing so by setting premium levels relative to income and by setting the prices of goods and services refunded. It generally refunds patients 70% of most health care costs, and 100% in case of costly or long-term ailments. Supplemental coverage may be bought from private insurers, most of them nonprofit, mutual insurers.

Immigration

France has had various waves of immigrants throughout its history. Between 1921 and 1935, for example, an estimated 1.1 million net immigrants settled in France, and an estimated 1.6 million European *pieds-noirs*, French citizens of various origins who lived in French Algeria before independence, returned to France as the country's North African possessions gained independence. During the 1960s, the nation's reconstruction and economic growth led to significant labor-immigration, as employers found workers in villages in Southern Europe and in North Africa. French law facilitated the immigration to mainland France of thousands of ethnic or national French from former colonies of North and West Africa, India, and Indochina.

Since the 1980s, France has continued to be a country of mass immigration. In recent years, immigrants have accounted for one quarter of the country's rebounding population growth. In 2004, a total of 140,033 people immigrated to France. Of them, 90,250 were from Africa and 13,710 from Europe. In 2008, France granted citizenship to 137,000 persons, mostly to people from Morocco, Algeria, and Turkey. According to a 2006 study by the French National Institute for Statistics and Economic Studies, the natural increase is close to 300,000 persons, a level that has not been reached in more than 30 years, while net migration is estimated at 93,600 persons, slightly more than in 2005.

Related Topics

- ► European Union
- ► Health care
- ► Labor migration

Suggested Readings

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For information about French migration history and policy. http://www.migrationinformation.org/index.cfm

For information from the Association for the Study of Modern & Contemporary France. http://www.asmcf.org/

For information from The Society for French Historical Studies. http://fhs.umn.edu/

To view digital copies of historical documents of France: http://pergamentai.mch.mii.lt/DokPranc/indexen.en.htm

FSU

► Russia

FSWs

► Female sex workers

Functional Health

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Functional health is science-based health care that treats illness and promotes wellness with a focus on the unique aspects of each patient. Interventions are tailored uniquely for individuals and are aimed at restoring physiological, psychological, and structural balance. Functional health can be thought of in terms of an optimal quality of life, as well as the absence of disease.

Functional health has been shaped by four core concepts: the biochemical individuality of each patient; the interconnectedness of organ function; a patient-centered approach; and the health and disease continuum.

Dr. Roger Williams is credited with coining the term "biochemical individuality." He discovered anatomical and physiological variations among people and how they related to their individual response to the environment. With efforts such as The Human Genome Project, the field of biochemical individuality has revolutionized how medicine views genes and their function. The genetic structure is no longer seen as "rigid" as previously considered. In terms of achieving functional health, due to differences at the biochemical level, what is an appropriate and effective treatment for one patient may not be for another.

A core aspect of functional health is the recognition of the interconnectedness of organ function. Chronic illnesses, for example, often comprise multiple organ systems and are only resolved as a complex system. Working on digestion, for example, without working on detoxification or immunity may be ineffective.

A patient-centered approach involves treating the patient as an individual with a specific history, genetic makeup, hormones, and lifestyle. Furthermore, there is collaboration between the provider and patient. Patient questions are encouraged, and the patient takes an active role in his or her care.

The view that health and disease is a continuum is the recognition that health is a relative state with illness. Disease and death are at one end of the continuum, and health and vitality are at the other. By understanding that most systems operate somewhere between dysfunctional and optimal levels, health is judged as interconnected.

Functional Health Literacy

Functional health literacy refers to individual level skills that move beyond readability and empower an individual to obtain, process, and use health information and services to make decisions and take actions. Functional health literacy includes skills necessary in the navigation of the complex health care system, includes prose, document, and quantitative literacy, and the ability to engage in the exchange of oral communication. The relationship between literacy and health is complex, impacting health knowledge, health status, quality of care, and access to health services.

Physical Activity Guidelines

The US Department of Health and Human Services reports that functional health affects all ages, sexes, and socioeconomic subgroups. Of particular focus is the functional health of older adults – since impairment disproportionately affects this age group. Additionally, it is difficult to define for older adults what is good functional health, because frequently there is an incongruity between what older adults think they can achieve physically and what they actually can achieve. Regarding other age groups, functional health may be an issue at earlier ages because of the overall absolute lack of physical fitness.

Related Topics

► Administration on aging
► Health education
► Health literacy

- ► Health outcomes
- ► Health status
- ► Leisure-time physical activity
- ► Quality of life

Suggested Resources

For information from the U.S. Department of Health and Human Services. http://www.hhs.gov/

For information on Physical Activity Guidelines. http://www.health.gov/paguidelines/meetings/200706/functional.aspx

U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, Literacy and Health Outcomes. http://www.ahrq.gov/clinic/epcsums/litsum.htm

U.S. Department of Health and Human Services, Physical Activity Guidelines for Americans, June 28 – 29, 2007 Advisory Committee Meeting Minutes. http://www.health.gov/paguidelines/meetings/200706/functional.aspx

G

Gambling

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The last several decades have been marked by the increased availability and accessibility of legalized gambling. The biggest contributor to the increase – the "democratization" of gambling – was the lottery, which has been a successful funding source in many states. Because they require little skill to play, involve a relatively small monetary risk, and offer wider accessibility, lotteries are played by people from every socioeconomic level and every age group. Casinos have also attracted more people to gambling – especially older adults after their retirement – for its purported entertainment value and resort-like environment. More recently, Internet-based gambling has seen rapid growth among younger generations of gamblers. As the availability and accessibility of gambling has increased, the 12-month prevalence rate of gambling behavior in the United States has increased from 61% in 1974 to 82% in 2001. The growth of gambling has been accompanied by a growing number of gambling problems. Current research indicates that nearly 1 in every 20 people in the United States is considered to have a problem or pathological gambling issue.

Immigrants may be most vulnerable to developing gambling-related problems for several reasons. Because of the seemingly large and quick rewards for relatively little effort, gambling is more prevalent among disadvantaged populations, i.e., minorities and people with lower socioeconomic status. With fewer financial resources and the expectation of better living, immigrants may be at a higher risk of gambling than the established population. In addition, cultural attitudes may increase the propensity for gambling and, consequently, a higher incidence of problem gambling. For example, the Chinese culture accepts and encourages gambling among friends and family for entertainment or cultural holidays. *Mah-jong*, a popular Chinese game, is frequently played at family parties or celebratory occasions and children learn to play *Mah-jong* from family members. Because of the cultural attitude toward gambling, they may not consider such social activities gambling. Finally, acculturation may contribute to increased levels of gambling for two reasons. First, immigrants who successfully adapt to the host culture act more like the established residents in the new environment with more gambling activities. On the other hand, as immigrants experience the adverse effects of acculturation, they may engage in gambling as a negative coping strategy, responding to emotional and psychological difficulties. The availability and accessibility of gambling is critical to the growth of gambling among immigrants. Sociocultural environments play such a critical role in immigrants' adaptation in which even members of the same ethnic group could exhibit different patterns of addictive behaviors depending on where they migrate.

Given the limited amount of research on gambling among immigrants, the most critical issue is lack of empirical knowledge. Although many immigrant cultures may have permissive attitudes toward gambling, they also stigmatize problem gambling (i.e., excessive gambling). This paradoxical attitude calls for additional research on the gambling issue. The stigma of problem gambling, along with the cultural definition of gambling as entertainment, may be reflected in the low rate of reported gambling and work as a barrier to treatment for people in need of help.

Related Topics

- ► Acculturation
- ► Acculturative stress
- ► Addiction and substance abuse
- ► Cultural background

Sana Loue & Martha Sajatovic (eds.), *Encyclopedia of Immigrant Health*, DOI 10.1007/978-1-4419-5659-0,

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Gambling Disorder

► Disordered gambling

Gangs

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Gang organizations have existed for more than 150 years in the USA. As an example, gangs of Irish and Italian immigrants proliferated in cities on the east coast of the USA during the nineteenth century. Five critical periods have affected the social and organizational development of gangs: the Great Wave of Immigration, the Expansion of Industrial Production (1940s through 1960s), the Deregulation of the Illicit Drug Market (1970s and 1980s), the Escalation of Mass Incarceration (1980s to present), and the Proliferation of Monopolistic Market Activity. Two factors are common to all five periods: poverty or a limited family income and worsened opportunities for socioeconomic mobility. These factors rendered gangs increasingly attractive.

In 2002, the National Youth Gang Survey estimated that there were 21,500 gangs in the USA, comprising approximately 731,500 gang members. Eighty-five percent of these members were believed to reside in large cities. According to the 1999 National Youth Gang Survey, almost one-half of all gang members were Hispanic/Latino, approximately one-third were African American, 13% were non-Hispanic White, 7% were Asian, and 3% were categorized as "other."

There are various forms of collective behavior that may occur; the absence of a standard definition for "gang" makes it difficult to distinguish between these activities. Bands can have a leader but lack a group organizational structure, or they can be a collective of individuals who act without a leader to oppose or attack something ("ganging"). A "crew" consists of three to five individuals who are organized specifically to commit theft. "Posse" refers to Jamaican groups that are organized for the sale of illegal drugs. The term "syndicate" refers to a group that is organized to engage in a wide range of legal and illegal businesses. In lower class communities impacted by poverty, racism, disenfranchisement, and low levels of social control, these forms of collective behavior are often characterized by territoriality, illegality, and self-definition.

Gangs can be thought of as being of first, second, or third generation. First generation gangs are generally localized to their own "turf" or territory and have a loose leadership structure. Their activities tend to be opportunistic. Second generation gangs are organized along the lines of a business with a central leadership and broader reach. They have a market orientation instead of a turf orientation, with much of their activity centered on drug trade. Third generation gangs are highly sophisticated and operate in a global environment, seeking increasing power and financial acquisition.

A gang is considered to be transnational if it has one or more of the following characteristics: (1) the gang is criminally active and operates in more than one country; (2) the criminal activities committed by gang members in one country are planned, directed, and controlled by gang leaders in another country; (3) the gangs are mobile and able to adapt to new areas; and (4) the criminal activities are sophisticated and transcend borders. However, because there is no standard definition for a transnational gang, the lines between transnational gangs and organized criminal enterprises are unclear. Transnational gangs are known to exist in the USA and other countries and have included Asians, Russians, Africans, Serbians, Bosnians, and Jamaicans, as well as individuals of other ethnicities and nationalities.

Two predominantly Latino gangs, Mara Salvatrucha (MS-13) and the Calle 18 (18th Street Gang or MS-18), have spread from the Los Angeles, California, area to other areas across the USA and elsewhere, becoming, in effect, transnational. MS-13's members include former Salvadoran guerillas and government soldiers with extensive combat experience; the gang has become notorious for its use of violence and brutality. MS-18, originally formed by Mexican migrants who were excluded from other Latino gangs in Los Angeles, became one of the first multiracial, multiethnic gangs in Los Angeles. MS-18 members in the USA now distribute drugs for Mexican and Colombian drug traffickers. MS-13 and MS-18 gang members may be involved in smuggling operations and could potentially use their skills and resources to smuggle terrorists into the USA; however, there is no indication that this has yet occurred. Because Central American immigrants live in some of the toughest areas of Los Angeles, they are frequent targets for existing gangs and gang recruitment.

MS-13 is now active in 33 states in the USA and various Central American countries. Most of its members are originally from El Salvador, Honduras, and Guatemala but have lived most of their lives in the USA. In some Central American countries, MS-13 has achieved the status of a third generation gang. The deportation of gang members to their countries of origin has facilitated the establishment of these gangs in Central America and the transport of new and longer-term gang members to the USA through illegal channels. The incarceration and deportation of the gang members from the USA has not been a successful law enforcement strategy but has resulted, instead, in the export of violent individuals to vulnerable Central American communities and the establishment, reinforcement, and expansion of these gangs throughout the USA and Central America.

Related Topics

- ► Illegal immigration
- ► Immigration status
- ► Irregular immigration
- ► Poverty
- ► Violence

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Gatekeeper

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The term gatekeeper has been customarily used to refer to the role of primary health specialists (usually a general practitioner or family doctor) that serve as main points of entry into the health system. The positive nuances of this term call attention to physicians' role in providing first-hand responses to their patients' needs. In this model, the doctor gatekeeper resembles the traditional family doctor who works holistically with patients and families within their communities at large.

Gatekeepers serving at community health centers, such as those treating minorities and immigrant populations, can play a pivotal role in health promotion and disease prevention particularly among disadvantaged communities. On the basis of knowing immigrants' needs well, they are in an optimal position to respond to their most pressing medical issues while coordinating needed referrals in an efficacious way – thus saving key resources, mostly money and time. Culturally versed gatekeepers also play important roles as "health brokers," particularly by understanding their immigrant patients' cultural beliefs (including being fluent in other languages), so they may be in a unique place to help them navigate the health system. Recent research has shown the "brokering" role that foreign doctors play in facilitating access and utilization of health care services to members of their same ethnic aggregate or national group.

Gatekeepers are often familiar with, and sensitive to, immigrants' explanatory models of disease; therefore, they may be able to help build bridges between traditional health systems and biomedicine. In addition, given their expertise with foreign patients' cultural and social milieus, gatekeepers may gain their trust and respect, aspects that are key when seeking adherence regarding time-sensitive health issues, such as scheduling children's vaccination and drug therapies for infectious diseases (i.e., tuberculosis and HIV) particularly among vulnerable populations, such as unauthorized immigrants.

Lately, the term gatekeeper has been utilized to designate the functions of primary care physicians in most managed care plans, which are mostly aimed at rationing and limiting the use of health care services. Gatekeepers within managed health care plans may be practitioners of general internal medicine, family medicine, pediatrics or obstetrics–gynecology, who are chosen by their patients from a fixed list of physicians. Whichever doctors play the role as gatekeepers, they are selected according to the needs of a relatively healthy "commercial" (i.e., non-Medicare) population of plan members. Within the managed care system in the USA, not only are gatekeepers the first providers with whom eligible immigrant patients get in contact with, but they are also the ones in charge of prescribing most medical procedures. Therefore, gatekeepers are key in managing the total cost of health care by limiting immigrants' access to specialized treatments. In recent years, the managed care system has spurred controversy regarding gatekeepers' role in severely curving the access and use of health services, including restricting admissions into hospitals and lengths of stay. Compared to other developed countries, US doctors are most likely to report their patients' difficulties in affording the rising costs of health care amid the increasing barriers they face in obtaining needed health services.

Critics argue that while doctors' gatekeeping role in the USA has led to lowering both health standards and the overall quality of health care, it has not been successful in controlling rising medical costs. For some authors, the very foundations on which health maintenance organizations' decisions are made are culturally biased, as they represent a population of largely middle-White healthy males that does not reflect the rich ethnic and immigrant diversity in the USA. In addition, although most health maintenance plans are required to have a formal grievance system in place, many patients (particular immigrants and ethnic minorities) are unfamiliar with these regulations. They often have limited knowledge about the required administrative procedures to follow which, together with their limited language skills, may severely restrict their ability to successfully advocate for their health rights. Without policy safeguards, the current physicians' gatekeeping role of most health maintenance organizations could actually contribute to worsen health care disparities, particularly in detriment to vulnerable immigrant populations.

Changes in the role of doctors are seen in other recipient societies as well, including those who still enjoy the benefits of universal health care and national health insurance plans. For instance, despite the fact that all nations within the European Union have ratified the human right to health care, rising national deficits and policy concerns about growing immigration streams have led to tightening the gatekeeping role of primary health doctors in those countries. Doctors' new roles tend to limit the access to specialized care available to documented immigrants and to discourage the use of primary health care services among unauthorized individuals. In England, for instance, efforts to reduce costs have led to proposals aimed at ending the figure of the family doctor as the main first point of contact for patients within the National Health Service. Nurses will be playing that role now, thus creating an additional barrier between immigrant patients and their doctors.

Related Topics

- ► Access to care
- ► Foreign medical graduates
- ► Health disparities
- ► Managed care
- ► Vulnerable populations

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Gender

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The term "gender" has been used in social sciences for decades, yet it has entered only recently in general usage. The terms "gender" and "sex" are sometimes incorrectly used interchangeably but they have distinct meanings. While "sex" refers to the biological and physiological characteristics that define men and women, "gender" refers to the socially constructed roles, behaviors, activities, and attributes that a particular society considers appropriate for men and women.

Other definitions emphasize that "sex" refers to being male or female according to reproductive organs and functions assigned by chromosomal complement, and "gender" refers to socially defined and derived expectations and roles rooted in biology and shaped by environment and experience. In other words, while aspects of sex are more or less the same between different human societies, aspects of gender often vary greatly. People are born female or male and then learn to be girls and boys and later, to be women and men. It is the learned behavior that makes up gender identity and determines gender roles.

According to World Health Organization definition, the different roles of men and women are prescribed by society. Men and women have different opportunities; often women have fewer opportunities and limited access to resources that may be available for men. In most societies, women have less power to make decisions, exercise their human rights, including those related to protecting health and seeking care in cases of ill health. But men and women as such are not a homogenous group, as what it means to be a man or a woman varies across cultures, races, and classes. Gender differences vary in intensity, as a result of the interplay of these factors.

Yet, what is common throughout all cultures is the historically configured relationship of subordination of women to men. This imbalance of power has a pervasive influence in many aspects of women's and men's lives, rendering them differentially vulnerable.

As men and women assume different roles and responsibilities, this sexual division of labor involves differential health risks. The female immigrants' experiences and needs are qualitatively different from those of men; this in turn has a different effect on their health.

It is important to take into account gender differences in the migratory process. Gender roles have a direct effect on who migrates, why and where, and how the decision is made and have an impact on the migrants themselves and on their health. Existing research demonstrates that migration may offer new opportunities for women to improve their lives and escape oppression, but sometimes it exposes women to new forms of vulnerability and oppression, exclusion or isolation as it entrenches traditional roles.

There is a need for further studies about the health and well-being of migrant populations, which include a gender perspective. There are many unanswered questions about the way in which gender interacts with other social health determinants and affects the health of migrant populations.

Related Topics

- ► Gender role
- ► Gender-based violence
- ► Intimate partner violence

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Gender Role

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As gender dynamics and the model for the traditional family have changed, immigrant concepts of gender roles and the traditional family have also changed. Historically, in the United States, new immigrant families tended to look like the television American families of the 1940s and 1950s, a time before women had careers, biracial marriages were considered normal, and children were purposefully born outside marriage. Today new immigrant families are experiencing a paradigm shift based on trends that American society has seen generally. So, where women are succeeding in the workplace and have a greater chance at upward mobility, this trend extends to immigrant women, and is important to immigrant health for several reasons.

First, where immigrant women have a greater chance of success than their husbands, husbands face an increased risk of depression and feelings of inferiority. Some immigrant women may be uncomfortable with the role due to an ingrained belief and greater satisfaction in being good wives and tending to family concerns. It is worthwhile to note that not all immigrants arrive to their host nation uneducated and underfunded. Malaysian women, for example, hold 50–60% of their nation's technology jobs such that if and when they immigrate, they typically are relocating to advance already strong careers.

But, in the alternative case of Malaysian women immigrating for other reasons, women accustomed to being the family's breadwinner may face misery if forced to quit work or unable to find a job. These feelings may parallel the feelings Latino men (in the machismo model) endure when struggling to find work in their host countries. This phenomenon suggests that it may not be necessary, at least initially, for immigrants to acculturate or incorporate the host culture's gender dynamics into their own cultural repertoire. Consequently, what is important to one's well-being, at least initially, is the opportunity to adhere to the individual's known and core set of beliefs regarding gender identity and conformity whether or not those beliefs are consistent with what Western society accords as progressive and in line with cultural mores. As time goes on, however, the need to acculturate and subscribe to the host culture's notion of gender roles increases (the acculturation hypothesis). According to the acculturation hypothesis, individuals, particularly women, who do not successfully incorporate new gender ideals into their ideology risk higher rates of mental illness.

Instead, women who immigrate with their partners do best by initially preserving their gender perspectives and ideas of proper gender roles. Unfortunately, little research has been devoted to the ways in which women who remain in their country of origin cope when their husbands emigrate. When husbands emigrate in hopes of finding a job that pays wages sufficient to send to their families back home, women necessarily expand their household roles, and subsequently, their gender roles. As a result of new gender roles and responsibilities, many women experience increased anxiety and depression. Preliminary evidence suggests that women who marry and conform to traditional female roles more readily oppose alternative egalitarian ideologies of gender.

The androgynous model coincides with the prevailing belief that gender roles are not intrinsic or biologic forces, but rather forces affected by environmental factors. Environmental factors that influence changing gender roles include gains in education, religion, the workplace, and historically masculine activities. The androgynous model also espouses the notion that how well a woman who remains behind adapts to environmental changes bears directly on her partner's success abroad. Regrettably, where successful adaptation aids a man's well-being abroad, statistically, successful adaptation adversely affects the woman's psychological well-being. It appears that the women who weather their partner's absence best, tend to do so by relying on the culture's traditional gender roles. This suggests that when women immigrate, it is best, at least for a time, to maintain one's core notions of gender. This is not, however, to say that gender ideals are stagnant. Attitudes on gender roles vary with time and between generations.

It is possible that the longer one is in a country (once she or he begins to acculturate by choice), or the longer one is in a situation involving increased obligations, the nervousness associated with stepping out of one's traditional role reasonably dissipates. But, changing ideology is a difficult process that takes much time and introspection; gender roles – perhaps some of the most ingrained roles in society – will not go lightly. It is worthwhile, particularly given today's constraints of dispersed and temporarily dispersed families, to determine whether education on gender roles where gender is introduced as a topic which is broad and androgynous, opposed to hyper-feminine or hyper-masculine, would help alleviate some of the initial tensions individuals face during the process of immigrating.

Based on the idea that gender roles and attitudes are difficult to alter, it seems that the best approach for low-income immigrants is to facilitate a gradual adjustment. While this may not be the most economically successful scenario in today's world, a world opening to women more quickly than to men, and while this scenario may not be feasible in terms of practicality in moving entire families, it is likely the easiest way to preserve the typical family model and permit immigrant families to adjust slowly to new gender roles.

It is also important to recognize that females and males, beyond gender conformity issues, are faced with very different problem sets when they immigrate. Researchers should encourage health care intervention efforts that consider not only a cultural perspective, but also consider a gendered perspective and analyze results accordingly. A case study of Carribean immigrants best illustrates this point. Research has found that female Caribbean immigrants tend to identify personal problems and an inability to adjust as their most significant stressors. When these problems are significant, female Caribbean immigrants tend to experience higher levels of negative physical health and depression. Male Caribbean immigrants, on the other hand, report loneliness. While an inability to adjust and loneliness are arguably related issues, male Caribbeans fair better with increased social networking. Female Caribbeans responded well to community and ethnic-related social events, and benefit from counseling and health and benefit from education.

Related Topics

- ► Acculturation
- ► Gender
- ► Occupational integration

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Gender-Based Violence

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Gender-based violence (GBV) is a term which encompasses a harmful act against someone's will, which occurs based on gender or sex. It can occur within the family or within the community. Most acts are not perpetrated by strangers, but rather by the very people upon whom the victims depend. GBV violates universal human rights in addition to usually being unlawful. Typically a female victim is more vulnerable to violence and has a lower status in society. Often the term is used interchangeably with Violence Against Women; however, men may also be victims of sexual violence based on gender – for example, when they are detained.

GBV can occur at any time in life. Cross-culturally different types of GBV occur. GBV includes not only domestic violence but also a range of offenses including sexual violence, trafficking, forced prostitution, rape by armed combatants in wartime, sexual slavery, harmful traditional practices (forced marriages, sex-selective abortions, honor killings, genital mutilation, and denial of education), sexual harassment, and confinement.

Research shows that certain groups are more vulnerable to GBV victimization than others. Those who are more dependent on others and who lack power in a society are more at risk. These groups include: single women (who may be heads of household), orphans and unaccompanied children, working children, child soldiers, the disabled, and the elderly. Refugees, internally displaced persons, and those in war-torn nations are at elevated risk as well.

Often victims do not report the crime because of fear of reprisal, self-blame, and stigma. GBV may ultimately end in homicide or suicide. Physical injuries, pregnancy, and sexually transmitted disease may also occur. Psychological consequences include post-traumatic stress disorder, depression, or anxiety.

The UN estimates that across the world, one-third of women have been victimized by a beating, forced sex, or other abuse. Further, statistics indicate that approximately two million women are trafficked each year, 90 million African women have experienced genital mutilation, more than 20,000 women were raped during the Bosnian war, and over 250,000 women were raped in the Rwandan genocide.

Prevention of GBV entails changing sociocultural norms which tacitly support GBV, rebuilding family connections and support systems, and empowering women and girls of all ages. A recent study found that immigrant status and its social context may have some protection against dating violence, a type of GBV.

Another recent study discussed targeting not only the micro level for prevention, but also the meso level (social organizations) and the macro level (beliefs about corporal punishment common in the immigrant group, for example).

Before any treatment of victims can proceed, it is important that members of the group be aware of the problem, and how and where to report GBV. Actions suggested by the UN include community awareness activities, training about response (including medical, psychological, and psychosocial needs as well as the justice system response), planning of reporting/monitoring/evaluation, empowerment of the immigrant community's response, and a plan to work with the abusers.

In treatment, ensuring confidentiality and physical safety are paramount. Maintaining compassionate non-judgment and respectfulness is important. Documentation of GBV is vital for the purposes of later proof. Support groups may be very helpful for immigrant women involved in GBV situations. Women may be provided a safe place to talk, taught about management of situations, and are encouraged to become less dependent on their abusers, moving toward self-sufficiency. Developing a common understanding of GBV and their situation is critical.

Related Topics

- ► Child abuse
- ► Domestic violence
- ► Homicide
- ► Honor killing
- ► Intimate partner violence

Suggested Resources

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Genocide

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The term genocide was coined in 1944 by the Polish Lawyer Raphael Lemkin and is defined as the deliberate and systematic destruction of a racial, political, or cultural group. In 1944, the General Assembly of the United Nations adopted the Convention on the Prevention and Punishment of the Crime of Genocide (CPPCG), which was eventually ratified by 140 nations, including the United States in 1986. The CPPCG characterizes genocide as follows: Genocide means any of the following acts committed with intent to destroy, in whole or in part, a national, ethnical, racial, or religious group, such as killing members of the group, causing serious bodily or mental harm to members of the group, deliberately inflicting on the group conditions of life calculated to bring about its physical destruction in whole or in part, imposing measures intended to prevent births within the group, or forcibly transferring children of the group to another group.

Genocide is not a "new world" novelty. In fact, there is archeological evidence suggesting that genocide might have taken place as early as the Stone Age. However, the twentieth century has been described as being "a century of genocides" with the worst massacres taking place, the most significant being the Holocaust. Other notable and more recent genocides took place in China (1959, 65,000 victims), Indonesia (1965–1966; 0.5–1 million victims), Guatemala (1978–1986; 60,000–2,00,000 victims), Uganda (1972–1979 and 1980–1986; up to a million victims), Burma, now known as Myanmar, (1978; 5,000 victims), Bosnia (1992–1995; 2,25,000 victims), Burundi (1993–1994; 50,000 victims), and Rwanda (1994; 0.5–1 million victims).

When discussing genocide and its effect on the world especially through immigration, it is important to understand the effects that genocide has on a population as a whole, as well as understanding the reasoning behind the acts being committed.

The genocide of a population stems from numerous issues. Looking back in time at one of the most infamous genocides of a population, the Holocaust, which occurred before and during World War II, the root issue is seen as Hitler's attempt to create the "perfect" Aryan race of people, referred to as eugenics. During this time Hitler also targeted those of Jewish heritage and attempted to use them as a scapegoat to explain Germany's economic woes.

One of the major genocides of the twentieth century happened in Rwanda, where up to one million people are believed to have perished. The strife was mainly between two groups of people, the Hutus and the Tutsis. In 1998, the International Criminal Tribunal for Rwanda made the landmark decision that war rape in Rwanda was an element of the crime of genocide. The Trial Chamber held that "sexual assault formed an integral part of the process of destroying the Tutsi ethnic group and that the rape was systematic and had been perpetrated against Tutsi women only, manifesting the specific intent required for those acts to constitute genocide." There was evidence to suggest that military leaders encouraged or even ordered their men to rape Tutsi women as well as condoned the acts taking place. The sexual violence in Rwanda stands out in terms of the organized nature of the propaganda that contributed significantly to fueling sexual violence against Tutsi women, the very public nature of the rapes, and the level of brutality toward the women. Therefore it is important not to underestimate the psychological trauma cause by sexual violence toward women from areas of genocides since the sexual violence impacts them in many ways, not only physically, but also psychologically to a much deeper level since the goal was to eradicate the Tutsi race.

In countries and regions experiencing the genocide of a people, individuals may be forced to migrate from their native land. These forced migrants, or refugees, are leaving their homelands usually against their will. In many cases, these individuals are unable to return due to persecution. Immigrants from the areas plagued by genocide have multiple health problems, ranging from the most common ones to illnesses specifically occurring in their country of origin. Moreover, psychiatric issues are more predominant in immigrants who come from those areas.

There are numerous barriers to accessing proper healthcare. First and foremost, immigrant healthcare is affected by the socio-political status of the countries of origin, and very often this is unstable, especially politically. Moreover, those people have taken refuge in camps in neighboring countries, resulting sometimes in massive exoduses. Morbidity and mortality rates in refugee camps tend to be extremely high. It is also important to remember that those "transients" have limited access to food and water let alone proper healthcare. They rarely have the basic concept of prompt medical visits as well as the importance of follow up appointments. Language and communication skills are also important barriers. When proper translation and paraphrasing are not available, this can cause a sense of alienation to this already very vulnerable population.

There are many different medical diseases and conditions that the immigrant populations from areas where genocides have taken place are predisposed to. The Immigration and Naturalization Service (INS) recommends screening for tuberculosis, HIV, syphilis, as well as other sexually transmitted diseases, hepatitis B, and parasitic infections, especially if refugees have lived in refugee camps for a significant amount of time. It is important to consider: (1) nutritional status, including growth and development, especially in children; (2) mental health, including screening for anxiety, depression, posttraumatic stress disorder, physical abuse, and substance abuse; (3) infectious diseases, including screening for diseases common to the refugee's country of origin, and (4) preventive screening, including cancer screening often not available in Third World countries (e.g., Papanicolaou [Pap] smears for the detection of cervical cancer). For example, a recent immigrant presenting with fever may have hepatitis, typhus, Q fever, encephalitis, dengue fever, typhoid, viral hemorrhagic fevers, helminthes (worms), malaria, or other infectious diseases that are endemic to the countries where they come from. Diarrhea may be caused by viral infections, Shigella (intestinal bacteria), amebiasis (parasites), cholera, or other unusual causes.

Physical examination frequently reveals dental problems. Common problems in children include anemia, asthma, hypertension, inherited diseases, and orthopedic problems. Refugees may have physical signs related to traditional health practices, such as coining (rubbing of coins over the skin) or cupping (application of heated cups to the skin) that can be mistaken for signs of abuse. Physical signs of trauma and torture, including scars from beatings, whippings, burns, and electric shocks, as well as lacerations may be present. Presentations of unusual diseases are common, including congestive heart failure from cardiomyopathy (enlarged and malfunctioning heart) in Chagas' disease (parasitic infection). A physical deformity or radiograph may reveal old fractures, including those resulting from falanga (beating of the soles of the feet). Female genital mutilation (formerly referred to as female circumcision) is practiced in some societies but can also be a result of sexual violence such as in female survivors of the Rwandan genocide.

This particular patient population has often been through numerous atrocities prior to immigration and thus the impact on mental health is very significant. Women, children, the elderly, and disabled are the most vulnerable. Very often, these patients come from areas of the world where torture and other forms of sexual, physical, and emotional abuse are still prevalent. Some of them have been victims of torture while others have witnessed the torture of loved ones. The World Health Organization (WHO) estimated that, in the situations of armed conflicts throughout the world, "10% of the people who experience traumatic events will have serious mental health problems and another 10% will develop behavior that will hinder their ability to function effectively. The most common conditions are depression, anxiety and psychosomatic (psychologically induced physical complaints) problems such as insomnia or back and stomach aches." In the instance of mental health, forced migration of a population due to genocide can cause many different challenges for a person to face.

In this entry, we will address the most important mental health issues that immigrants from countries plagued by genocides have to face. We will discuss the following:

1. Posttraumatic stress disorder (PTSD)
2. Depression and anxiety
3. Bereavement
4. Cultural assimilation and developmental effects

PTSD is an anxiety disorder that develops after a person sees or is involved in an extreme traumatic event. The person reacts to this experience with fear and helplessness, persistently relives the event, and tries to avoid being reminded of it. Immigrants from countries where genocides have taken place are at high risk of developing PTSD since these people may have experienced and been subject to torture, rapes, mass murders, massive displacements among the many atrocities. Survivors suffer from confusion, anxiety, depression, flashbacks, difficulty concentrating, sleep disturbances, anti-social behavior and acting out.

The physical and mental health problems of the survivors of the genocide in Rwanda have been well documented. In a community based study examining 2,091 subjects, 25% met symptom criteria for PTSD. Respondents who met PTSD criteria were less likely to have positive attitudes towards the Rwandan national trials, suggesting that the effects of trauma need to be considered if reconciliation has to be successful. In another study conducted in two communes close to Kigali, the capital of Rwanda, subjects were asked to freely list problems that occurred after the genocide in 1994. They were also asked to sort pile the problems that occur together as "syndromes." The results suggest that this population experiences depression, referred to as *agahinda* or deep sadness or grief, as a result of the events. They may also experience PTSD which is referred to as *guhahamuka*, or mental trauma. Local people do not classify the effects of trauma into the same depression and PTSD syndromes as in the US. However, these disorders are often comorbid, making distinction between the two syndromes difficult.

Another significant place where genocide happened was in the Balkans. A survey among Kosovar Albanians found that 17% reported symptoms of PTSD. There was a significant decrease in mental health status and social functioning with increasing amount of traumatic events in the elderly and those with psychiatric illnesses or chronic health conditions. In another study conducted on Bosnian survivors of genocide, they were reported of having been severely traumatized as a result of the Serbian nationalists' genocide. Results indicated that individuals were exposed to an average of 16 types of traumatic experiences; 42% met criteria for PTSD.

Depression and anxiety are also very common among immigrants who come from areas where genocides have taken place. Being victims or witnesses of torture, displacement, and losing loved ones may similarly predispose people to anxiety and depression. Depression usually manifests as a low mood most of time, difficulty falling asleep or frequently waking up at night, low energy and poor motivation, hopelessness and helplessness, as well as ruminatory thoughts. In severe cases, depressed patients attempt suicide. Anxiety can manifest as hypervigilance, that is an increased awareness of danger and the surroundings; constant worry about everything in general or as panic attacks which are characterized by the sudden onset of difficulty breathing, nervousness and a sense that something bad is about to happen. In a study that was done in Afghanistan, 39% described symptoms of anxiety. In the study above that was carried out in Kosovo, there were also reports of severe depression.

Immigrants from areas where genocides took place may have interruptions in their ability to adequately cope with the grief and loss they have experienced. Research on traumatic loss, such as someone would face after surviving the genocide of their people, has shown to have stronger, more long lasting effects on an individual which can prolong a survivor's grief symptoms. It has been said that loss through genocide can complicate the grieving process through a variety of ways. For one, according to a research on the Rwanda genocide in 1994, due to the violent nature of the loss in genocide, survivors may be forced to deal with many other stressors brought on by the loss and may be lacking in social support when an individual's whole community is affected. Suffering from PTSD symptoms might also inhibit one's ability to properly grieve for their loved ones. Survivors of genocide might have their grieving process inhibited due to the inability to participate in certain cultural funeral rituals such as viewing the body that promote closure in the loss of a loved one, due to threats or anxiety caused by threats and violence.

In 1995, there were 165,839 widows in Rwanda following the genocide. Research was done on many of these widows to follow their grieving patterns and the widows' ability to properly grieve after the traumatic loss of their husbands. Three years after the loss of their husbands at least 20% of the women who were interviewed by the researchers were considered to be prolonged grievers (or having prolonged symptoms of grief). This complication in the grieving process was attributed to the traumatic nature of the loss these women had faced. The most prominent feeling reported by women who had lost their husbands in the genocide was separation anxiety. Other symptoms reported were mistrust of others, and the feeling that life was meaningless or empty now that their husbands were gone. The study of individuals who have survived genocides such as the one in Rwanda have sparked the debate to include more specific criteria for diagnoses related to grief and loss in mental health.

Genocide carries with it negative psychological effects on a group of people being forced to leave their country. These forced migrants must often discontinue their cultural practices out of fear that those exact practices are what caused the acts of genocide to occur in the first place. Immigrants who have relocated due to these acts may also worry that their cultural practices will not be accepted by those surrounding them in their new land. These fears might create a feeling of forced assimilation into a new culture for those who have been forced to migrate to a new land. Issues such as how a society accepts others from outside can affect an immigrant's ability to continue their rituals and practices that they have held dear up until their forced migration to a new country. Researchers have shown patterns of emotional climates of fear in countries that have experienced genocide or other acts against humanity. This inability to continue with past rituals and cultural practices creates an inability for immigrants escaping genocide to move beyond the experience.

Immigrants from countries where genocides have taken place are vulnerable and at a high risk for the development of certain condition as compared to other immigrants. Most important of all, this patient population deserves a lot of empathy, care, and understanding as they have already been through the worst imaginable atrocities.

Related Topics

- ► Bereavement
- ► Ethnic cleansing
- ► Gender-based violence
- ► Holocaust

- ► Mood disorders
- ► Posttraumatic stress disorder

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Germany

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Introduction

Germany, officially the Federal Republic of Germany, is a country located in the western and central regions of the continent of Europe. The nation covers an area of 357,021 km^2, and is bordered to the north by the North Sea, Denmark, and the Baltic Sea; to the east by Poland and the Czech Republic; to the south by Austria and Switzerland; and to the west by France, Luxembourg, Belgium, and the Netherlands. With 81.8 million inhabitants, Germany is the most populous member state of the European Union (EU). The country is home to the third greatest number of international migrants worldwide; in 2009, immigrants in Germany comprised 12.3% of the country's total population and 5.4% of the world's population.

History

Beginning in the tenth century, German territories formed a central part of the Holy Roman Empire. During the sixteenth century, northern German regions became the center of the Protestant Reformation; however, the southern and western regions remained influenced by Roman Catholicism. The country was first unified in 1871, with the inception of the German Empire. The German Revolution, from November 1918 until August 1919, followed World War I, and at the formal establishment of the Weimar Republic, it resulted in the replacement of Germany's imperial government with a republic government.

Germany's liberal democracy lapsed in the early 1930s, leading to the ascent of the National Socialist German Workers' Party (NSDAP) and Adolf Hitler in 1933; this year is recognized generally as the end of the Weimar Republic and the beginning of Hitler's Third Reich. The period was marked by a dictatorship and the initiation of World War II. At the conclusion of World War II, during 1945–1949, Germany was divided into four occupation zones – with the United States, Great Britain, France, and the Soviet Union each controlling a zone. Subsequently, Germany was divided into two states, the socialist German Democratic Republic (GDR), informally called East Germany; and the Federal Republic of Germany, informally called West Germany. Germany was reunified on October 3, 1990. The Bonn-Berlin Act was adopted by the parliament in March of 1994, identifying Berlin as the capital of the reunified Germany once again. The act enabled Bonn to hold status as a federal city, thereby, retaining some federal ministries. The relocation of the government was completed in 1999.

Since reunification, Germany has taken a more active role in the European Union (EU) and in the North Atlantic Treaty Organization (NATO). For example, Germany sent troops to Afghanistan as part of a NATO effort to provide security in that country after the Taliban were expelled. Notably, this deployment was controversial. After the war, Germany was bound by domestic law only to deploy troops for defense roles. Although deployments to foreign territories were understood not to be covered by the defense provision, a parliamentary vote on the issue effectively legalized the participation in a peacekeeping context.

The first female Chancellor of Germany, Angela Merkel, was elected in 2005. Supported by her own parliamentary group, she led a grand coalition from 2005 to 2009. Following the general elections in September of 2009, Merkel built the current coalition government that replaced the Social Democratic Party with the Free Democratic Party (FDP).

Geography

Germany is located in the western and central regions of the continent of Europe. The nation covers 357,000 km^2, comprised of 349,000 km^2 of land and 8,000 km^2 of water. In terms of area, it is the seventh largest country in Europe and the 63rd largest in the world. Germany shares borders with more European countries than any other country on the continent: Denmark in the north; Poland and the Czech Republic in the east; Austria and Switzerland in the south; France and Luxembourg in the southwest; and Belgium and the Netherlands in the northwest.

The nation's elevation ranges from 2,962 m in the south in the mountains of the Alps, to the shores of the North Sea in the northwest, and to the Baltic Sea in the northeast. Between these extremes lie the uplands of central Germany and the low-lying lands of northern Germany, traversed by some of Europe's major rivers such as the Rhine, Danube, and Elbe. The most significant natural resources are iron ore, coal, potash, timber, lignite, uranium, copper, natural gas, salt, nickel, arable land, and water.

Climate

Most of Germany has a temperate seasonal climate, with a relatively moderate temperature variation between summer and winter, though temperatures can exceed 30°C for prolonged periods. The climate is moderated by the North Atlantic Drift, the northern extension of the Gulf Stream. This warmer water affects the areas bordering the North Sea, including the area along the Rhine, as it is a contributory to North Sea. Consequently, in the northwest and the north, the climate is oceanic, typified by cool summers, warm winters, and a narrow annual temperature range. As precipitation is dispersed more evenly through the year, ordinarily, it lacks a dry season. Rainfall occurs year round, peaking during the summer. In the east, the climate is more continental; winters can be harsh and cold, while summers can be very warm, with a long dry period. Central and Southern Germany are transition regions that vary from moderately oceanic to continental.

Although the maritime and continental climates prevail over most of the country, the Alpine regions in the extreme south and, to a lesser degree, areas of the Central German Uplands have a so-called mountain climate. This climate is characterized by lower temperatures because of higher altitudes and greater precipitation caused by air becoming moisture laden as it lifts over higher terrain.

Biodiversity

Germany is known for its many zoological gardens, wildlife parks, aquaria, and bird parks. More than 400 registered zoos and animal parks operate in Germany; it is believed to be the largest number in any single country of the world. The Zoologischer Garten Berlin is the oldest zoo in Germany and presents the most comprehensive collection of species in the world.

Culture

Germany is referred to by many as *the land of poets and thinkers*; German culture has a rich and lengthy history, with significant contributions to world literature, philosophy, science, technology, art, music, cinema, religious tradition, and more. German cultural contributions have been influenced by European high culture, Western pop culture, and the globally connected subculture.

In Germany, the 16 federated states manage the cultural institutions. There are 240 subsidized theaters, hundreds of symphonic orchestras, thousands of museums, and over 25,000 libraries spread over 16 states. These cultural opportunities are enjoyed by many millions: there are over 91 million German museum visits every year; annually, 20 million go to theaters and operas; while 3.6 million attend performances by symphonic orchestras. The United Nations Educational, Scientific, and Cultural Organization (UNESCO) has inscribed 33 properties in Germany on the World Heritage List.

Government

Germany is a federal, parliamentary, representative democratic republic that is governed under a framework laid out in the 1949 *Grundgesetz* – translated as *Basic Law* – a constitutional-type document. In the articles of the document are expressed the fundamental principles guaranteeing human dignity, the separation of powers, the federal structure, and that the rule of law is valid in perpetuity. Generally, amendments to the *Grundgesetz* require a two-thirds majority of both chambers of the parliament.

The President is the head of state and is invested primarily with representative responsibilities and powers. He or she is elected by the federal convention, an institution consisting of the members of parliament and an equal number of state delegates. The second highest German official is the President of the Parliament, who is elected by the parliament, and is responsible for overseeing the daily sessions of the body. The third highest official and the head of government is the Chancellor, who is appointed by the President of the Parliament, and who exercises executive power, similar to the role of a Prime Minister in other parliamentary democracies.

Economy

Germany has a social market economy, a mixed economy that seeks to strike a balance between capitalism and the market economic system of socialism, combining private enterprise with government regulation. In 2009, Germany had the largest national economy in Europe and the fourth largest worldwide by nominal GDP. Contributions to the economy by sector are service (70%), industry (29.1%), and agriculture (0.9%). In July 2010, the average national unemployment rate was 7.5%, ranging from 4.1% in Bavaria to 13.6% in Berlin. Germany was the world's largest exporter from 2003 to 2008. Most of the country's export products are in engineering, especially in machinery, automobiles, chemical goods, and metals. Germany is the leading producer of wind turbines and solar power technology in the world.

Notably, more than 2 decades after German reunification, standards of living and per capita incomes remain significantly higher in the states of the former West Germany as compared to states of the former East Germany. The modernization and integration of the eastern German economy is scheduled to last until the year 2019, with annual transfers from west to east amounting to roughly $80 billion.

Demographics

Germany is the most populous country in the European Union; in terms of population, it ranks as the 15th largest country in the world. In January 2010, the nation had an estimated 81.8 million inhabitants and a population density of 229.4 inhabitants per square kilometer. Germany has one of the lowest fertility rates in the world, at 1.4 children per mother, or 7.9 births per 1,000 inhabitants in 2009. Depending on the level of net migration, it is forecast that the population will shrink to between 65 and 70 million by 2060.

Germans comprise 91% of the population of Germany. As of 2004, about seven million foreign citizens were registered in Germany, and 19% of the country's residents were of foreign or partially foreign descent, including persons descending or partially descending from ethnic German repatriates, 96% of whom lived in Western Germany or Berlin. It is estimated by the Federal Statistical Office of Germany that nearly 30% of Germans aged 5 years and younger have at least one parent who was born abroad.

Education

In Germany, the federated states are responsible individually for educational oversight, and the federal government has only a minor role. Kindergarten education is optional and is provided for all children between 3 and 6 years old, after which school attendance is compulsory for a minimum of 9 years. Usually, primary education lasts for 4 years; public schools are not stratified at this stage. Secondary education, however, includes three traditional types of schools: the *Gymnasium* enrolls the most academically gifted children, prepares students for university studies, and attendance lasts 8 or 9 years; the *Realschule* lasts 6 years and has a broader range of emphasis for intermediate students; and the *Hauptschule* prepares students for vocational education. Admission into a school is based on academic ability as determined by teacher recommendations.

Health Care

Germany's health care system has the distinction of being the world's oldest universal health care system, with origins dating back to social legislation in 1883. Currently, the population is covered by a basic health insurance plan provided by statute that provides a standard level of coverage. Private health insurance is available, making available additional benefits. According to the World Health Organization (WHO), Germany's health care system was 77% government funded and 23% privately funded as of 2004. In 2005, Germany spent 10.7% of GDP on health care; ranked 20th in the world in life expectancy with 76.5 years for men and 82.1 years for women; and it had a very low infant mortality rate of 4.3 per 1,000 live births.

Migration

While in the nineteenth and first half of the twentieth century Germany was noted as a country of emigration, since the mid-1950s, the nation has become one of the most important European destinations for migrants. The recruitment of guest workers, the influx of ethnic Germans from Eastern Europe and the former Soviet states, and the reception of asylum-seekers have led to the growth of the immigrant population in the country. On January 1, 2005, Germany adopted a new immigration law that altered the legal method of immigration to Germany, adding new immigration categories to attract professionals for the German labor market. The new law eased immigration for skilled employees and academics; however, for unskilled workers the labor market remains relatively closed.

The United Nations Population Fund lists Germany as host to the third highest number of international migrants worldwide, hosting approximately ten million of all 191 million migrants. Since 2000, as a result of restrictions to Germany's laws on asylum and immigration, the number of immigrants seeking asylum or claiming German ethnicity has been declining steadily. In 2009, 20% of the population had immigrant roots, the highest recorded since 1945. As of 2008, the largest national group of people with a migrant background was from Turkey (2.5 million), followed by Italy (776,000), and Poland (687,000). Large numbers of people with full or significant German ancestry are found in the United States (50 million), Brazil (5 million), and Canada (3 million).

As Germany continues to experience a considerable rate of immigration, the integration of migrants has become a main focus of federal policy – a policy with both economic and social import. Historically, Germany has had an immigration policy by which citizenship was rarely granted, regardless of how long the immigrant had legally resided in the country. Over the past decade, however, there have been several key policy developments. In 2000, for example, a new citizenship law was enacted. For the first time in Germany's history, children born to foreigners automatically receive German citizenship, provided one parent has been a legal resident for at least 8 years. However, if children choose to hold dual citizenship, German and the citizenship of their birth parents' country of origin, they must choose to retain one or the other by the age of 23. In August 2000, Germany introduced a "green card" system to help address that demand for highly qualified information technology experts. However, in contrast with the American green card, which allows for permanent residency, Germany limits its green card holders' residency to a maximum of 5 years.

Although the shift in immigration policy allows some immigrants easier entrance into the country and navigation through the process of citizenship acquisition, frequently still, new immigrants face prejudices and challenges integrating into the native population. Some migrant groups experience higher rates of delinquency and more general integration problems. In spite of police operations and legal measures meant to arrest such behavior, migrants may still be subject to racist assaults. The rate of occurrence is even greater in rural areas or small towns in the former East Germany.

Related Topics

► European Union

Suggested Readings

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For information about Germany from the United Nations. http://www.un.org/en/index.shtml

For information about Germany from the World Health Organization (WHO). http://www.who.int/en/

Ghetto

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When first used in the sixteenth century, the word "ghetto" had a different significance than it has today. Originally, "ghetto" was an area in Venice to which Jews were constrained to live. The Venetian ghetto was meant to diminish the influence of Jews in affairs of the state because this population was often very rich and dominated the commercial activity of Venice. With time, the word came to have a broader significance and to not reflect only areas where Jews live. The ghetto was a form of an ethnic enclave, gathering together people belonging to the same ethnicity. Later it came to mean a population that did not necessarily share the same ethnicity, but belonged to the same social class. Such neighborhoods were the result of social discrimination and racism, as it was impossible for minorities, religious or otherwise, to settle where they chose.

In the nineteenth century such enclaves were formed on ethnic basis as in the USA, due to racial segregation of housing. The mass of migrants in several of the biggest American cities, such as New York, Chicago, and Boston, made it possible for new ethnic enclaves with Italian, Chinese, Spanish, and Jewish populations to rise. This was an effect of the industrialization process which was reinforced by rapid urbanization. In a similar time frame, African American neighborhoods began to form in American cities as a result of the migration of African Americans from the rural South. In order to escape Southern racism, many African Americans moved toward Northern cities seeking employment in the new industrial economy of the north. During the nineteenth century and the beginning of the twentieth century, technological progress led to major changes in demography and urbanization. A new labor force moved from the rural areas to the more developed and industrializing cities. The labor competition was fierce partly because of the large migration of African Americans in a short period of time and partly because of the waves of European immigrants also in search of jobs. As a result, shortages in housing occurred and the new population had no choice but to accept any kind of housing they could afford. Ethnic identity strengthened as they found a common goal in protecting their neighborhoods. The white collar workers moved to suburban residential areas to get away from the pressure created by the new residents and used restrictive covenant clauses to ensure that their neighborhoods would maintain their type of population.

As industrialization created new job opportunities and labor was needed in order to extract natural resources or perform other type of manual labor, more African Americans moved toward the cities. The population of these cities, mostly White, resorted to discriminating actions directed at keeping the newcomers away from their neighborhoods. This practice was called redlining and it denied or made it impossible for African Americans to have access to various facilities such as food stores, health insurance and care, and housing. This contributed to the formation of ethnic districts, preponderantly formed in the USA by African Americans in conditions of segregation, and which came to be called "Ghettos."

Technological and industrial progress brought significant changes in the geography of urban communities, resulting in fragmentation of the urban form. Associated with the economic and social background, this fragmentation translated into the end of a coherent, uniform city and, instead, emerged as an independent city, a melting pot, divided into different social groups. In other words, through time, the formation of ghettos changed in correlation with the economic, social, and political factors. Discrimination and racism in the USA then led to urban decay, which was deepened by the restrictions that the African American population faced. The newly formed ethic enclave was marginalized and denied basic rights.

White flight was a new sociologic and demographic change that put a mark on the evolution of the ghetto. As the minority population was increasing in the cities, the White population was moving to new areas, the suburbs, where it was possible to maintain a restrictive housing policy. Once World War II came to an end, a new wave of African Americans, immigrants from Mexico, and even European immigrants established themselves in large American cities. As a result, social inequalities grew and much of the middle class White population decided to move to more private and quiet areas. This led to a decline in the infrastructure of the cities as the neighborhoods inhabited by African Americans or immigrants were left behind. While the transportation infrastructure to connect the cities with the suburban areas was developing, the city infrastructure was declining, because White flight significantly reduced the city's budget. At the same time, federal guaranteed mortgages were exclusively favoring the White population and minorities were left only one choice, renting. Even though some African Americans could afford to buy a property, they could not move into a suburban White area as the redlining policy was still in place.

Following the White flight and the hurdles in economy, the ghettos suffered severe changes that had an impact on the city as a whole. By mid-1970s urban decay was visible in the poor transportation, the high unemployment, and the many abandoned buildings. Many parts of New York City were offering an unhealthy landscape, with empty lots, a weak infrastructure, and a high unemployment rate. The birth of the suburban areas diverted taxes from the cities and as the infrastructure of highways and railroads needed to connect the suburbs with the city grew, the cities' infrastructure was neglected. The abandoned city areas attracted criminals and soon street gangs formed. Left abandoned and in a precarious socioeconomical state, the ghetto became a place for illegal activities, such as drug trafficking. Facing racial discrimination, the population of the ghetto was vulnerable and was left with no choice other than to live in such areas. Clearly, suburban sprawl combined with the development and growth of industrial capitalism had changed the geography of the city.

The ghetto came to be associated with a confined urban area, marked by invisible borders, where a specific ethnic or racial population, mainly African American, lived and struggled in poverty. Nonetheless, the term ghetto means much more than that and it has to do with a certain style of life and is the starting point for an authentic culture that reflects the social disparities, the racism, the roots, and the soul of the urban African American population. A home not only for the African Americans, but for many immigrants and other minorities, the ghetto is not solely related to violence and poverty. The ghetto is in fact a cultural and ethnic experience, influenced by socioeconomic factors that have influenced the lives of the ghetto population. Harlem is one of the most famous neighborhoods of this kind and was a center for the artistic work of the African American community. The old architecture of the city was preserved in Harlem and the old buildings are now a symbol of the old New York.

Although one of the most emblematic ethnic enclaves, the African American ghetto is not the only type of ghetto. The Brazilians have the so-called favelas, the Spanish have *el barrio*, now also common in the western USA along the border with Mexico, while in Europe, most ghettos were the homes of the Jewish population, confined in certain areas of European cities. Either formed voluntarily, by a population that due to the economic and social conditions settles in a city's neighborhood, or formed involuntarily, when minorities are forced into particular areas, the ghetto's substance has varied with time. The ghetto, a place of segregation, of alienation for minorities, the poor and underdeveloped, which suffers the violence of gangs and illicit businesses, is also the place where the African American culture grew and expressed itself. Many singers and writers came from the ghetto and used this experience in their work, bringing originality and passion in their art.

Related Topics

- ► Blacks
- ► Cultural background
- ► Discrimination
- ► Ethnic enclaves

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Global Health

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Global Health: Definition

Recently, several prominent organizations have called for a common definition for global health. As of yet, however, a consensus has not been reached. As organizations grapple with a definition of global health that captures its essence adequately, common themes have emerged. In general, organizations have defined global health in three different ways: (a) as a state or condition; (b) as a goal; and (c) as a field of study, research, and practice. Global health has been framed by leading organizations as health concerns that transcend national boundaries, have the potential to influence or be influenced by circumstances in other countries, and are best addressed cooperatively. Themes that underpin global health literature include an equal concern for the health of all people worldwide, the recognition of a shared responsibility for improving health status, and achieving equity in access to and quality of care.

Significance of Global Health

The general public of developed countries frequently associates global health with concerns exclusive to developing countries. But recent research underscores that importance of global health to citizens of all countries – from the least to the most developed. Researchers have outlined four broad reasons why citizens of all nations should share in the responsibility of global health. Their rationales are concerned with the following categories: humanitarian, equity, direct impact, and indirect impact.

The three diseases impacting most upon developing nations are AIDS, tuberculosis, and malaria. In 2005, an estimated 2.8 million people died from AIDS, while more than 15 million children have been orphaned as a result of the virus. More than three million people die annually from tuberculosis (TB) or malaria. Advocates for a global health perspective contend that such suffering is needless and that humankind can work together to save millions of adults and children from such pain.

Concerning equity, it is particularly notable that approximately 90% of the world's health care resources are spent on diseases that affect 10% of the global population. Working to solve global health problems will help ensure that financial resources are distributed equitably across all countries.

The interconnectedness of populations continues to increase with globalization. As such, diseases can move as freely as people and products. Infectious diseases can cross national borders easily and pose immediate threats to developed countries. Working to solve global health problems includes addressing diseases that are not usually thought of as threats to developed nations.

Global health matters to all citizens for indirect reasons as well. For example, rising incidences of diseases like HIV/AIDS, malaria, and tuberculosis are increasing poverty, political instability, and strife in many countries. Due to globalization, these outcomes in less developed countries carry the potential for negative political and economic consequences worldwide. Working to address global health problems can help prevent civil strife in other countries, can support economic stability, and may lead to an increased quality of life worldwide.

Global Health Trends

Infectious and Communicable Diseases

The emergence and reemergence of infectious and communicable diseases is a highly concerning trend. An infectious disease is any disease caused by pathogen invasion, including bacterial, viral, fungal, or protozoan infection. Frequently, infectious diseases are contagious, although some are not but can be transmitted from animal to person or from person to person. A communicable disease is carried by microorganisms and can be transmitted through people, animals, surfaces, foods, or air. Of particular concern to global health are those diseases that are becoming drug resistant, examples include malaria, tuberculosis, viruses such as severe acute respiratory syndrome (SARS), avian influenza, and other pandemics.

The World Health Organization reports that human mobility largely is responsible for the reemergence of infectious diseases. In addition to human transport, ecologies are taxed with accommodating a revolving door of new insects, livestock, and food products that carry infectious agents from country to country and from continent to continent. The spread of poliomyelitis from Nigeria between August 2003 and July 2005 is an example of the reintroduction of an infectious disease to an area where interventions had achieved the goal of elimination. Wild poliovirus, genetically linked to endemic poliovirus in northern Nigeria, was reintroduced into polio-free countries in

Africa, the Middle East, and Asia. In many countries, routine polio vaccination programs had been neglected by governments after a polio-free status was reached, and campaigns to deliver vaccines to children had been stopped due to a lack of resources. When wild poliovirus was reintroduced, there was no protective barrier to transmission; as a consequence, polio reemerged in 18 polio-free countries.

Health Inequities

Health inequity is defined as disparities in health resulting from systemic, avoidable, and unjust social and economic policies and practices that create barriers to opportunity. Within and across countries and cultures, there are persistent health inequities in access to health information and in access to care. The inequities manifest in measures such as life expectancy and under-five mortality, among others. For example, the range in average life expectancy worldwide is from 34 years in Sierra Leone to 81.9 years in Japan. Furthermore, in Indonesia the under-five mortality is nearly four times higher in the poorest fifth of the population than in the richest fifth; and in England and Wales the latest data reflect a 7.4 year gap in life expectancy between men in professional occupations and men in manual labor occupations. The World Health Organization has reported that a combination of bad policies, economics, and politics is mostly to blame.

Fragile Health Systems

The fragile health systems in developing countries pose an added threat, as the basic health care needs are greater frequently than the available human resources. In those cases, the capacity of the health system cannot meet the demands of basic health care for the vast majority of the population. Through medical assistance programs, organizations such as Direct Relief seek to equip health professionals who are working in resource-poor communities to better meet the challenges of diagnosing, treating, and caring for people – without regard to politics, religion, gender, race, or ability to pay.

Direct Relief has worked for several years with the Dean of the Medical College in Malawi, who has trained the small team of Malawian doctors running the health system. Currently there are approximately 250 physicians working to care for the health needs of a country of 13 million. The work of this and similar organizations serves to strengthen clinics in poor areas – around the world and in the United States. In so doing, in addition to the individual health needs that are met, a network is created for responding to disasters.

Global Health Initiatives

An emerging trend in health is a focus on partnerships, including those between the public and private sectors, as well as global health initiatives. Global health initiatives typically are programs targeted at specific diseases. Usually, the endeavors channel additional resources to specific health efforts. The major global health initiatives launched between 1998 and 2000 were: (a) Roll Back Malaria, (b) Stop TB, and (c) the Global Alliance for Vaccines and Immunizations.

Roll Back Malaria is a global strategy to reduce deaths from malaria. Specific strategies outlined in the initiative are: increasing access to prompt and effective treatment; increasing protective intermittent therapy for pregnant women; providing prevention tools such as insecticide-treated bed nets; facilitating rapid response to malaria outbreaks; and developing new products for the prevention and treatment of malaria.

The chief goal of Stop TB is to stop around the world the spread of TB. One of its objectives is to promote implementation of the directly observed therapy short-course strategy (DOTS). The DOTS strategy combines diagnosis of TB and registration of each patient, followed by a standardized multi-drug treatment and a secure supply of anti-TB drugs for all patients in treatment. Individual patient outcome evaluation is done to ensure cure, while cohort evaluations are done to monitor the overall performance of the program.

The Global Alliance for Vaccines and Immunization is a global effort to strengthen childhood immunization programs and to bring new vaccines into use in developing countries. The initiative includes vaccines against hepatitis B, childhood meningitis, yellow fever, and respiratory infections – the leading cause of death in children under 5.

The United Nation's Summit on the Millennium Development Goals was held September 20–22, 2010. The Summit concluded with the adoption of a global action plan to achieve eight anti-poverty goals by 2015, as well as new commitments for women's and children's health and other initiatives against poverty, hunger, and disease. The eight Millennium Development Goals are ending poverty and hunger, providing universal education, establishing gender equality, increasing child health, increasing maternal health, combating HIV/AIDS, establishing environmental sustainability, and entering into global partnership.

Related Topics

- ▶ Access to care
- ▶ Border health
- ▶ Disease prevention
- ▶ Health determinants
- ▶ Health disparities
- ▶ Health policy
- ▶ Health status
- ▶ Immunization
- ▶ Infectious diseases

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For information on global health from the Centers for Disease Control and Prevention. http://www.cdc.gov/globalhealth/

For information on global health from the Global Health Council. http://globalhealth.org/

For information on infectious diseases from the Infectious Diseases Society of America (IDSA). http://www.idsociety.org/

For information on the United Nation's millennium development goals. http://www.un.org/millenniumgoals/

Grandparents and Grandchildren

- ▶ Family

Grief and Grieving

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Grief is a complex emotional response to loss. A wide range of feelings can arise from a loss, such as shock, sadness, anger, guilt, anxiety, fear, psychological numbness, disbelief, loneliness, or depression. Grief often involves physical symptoms such as fatigue, lowered immunity, loss of appetite, or sleeplessness. Various types of losses can cause intense grief, including death of a loved one, loss of health, losing a job, a relationship breakup, loss of a friendship, loss of safety after a traumatic event, or immigration. Subtle or less obvious losses can also lead to grief. Some examples include graduation from school, retirement, moving to a new home, or changing jobs.

There are two classic grief theories: stage-oriented grief theory and task-based grief theory. Psychiatrist Elizabeth Kübler-Ross developed a grief model of five stages, based on her research on patients suffering from terminal illness. But later this model has been applied to other types of losses such as death of a loved one. The five stages of grief consist of denial, anger, bargaining, depression, and acceptance. Kübler-Ross and Kessler noted that the five stages are not stops on a linear timeline in grief. Bereaved individuals can engage in several phases simultaneously or skip some stages. However, this stage-oriented grief theory has been criticized because it limits the mourner to a passive role.

Task-based grief theory emphasizes an active role of the mourner – they need to take action and can do something with their grief and grieving. This approach also allows interventions from the outside. William Worden suggested a task-based grief model. Worden's model includes four tasks: to accept the reality of the loss, to work through the pain of grief, to adjust to an environment in which the deceased is missing, and to emotionally relocate the deceased and move on with life. The task-based approach to grief contributes to explicate what tasks grieving individuals need to accomplish to heal.

Grief theories are helpful in framing and identifying the feelings, symptoms, and tasks that individuals with loss may be experiencing. Thus, these theories help people prepare to cope with loss and grief, which are inevitable across the life course. Nonetheless, grief is a personal and highly individual experience. Therefore, grief theories should be used only as a guideline.

The grief process depends on an individual's personality, coping style, life experience, faith, and the nature of the loss. Grieving signifies culturally patterned expectations about the expression of grief. For example, Buddhist worship at shrines of deceased loved ones shows the importance of continuing bonds with the deceased, which are not recognized in most US cultures. Therefore, professionals working with immigrants need to be knowledgeable about the influence of cultures and religions on coping with loss and expression of grief.

Related Topics

- ► Acculturation
- ► Bereavement
- ► End-of-life care
- ► Fatalism
- ► Hospice
- ► Resilience

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Guatemala

- ► Central America
- ► Hispanics
- ► Latinos

Guest Worker

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According to the United Nations Expert Group Meeting on International Migration and Development on June 2005, there are 90 million migrant workers worldwide. Economic development and the demand for high-tech skills created the opportunities for skilled and unskilled workers to find employment outside their country. As a result, employment market disparities between countries grew deeper and affected vital sectors of the origin countries. This negative effect can be avoided if the developed countries that receive professionals on the labor market would provide the necessary human capital for the countries of origin. Furthermore, developing public policies and guest worker programs that would reduce the dependence of the migrant could counteract the negative effects of labor migration. Cooperation between sending and receiving countries will make recruitment more efficacious and would improve the distribution of human resources.

The significant migration process that started decades ago is only increasing nowadays and migrants go through some terrible experience in order to arrive in developed countries. Reports about people dying in the Arizona desert or in the Mediterranean Sea evidence the decision that these people made: to search a better life outside their country.

Nevertheless, the foreign workers must not be confused with refugees, as the migrant workers are motivated to enter the employment market of another country and not by an external factor that practically forces them to leave the origin country. In fact, migrant workers are drawn to settle in developed countries by an increase in the demand for human capital. Migration is a phenomenon that extends over centuries and the intensity and flow increased along with the technological development and the industrialization. However, international migration is a rather new development and long distance migration worldwide is rare. One of the influencing factors is the emotional context and its impact on an individual's life, as it means separating themselves from family. In addition to this, governments regulate the immigration process and control the influx of migrants within the national borders.

Migration is a phenomenon caused by economic or noneconomic factors. Individuals that are economically driven to leave their origin countries are usually entering the labor market of the receiving country as they identify a demand that they think they can satisfy. Even so, within migrant workers we can establish categories, depending on their education and skills, and their regular (documented) or irregular status (nondocumented). A special category is represented by *guest workers*, who are usually highly skilled individuals that come to meet the demand in the labor market of the receiving state. Their status is somehow special because their migration is either encouraged by a public policy that facilitates the access of highly skilled workers in the economy sectors that need an outside input, or by a stable agreement that offers an income and documented access to a developed country. The latter situation refers to students that have been awarded fellowships and who will be paid for their research projects. However, they are most likely facing significant wage differences in part as a direct result of their status.

Guest Worker Programs in Western Europe

Western European countries promoted worker recruitment programs until the mid-1970s, as the economical development required additional work force, mostly unskilled workers. Countries like France, the United Kingdom, and the Netherlands recruited the workers from their former colonies territories, who had a right to citizenship. However, in the USA, during the Cold War period, another type of labor migration was being encouraged, the migration of scientists from the Soviet area.

Germany was one of the countries that developed a rotation system in order to ensure that the guest workers were in the country only for a limited period. The state involvement was significant and the guest workers had limited rights. These guest workers were being discriminated and poorly paid and their stay in the receiving country was designed only to serve the labor market demand. Their social interaction was minimal and their necessities reduce to basic accommodation. Though these systems existed, they finally lead to irregular flows of migrants, mainly as a result of family reunions.

Europe's economic boom was sustained by the labor force of the guest workers who were employed in the low paid jobs and did not have high expectations or a significant power to negotiate. Sectors of the economy became highly dependent on the guest workers' labor and it soon became clear that the *rotation principle* had fallen into nonuse. By the time the oil crisis came, the guest workers had settled in the receiving countries and managed to bring their family with them. The socioeconomical consequences arose, especially as a result of the crisis and the work force recruitment ceased. Even so, the hoped-for result did not come, as the guest workers did not leave the receiving country; by that time they were settled and had formed ethnic enclaves.

From Guest Worker to Permanent Resident

The large number of guest workers that came to Western European countries and the family reunions clearly point out that many of them would not leave the receiving countries. Many of these guest workers have lived in the receiving countries for many years and they have formed a family or managed to bring their closest family members to them. Guest workers are usually expected to leave the receiving country after a time, because even if the earnings are higher than in the origin country, the living expenses are also higher; it was assumed that this would have a discouraging effect, which will make guest workers want to return to their countries. Many of them did so and left the receiving country with the savings resulted from the higher income. The origin country's living cost is lower and the savings could ensure a good living.

Nevertheless, if a crisis emerges and the economy is severely affected, the migrants will find it wiser to remain in the developed countries rather than return to the origin ones. The sending countries, usually developing countries, would feel the consequences of a crisis more acutely. Following this reasoning, it is more profitable for guest workers to remain in the receiving countries during economical crisis.

Another aspect that cannot be neglected is that the guest workers gradually become integrated into society, participating in the welfare system, social manifestations, and education. As a result, they become entitled to receive the state's protection in case of unemployment, disease and should be granted access to such benefits. Moreover, there are legal aspects that proibit a State from expelling documented migrants without clear and convincing evidence that there is a legal basis for doing so.

The guest worker system in Western Europe promoted a labor market model in which the migrant was rendered inferior. The receiving society was not willing to integrate them and guest workers were victims of economical disparities and racial discrimination. This aspect pushed the guest workers to live in specific areas, where the infrastructure was poor. Ethnic enclaves were thus formed and the guest workers developed a cultural and social model of inclusion. In these neighborhoods, they could freely express their culture and beliefs and raise a family.

Today's Europe is the result of this socioeconomical policy and the effects that it produced on migration, foreign workers, and ethnical identity. The trends of migrant workers flow in Europe raised concerns about the factors that produce negative effects toward migrants. This refers to the social exclusion, restricted access to all the labor market's segments, and poor housing. Concerns were raised regarding whether the temporary labor recruitment is not entirely beneficial and could bring about increasing difficulties.

A 2001 Report, the Sussmuth Commission Report, argued that Germany was already an immigration country that could satisfy the labor shortage only by employing both skilled and unskilled foreign workers. Moreover, in Britain, a released Home Office report from 2001 emphasizes the positive effects of foreign workers. The debate over the costs and benefits of labor migration was present also in Canada, USA, Australia, and Japan. All these countries have a high immigration rate.

Changing the approach to labor migration was based on economical reasons. It is a fact that the labor force in the developed countries is not willing to accept some of the low skilled jobs and the countries are unable to export all these jobs in the developing countries. There are sectors of the economy that cannot be moved over the borders, require few skills, and are poorly paid. The construction industry, services industry, and the health care system have to be based in the same country with the beneficiaries of the services. A reasonable solution appears to be allowing the migrants, the guest workers to be employed in filling the labor market gap.

Another factor to be taken into consideration is the aging population opposed to the decreasing birthrates. As a direct effect, the working population will decrease and will put pressure on the social welfare system, at the same time that the older population will almost double its size.

Models of Guest Worker Programs

State policies regarding migrant admission programs can be classified into two categories: relatively open and closed government policies. The first schema allows the foreign worker the possibility of settling in the receiving country, upon completing some requirements. A certain period has to have passed between the time the migrant entered the labor market as a guest worker and the time when he applies for a more permanent status.

Closed temporary labor migration programs follow the rule that the guest worker has to return to his origin country after an agreed period. Seasonal workers fit into this category, as their services are required only at specific moments of time and for a limited period.

Temporary migration schemes bear benefits for the countries involved and for the individual as well. A shortage in labor is met in the receiving country, while the origin country will benefit from the knowledge and skills that the guest workers accumulate in the developed country. Once the labor shortage is resolved, the country will compete more successfully on the global markets. Besides the skills and knowledge of the guest workers that return, the origin country will be sensitive to the effect of the remittances. The money sent back home can be reinvested or can help improve the standard of life of the family left behind by the guest worker.

Documented migration, such as guest worker schemes, represents an opportunity both for the receiving country and the origin one, rather than a threat. The demand of one State can be met by interaction with another State, in order to maximize mutual benefits.

Related Topics

► Brain drain
► Bureau of Immigration and Customs Enforcement

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Gujaratis

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Gujarat is one of the states in India, located in the northwest. The languages spoken there are Gujarati, Hindi, and English. The major religions practiced there are Hinduism, Islam, Jainism, Sikhism, and Christianity. The population of Gujarat is around 5.06 crore (1 crore = 10 million). Ancestrally, Gujaratis are similar to most other North Indians, who for the most part seem to share background with the central Eurasians. (Eurasian was first coined in 1844, to refer to individuals of European (i.e., British) and Asian (i.e., Indian) descent.)

Many people in India migrate within Gujarat looking for work. However, there have been trends in immigration out of India by those seeking a better life. Initially, the Gujarati people moved to East Africa and worked themselves up to own businesses and work in management between the British and Africans. Many subsequently immigrated to England or Canada as these two countries had less restrictive immigration laws. And then in 1972, when Idi Amin expelled all South Asians from Uganda, approximately 7,000 persons went to Canada as refugees. Prior to the 1940s, the USA had very restrictive immigration laws and restricted Asian women from entering the USA. Thus, many of the Asian men married Mexican women. After World War II, the US immigration laws became less restrictive and more Indians in addition to the professionals and students already present started entering the USA.

Gujarati people have also immigrated to Australia, Canada, England, and the USA. Despite emigrating from their native land, Gujarati people maintain strong cultural ties and traditional norms. Traditionally a family dwelling would contain three generations of a family. However, in Western society this is more difficult to maintain but families will often continue to maintain strong ties, with cousins, aunts, and grandparents, when they cannot live in the same house. It is traditional for the oldest male child to take in the parents and care for them, and this tradition is maintained still. Thus, the use of nursing homes or assisted living facilities is relatively rare.

Gujarati people will tend to gravitate toward each other and buy homes in similar areas. This allows them to have a sense of community even if their biological family may be far away. In a traditional home, Gujarati will be spoken in the home, and English at work or school. Cultural programs are a large part of socializing not only for the adults, but for their children. Girls can learn the traditional classical dances of Bharatanatyam, which is a classical Tamil dance; Kathak, which is a classical Hindi dance; and/or Raas Garba, which are traditional Gujarati dances. Raas and Garba are two separate dances where Raas is danced with sticks, dandiya, and a partner, while Garba is danced in a circle not requiring a partner.

In India, children grow up learning both Gujarati and Hindi, as Hindi is a more "universal" language across India. In order to not lose their traditions, parents will have their children take classes, and speak these languages at home. Growing up in an Indian home can create ethnic identity crises for the younger generations, especially if the older generations are in disharmony with the dominant culture.

Related Topics

- ► Asian Indians
- ► Dowry
- ► Emigration
- ► Ethnic minority group
- ► South Asians

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H

H1N1 Virus

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Each year, approximately three to five million illnesses and 250,000 to 500,000 deaths worldwide are attributed to influenza. As the 2008–2009 influenza season waned in April 2009, a novel strain of influenza A virus was identified by the US Centers for Disease Control and Prevention (CDC). The first cases were detected in California; subsequently, several deaths of young adults and children in Mexico from a severe respiratory illness were identified to have the same novel influenza A strain. Cases were soon reported from countries outside North America, including the UK, Australia, Chile, and Japan. Based on sustained person-to-person transmission in community outbreaks in at least one country in two or more World Health Organization (WHO) regions, the pandemic alert level was raised from phase 5 to phase 6, thus an indication that containment of the virus to a particular geographic region was not possible. The 2009 H1N1 influenza virus had been detected by laboratories in 74 countries and territories when WHO declared a global pandemic of H1N1 influenza A on June 11, 2009, the first influenza pandemic in 41 years.

The 2009 H1N1 influenza virus was determined to be have been globally distributed in less than 6 weeks, compared to the pattern typically seen of 6 months or more from past influenza pandemics. Modern air, sea, and land transportation was one factor in the rapid spread of the 2009 H1N1 influenza virus.

Another contributing factor was the lack of immunity of the general population worldwide against the virus. The 2009 H1N1 influenza strain was ultimately determined to exhibit "antigenic shift" or novel reassortment of previously seen individual gene segments that originated from humans, birds, and pigs from North America and Eurasia. The 2009 H1N1 influenza virus was transmitted easily from person-to-person. Pregnant women and persons aged 24 years or younger were at higher risk for severe complications from infection with 2009 H1N1 influenza. American Indian and Alaska Natives in the USA were observed to have disproportionally higher case fatality rates from 2009 H1N1 influenza than the general population. This trend was also seen in indigenous populations from Canada, Australia, and New Zealand.

Traditional (e.g., television, radio, newspapers, Internet) and social (e.g., Twitter, Facebook, YouTube) media were utilized to disseminate public health recommendations and information about the 2009 H1N1 influenza. WHO frequently updated its website to include press briefing transcripts, situation updates, fact sheets, and guidance documents. In the USA, the CDC maintained a Spanish language HINI "mirror" website which reflected information published on the English language site. Key resources were also developed in multiple languages including Chinese, Vietnamese, Korean, French, German, Arabic, Russian, Amharic, Farsi, Somali, Karen, Cambodian, and Kirundi. These materials were easily accessible on the website by the public, as well as professionals in medicine, public health, immigrant health, and social services.

Vaccine development and distribution activities were initiated as one aspect of the public health response to the pandemic, in addition to evolving infection control, prevention, and treatment guidance. In October 2009, the 2009 H1N1 influenza vaccine supply became available in the USA. The initial vaccination strategy targeted high-priority populations including health care workers and first responders (e.g., paramedics, emergency medical technicians), infants 6 months through young adults 24 years of

Sana Loue & Martha Sajatovic (eds.), *Encyclopedia of Immigrant Health*, DOI 10.1007/978-1-4419-5659-0,

age, and adults 25 through 64 years of age with chronic health disorders. As production increased, 2009 H1N1 influenza vaccination eventually became available for the general population. Large scale immunization efforts were organized and public health entities offered free vaccination through public health or community clinics, and single-day vaccination sites in public venues (e.g., stadium parking lots, high school auditoriums, large church buildings) to provide additional vaccination locations for the public. Despite the availability of free vaccine, immigrant and migrant populations were more at risk for not receiving 2009 H1N1 influenza information and vaccination recommendations, thought to be due to language barriers, transportation or work issues, or concern about legal status.

One year after the declaration of the pandemic, laboratory-confirmed cases of 2009 H1N1 virus have been reported in more than 214 countries and overseas territories or communities, including over 18,156 deaths.

Related Topics

- ► Infectious diseases
- ► Influenza
- ► International Health Regulations
- ► Quarantine
- ► Travel and travel health

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Suggested Resources

Pan American Health Organization. www.paho.org

U.S. Centers for Disease Control and Prevention. www.cdc.gov

U.S. Health & Human Services Influenza Preparedness and Response. www.flu.gov

World Health Organization. www.who.int

Hague Convention on Child Abduction

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With increasing globalization, violent acts toward children are no longer seen in a national context, as offenders can easily cross borders and avoid punishment or take the victim to another country. The Declaration of the Rights of the Child in 1959 stated that special protection and care is to be given to children and their safety and health, whether it is mental, physical, spiritual, or moral. The basic principle to follow is to always have in mind the best interests of the child.

The need to regulate and to establish a framework for nations when confronted with child abuse is an obvious and necessary concern. When talking about children's rights, the main focus should be on the child's best interest, regardless of who the offender may be. The regulator must consider the protection of children not only against external threats from outside of the family, but also parental abuse and neglect.

One of the most significant international agreements that governs the procedure in case of kidnapping of children or taking a child across the national border without consent is the Hague Convention on the Civil Aspects of International Child Abduction, established in 1980. With more than 50 signatories, the Convention is a multilateral treaty establishing a procedure that ensures that any child that is a victim of kidnapping or retention will be taken back to his or her national or resident country as soon as possible. The abduction is considered an international matter and the priority is to return the child to his previous residence, under the same legal conditions as it was before the kidnapping occurred. Most important, the Convention is a step forward in cooperation between States all around the world and recognizes that parental kidnapping is as serious a problem as any other type of abduction. Regarding the removal of the child from his previous environment, this must be made by a person that seeks to obtain legal custody in another country than the one where the child lives. Indeed, in most of the cases, this person is one of the child's parents or a third party that acted upon a parent's instructions.

The Hague Convention on the Civil Aspects of International Child Abduction entered into force by the end of 1983 and it sets a specific *modus operandi* in case there is any unlawful change in the actual domicile or residence of a child, even though this change was made by one of the child's parents. Transport of a child across international borders without having permission of doing so it is subject to international jurisdiction; the Convention ensures that the parent that acts in this manner will not benefit from a different law than the one existing in the State of domicile/residence of the child at the moment of the abduction. Each party that has become a member of the Convention has the obligation to ensure that the custody rights and the access rights given by one of the contracting States will be respected in the same manner in any other contracting State. This way, the international agreement ensures that kidnappers will not be able to benefit from a more indulgent law, one that will provide them more rights.

Stated purposes of the Convention are the *rights of custody* and the *rights of access* that are defined within the Convention's text. For example, the *rights of custody* will include all the rights that are relevant to the care of the child and in establishing a residence. On the other hand, the *rights of access* are considered to be any lawful act to take a child away from his continuous and steady residence, but only for a determined period of time.

In understanding the role and the functions of the Hague Convention, a fundamental fact is that the treaty itself does not give any particular rights or create a new legal status. Rather, it seeks to protect the best interest of a child by facilitating respect for the national law that established certain rights for one of the two parents. Moreover, this relates to the legal custody of the child and the problems that might derive from it; it does not address legal custody battles, but establishes ways that the custody rights given by one member State will be respected in all the other member States. The Convention merely ensures that a child will be returned safely to the country where he had his legal domicile/residence before the disruptive act had taken place. The purpose is not to bring the child under the guardianship of the parent who is entitled by law, but just to return him to the country from which he was kidnapped. For a better understanding of this principle, the Convention defines the wrongful removal or retention of a child. In doing so, the agreement emphasizes the situations when the Convention is to be applied and states that when the child attains the age of 16, the articles of the Convention will no longer be applicable.

According to Article 3 of the Convention, there are two conditions when the removal or the retention of a child is subject to this international agreement. The first is when removal/retention interferes with the custody rights given to a person, institution or any other type of tutelage, and violate them. Of course, these rights should have been previously given by the legal authority of one of the Convention's member States and the child should have had a continued residence in that State previous to his removal. Another condition is that the rights that are severely affected by the removal of the child are fully exercised before the disruptive act or should have been exercised if not for the removal.

The Hague Convention on Child Abduction rests on three pillars that ensure the international cooperation and an effective and quick approach to the matter: *Central Authority*, *implementation of measures*, and *preventive measure*s. Designating a Central Authority is compulsory at the time of ratification or the time when the Convention enters into force. In fact an office or a position, the Central Authority is an agency that has the duty to see that the obligations and functions of the Convention are applied and respected. Another prerequisite is that it has strong and operative connections with the justice and social systems in that country. The implementation of measures comprises all the resources, the cooperation, communication, consistency, transparency, all the procedures, and the progressive implementation that help clarify the structure of the Convention and carry out the obligations of the Convention.

In order to ensure that the purpose of the Convention is met, the member States should also adopt *preventive measures* that will help to reduce the risk of abductions. These include enforcement of the domestic law, establishment of bilateral agreements, and the creation of specialized organisms that provide counseling and facilitate mediation to those involved in custody battles.

Related Topics

- ► Child abuse
- ► European Court of Human Rights
- ► Human rights
- ► Trafficking

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Haiti

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Introduction

This document presents an argument for the need to clarify culturally bound mental health symptoms for Haitians in Haiti, in the USA and abroad. It begins with a brief introduction to Haitian geography and history. It continues with the impact of centuries of violent and oppressive rule and of inequity and stigma that often characterize Haitian life in the USA. Next, it presents a discussion of the January 12, 2010, earthquake and its expected psychological impact on Haitians at home and abroad. Following, three examples of mental health symptoms that were directly observed by the writer during a visit to Port-au-Prince in May, 2010 are offered as support for the need to clarify culturally bound mental health symptoms for Haitians in Haiti, in the USA and abroad. Finally, a call is made for purposeful focus on the mental health symptoms of Haitian survivors of the Haitian earthquake of 2010, with emphasis on identifying and treating those symptoms in a biopsychosocial context that is familiar and meaningful for individuals of Haitian descent.

Haiti: Beauty in the Midst of Conflict

Haiti occupies the western third of Hispaniola, an island it shares with the Dominican Republic. The Atlantic Ocean borders Haiti on the north and the Caribbean Sea forms the southern boundary. Haiti is the first Black republic in the western hemisphere. It gained independence from France in 1804. General Jean Jacques Dessalines, who featured prominently in the war for independence, was assassinated in 1806.

Before and during French rule, Haiti was known as the Pearl of the Antilles and was one of the richest colonies in the world due to its abundant natural resources and slave labor. Despite freeing itself from French rule, Haiti remains the poorest nation in the western hemisphere. Internal division between the light-skinned Haitian elite and the dark-skinned peasants at the time of the country's independence from France led to centuries of conflict that persists today. As an example, a civil war between the Black northern kingdom of Henri Christophe and the southern republic of the light-skinned Alexandre Pétion divided the country between 1807 and 1820. For over two centuries now, the elite have maintained control of the government and have occupied the most desirable sections of Haiti. The peasants have traditionally lived in the rural areas and in condensed regions of the capital.

Past US Involvement in Haiti

The USA invaded and occupied Haiti for 19 years, beginning in 1915. The main legacy of that period of occupation was a trained military. Sadly, American Marines forced peasants to build roads and perhaps violated other civil rights, fostering organized resistance to their presence under the leadership of Charlemagne Péralte. Péralte would subsequently be assassinated by US Marines in 1919. Following the US occupation, Haiti has been embroiled in persistent and recurrent political turmoil, with a series of leaders who did not always seem concerned with the plight of the masses.

The Age of Duvalierism

Among the most notorious of Haiti's past leaders was the dictator, Francois "Papa Doc" Duvalier. He was a self-proclaimed "President a vie," or "President for life." He died in 1971, ending a regime of terror that was supported by his *tonton makouts*, a military group that insured compliance with Papa Doc's demands. His only known son, Jean Claude Duvalier, assumed power upon his father's death and became known as "Baby Doc." The latter left Haiti in 1986 after widespread protests influenced the USA to arrange for political asylum for him and his family in France. At the time that this manuscript is being composed, Jean Claude Duvalier had recently returned to Haiti a year after the 2011 earthquake and weeks after a failed election that was fraught with accusations of fraud and misconduct.

Despite the cruelty associated with the Duvaliers, it was not until 1990 that a friend of the masses, Jean Bertrand Aristide, was elected as president. A coup d'état facilitated by the army, and encouraged by those who did not appreciate Aristide's loyalty to the masses and the fact that some questionable elements from the underclass seemed so supportive of him, led to the overthrow of Aristide's government in 1991. He was placed back in power in 1994 after 3 years of violence in the nation illustrated that the masses were dissatisfied with the subsequent rulers and with him being deposed. Shortly afterward, the USA withdrew its support of Aristide, perhaps because he demonstrated friendships with Cuba's dictator Fidel Castro and with other enemies of the USA. President Rene Preval is the leader of the nation at the time that this article is written.

Haitian Immigration to the USA

Although many Haitians left Haiti following Aristide's exile, it was not the first emigration of Haitians from Haiti. The first groups of Haitian immigrants traveled to the USA during the American occupation of Haiti, fleeing the harshness of the American invasion and occupation. It is believed that many of these early Haitian immigrants assimilated into African-American society, identifying themselves as West Indians. The early years of Papa Doc Duvalier's regime also influenced the emigration of many educated upper class Haitians to the USA. Most of these immigrants were anti-Duvalierists, and were from the educated upper class. Their primary language was French, although many spoke English and all of them also knew how to speak *Kreyòl*. However, many identified as "French" since that language was associated with being higher class. Many of these educated Haitians also traveled and remained in France, in Canada (especially Quebec and Montreal), in Guadeloupe, and in the French Congo, where their high education level and their ability to speak French made them natural leaders in education and medicine. Their emigration led to a decrease in the number of educated persons in Haiti. Many middle and lower class Haitians soon followed, seizing the opportunity to flee the violence in Haiti, while grasping at the available economic opportunities.

Possibly the most well-known and greatest influx of Haitians to the USA is that of the "boat people." The first boat people landed in Florida in 1972 following Papa Doc's 1971 death. They were largely uneducated Haitians from both rural and urban regions of Haiti who had made tremendous personal and financial sacrifices to flee the violence and inequity that characterized Baby Doc's regime. They were also fleeing the political upheaval that was anticipated following the death of Papa Doc. Their primary language was Haitian *Kreyòl*. Their treacherous journeys to Miami in overloaded boats were often fruitless, as the USA developed policies that classified them as economic rather than political refugees. Consequently, their boats were either intercepted at sea and they were returned to Haiti, or they were imprisoned in Miami-Dade's Krome Detention Center. As prisoners, they were subject to deportation. Many actually requested deportation rather than languishing in Krome. In 1993, the US Supreme

Court supported the deportation of Haitian immigrants on the grounds that they had entered the USA illegally. Although the flow of Haitian boat people stemmed only with the election of Aristide in 1990, many continue to attempt the life-threatening journey to the USA.

Haitian Enclaves in the USA and the World

There has been an estimated 87% growth in the number of Haitians in the USA over the past 2 decades. Between 400,000 and 750,000 persons of Haitian origin currently reside in the USA. These figures are probably lower than the actual numbers since many who fear deportation do not participate in the United States census. Also, stigma associated with being erroneously associated as carriers of the human immunodeficiency virus (HIV) causes many to keep a low profile or to self-identify as being from the "West Indies," or from other Caribbean groups.

Miami-Dade-Dade County has the largest population of Haitians in Florida, in excess of 109,000, roughly 4.7% of the total population. North Miami-Dade is known for its large Haitian-American population, and Miami-Dade-Dade's Little Haiti has the largest concentration of Haitians in the state. Miami is currently the number one place of Haitian settlement in the USA, followed by Boston, New York, and Chicago. Baltimore, Washington DC, New Orleans, Houston, and Los Angeles also have a substantial number of Haitian residents.

The USA is not the only place where Haitians have set up residence. There are Haitians in Canada, particularly in Montreal and Quebec. Many have left Haiti to work as school teachers and college professors in the French Congo, in Guadeloupe, in Martinique, and in other French-speaking enclaves. Some with less education have flocked to the Dominican Republic, Cuba, and the Bahamas, in search of employment or of opportunities for commerce. Among those who have remained in Haiti, many have remained by choice because they have the financial means to enjoy both Haiti and the other countries to which they travel for work and, or, vacation. Other less fortunate Haitians, if they desire to travel, may have remained because they lack the opportunity to travel to other countries. Still others remain because they possess strong love and respect for their country and out of a sense of respect for their ancestors' struggles and achievements. Those who have remained in Haiti are the ones who may be most affected by the confluence of structural and natural violence which have characterized the experience of Haitians at home and abroad. They are among those who were additionally traumatized by the devastating events which impacted the small island nation on January 12, 2010.

Need for Clarification of Haitian Expression of Mental Health Symptoms

In spite of the large presence of Haitians in the USA and in other nations around the world, there is a dearth of literature on how to provide mental health services to Haitians. There are several factors that call for culturally based clinical approaches with Haitians in the USA and around the globe. First, their health beliefs and practices often clash with Western conventional health care. Second, there was a documented 60–75% of US Haitians who were erroneously diagnosed as paranoid schizophrenics, and the error was discovered only after treatment with neuroleptics and related psychotropic medications proved ineffective. Third, there is a dearth of culturally bound syndromes for Haiti in the current Diagnositc and Statistical Manual of Mental Disorders (DSM IV-TR). Fourth, the January 12, 2010, earthquake that occurred in Haiti will have mental health consequences for Haitians at home and in the diaspora. These could range from mild stress to acute stress disorder to posttraumatic stress disorder, depending on whether survivors had a direct experience of trauma and loss or indirectly witnessed the devastating impact of the earthquake.

Grief Interrupted: Psychosocial Symptoms Among Haitians in the Aftermath of the January 12, 2010, Earthquake – Where Do We Go from Here?

On January 12, 2010, a 7.0 earthquake hit the tiny island nation of Haiti at about 4:53 PM (Haiti local time). The epicenter of the earthquake was approximately 10 miles from the nation's capital, Port-au-Prince. An estimated 230,000 people of the three million who were affected by the earthquake lost their lives. Some estimate this figure to be an underestimation since many of the deceased are still unaccounted for at the time of the writing of this article.

In the aftermath of the earthquake, many international aid organizations, representatives from diverse nations, and foreign journalists flocked to Haiti to provide humanitarian and medical aid and to document the physical impact of the earthquake on those who survived. Little is known about the psychosocial impact of the earthquake on the survivors and on those in the Haitian diaspora who are part of their social network.

What is clear is that Port-au-Prince, the nation's capital, is still under debris at the time that this article is being written. The government gives the appearance of making furtive efforts to rebuild, involving engineers, architects, and other professionals from around the world. Many of those who died when buildings collapsed on them are still under the rubble. Seldom are those who are directly impacted by personal, social, economic, and psychological loss involved in discussions about how to obtain shelter, or how to manage the recurrent psychological aftershocks of the earthquake. In the meantime, what is known about grief, loss, trauma, and the traditional Haitian grieving process suggests a dangerous omission to the Haiti Reconstruction plans: consideration of what may be grievous disruption to the traditional Haitian grieving process. This omission may bring serious mental health consequences for the survivors of the January 12, 2010, earthquake.

Haitian Death Rituals Before the Earthquake

Before the January 12, 2010, earthquake, the immediate family, close and distant relatives, friends, and friends of friends gathered together to cry and pray with the family of the deceased. It would appear as if the entire community was affected by one individual's death and by one family's grief. It was always expected that the oldest surviving family member would make the funeral arrangements and notify friends and family living away. The bodies of Haitians who die in Haiti or in the USA have been known to be kept for days and sometimes over a week, awaiting family members and friends to gather from all over the world. Specific protocols were in place to signify to others who may not have known the deceased that there has been a loss in the family. These include the "deuil," a tradition of wearing black, navy blue, dark brown, dark purple, or some other dark color to indicate mourning. The depth of darkness of the mourning dress indicated the survivor's familial proximity to the deceased, i.e., black for parent, children, etc. . . . The taking on of "deuil" signified that mourning had officially begun, and occurred at least by the 7th day after the death of a loved one.

Impact of the January 12, 2010, Earthquake on the Grieving Process of Port-Au-Prince Residents and Haitians in the Diaspora

Recent travel to Port-au-Prince indicates that there has been an egregious disruption in the grieving process. Two examples will serve as corroboration. In May of 2010, the writer was returning from a visit to a tent city in Cite Soleil, one of the worst slums in Port-au-Prince. On the road lay a man covered in blood, and his helmet lay about 12 feet from him. Men, women, and children walked past him, glancing casually and returning to their tasks. Surprised, the writer addressed this with members of a community focus group the following day. The response was that Haitians have become *dekonsantre* (desensitized) to death. The explanation was that in the immediate aftermath of the earthquake, impacted persons sought friends, family members or neighbors to comfort them in their grief. However, many who had lost five family members only found others who may have lost eight family members or more when they reached out for comfort. What had been a beautiful ritual of communal grieving and support had become a lonely experience of isolation and detachment.

A second example of grief interrupted in Haiti was the writer's observation of a beautiful woman walking down a congested street of Pétion Ville in the same week that the above situation occurred. The woman was slim and tall, with long slender arms on which she wore a dusty bracelet. She wore rags that remained from what appeared to have been a beautiful dress. The dress was so covered with dust and dirt that it was hard to determine what the original color had been. As she walked down the angled sidewalk, she gesticulated wildly, her mouth forming silent words that could not be heard above the din of afternoon traffic in Pétion Ville. She pointed erratically to debris on her left, then to the sky, and then to debris ahead and on her right. Behind her trailed a boy who was small in stature and in posture. His face was dusted with the same gray matter that colored his mother's dress. He wore a look of consternation mixed with fear and awe on his face. His eyes never left the back of her head, as if he strained to hear her words. He looked tired and thirsty. Yet, he followed her. No one intervened, although many noticed. It was hard to tell how long both had been walking, where they were from, or where they were going. They simply walked on. No one seemed to have time to comment or comfort.

A final example of grief interrupted involves Haitians in the diaspora; specifically, this writer's own experiences in the aftermath of the January 12, 2010, earthquake. Personal loss had to be managed and grieving postponed as she prepared for the tragic loss of a dear aunt at the same time that she prepared for a service trip to a rural Haitian orphanage and a subsequent research trip among earthquake survivors. Following, she had an even more personal tragic experience as she was the victim of a home invasion and assault in faculty housing on her university campus. For her and for other Haitians in the diaspora who experience compounded trauma, culturally specific mental health intervention is a must.

Conclusion

Despite the large presence of Haitians in the USA and around the world, and in spite of a history marked by structural and political violence, there has been a serious lack of focus on their mental health. The January 12, 2010, earthquake has compounded centuries of violence, oppression, and deprivation. Haitians are a resilient people. However, loss from an earthquake is new to them. Purposeful attention to their psychological health and survival is needed, if they are to continue as a resilient people. Mental health must be an integral part of Haitian reconstruction, not only for Haitians in Port-au-Prince, but for those who reside in the diaspora.

Related Topics

- ► Cultural competence
- ► Culture-specific diagnoses
- ► Emigration
- ► Grief and grieving

Suggested Readings

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Hate Crime

- ► Discrimination
- ► Violence

Health Barriers

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Most voluntary immigrants have better health than their native-born peers. This good health status means that immigrants in the USA arrive with more "health capital" than natives, although that advantage declines over time. The decline in health advantage is largely due to health barriers that immigrants face, including health risks and significant health care barriers. This entry will briefly describe some of the disproportionate health risks that immigrants face and provide more extensive information about the barriers they experience in obtaining health care that might buffer some of those risks. Because of the heterogeneity of immigrant populations and the circumstances where they live, the examples and data will largely focus on the largest immigrant group in the USA (Mexican immigrants) and the state with the most immigrants (California). The pattern of health risks and barriers that immigrants in the USA face is similar to those that immigrants in other countries face, although the types and magnitude of risks and barriers vary considerably by both receiving and sending countries.

The Immigrant Health Advantage

Most immigrant populations in the USA – as in other wealthy countries – have better mortality patterns than their native-born peers, regardless of race/ethnicity. Immigrant Latino males, for example, had a 3.8 year life expectancy advantage over US-born Latino men in 1999–2001, while Latino immigrant women enjoyed a 2.1 year advantage over their native-born counterparts. This advantage in mortality is also seen in disease prevalence rates among adults. Among the most common chronic conditions, native-born Latino adults had higher rates of most diseases than immigrant Latinos in the 2007 California Health Interview Survey, even after adjusting for age, education, gender, and poverty. For example, native Latinos were 1.3 times more likely to have diabetes than similar immigrant Latinos, 1.4 times more likely to have any diagnosed heart disease, and three times more likely to report asthma.

This health advantage could be used as an excuse to pay less attention to health barriers experienced by immigrants. The longer immigrants stay in the USA, however, the more their health status becomes similar to that of the US born. Diabetes rates, for example, are 50% higher among Latino immigrants in California who have been in the USA 15 or more years compared to those in the country for a shorter time, after adjusting for age, education, gender, and poverty levels. If we can identify the risks and health barriers that immigrants experience, we might be able to reduce the barriers and thereby extend the health advantage immigrants bring, saving both money and lives in the process.

Work-Related Barriers

Most immigrants who come to the USA are part of working families. In California, for example, 91.8% of recent Mexican immigrant men ages 18–64 are in the labor force, compared to 84.5% of US-born non-Hispanic Whites. Yet the segment of the labor market that employs Mexican immigrants is the lowest paid and includes some of the most dangerous of occupations. While almost 20% of employed men in California are Mexican immigrants, they are disproportionately concentrated in low-skill occupations such as agricultural workers, gardeners, certain construction jobs (such as cement workers, roofers, and laborers), some manufacturing jobs (such as packaging machine operators and metal/plastic workers), and various service occupations (such as dishwashers and cooks). This pattern is similar throughout the world where international labor migration is often concentrated in "3-D" jobs: dirty, difficult, and dangerous.

The risk of accidental death or suffering a fatal injury on the job in the USA is highest in the occupations that employ large numbers of Mexican immigrants. Heavily Mexican immigrant occupations that pose a particularly high risk for occupational injury and illness in the USA include agriculture, sweatshop textile work, day labor, and construction. Farm work alone employs less than 3% of the work force nationally, but accounts for 13% of all workplace fatalities. Mexican immigrants account for at least 40% of the agricultural labor force nationally, and 85% in California. In addition to deaths from equipment accidents and other causes, farmworker health is compromised by exposure to pesticides and other chemicals; their families are likewise at risk for both primary and secondhand pesticide exposure. Other occupational injuries include back injuries that are common among immigrant nursing home aides and construction workers, lacerations and broken bones from falls, and burns. Immigrant workers are more likely than others to not report these injuries for fear of losing their jobs, as well as due to not wanting to lose wages from taking unpaid time off, even when their injury would be covered by workers compensation insurance (which does not verify immigration status). Some immigrant workers are not aware of their rights under workers compensation, which also serves as a barrier to obtaining care for their work-related injuries and illnesses.

While farming has the highest fatality *rate*, transportation and material moving have the highest *number* of occupational fatalities, followed by construction/extraction, service, mechanics, farming/fishing/forestry, and manufacturing. These occupations that have the most occupational deaths also disproportionately employ immigrant workers.

In 2006, Mexican immigrants in heavily immigrant occupations in California earned $20,200 per year for men and $13,300 for women, approximately one-third less than Mexican immigrants who worked in occupations that were not reliant on Mexican immigrant labor. The jobs that rely on Mexican immigrant labor also are less likely to offer health insurance, leaving 60% of working Mexican immigrant men and 46% of similar women uninsured in California.

The segmented labor market that relies on large numbers of immigrant workers serves to concentrate immigrants into an employment sector that creates both an above average need for health services, while at the same time creating multiple barriers to the workers seeking needed care.

Access to Health Care Barriers

Barriers to health care for immigrants make it more difficult for immigrants to maintain their initially good health status. The timely and appropriate use of health services promotes cost-effective care, particularly preventive services and care for ambulatory-sensitive conditions like diabetes and hypertension. From this perspective, policies and financing for immigrant health are not a burden, but an investment. Most immigrants, however, face a number of barriers to obtaining needed health care, including a lack of available services, accessibility barriers, and problems with the acceptability of the care provided.

Problems with the *availability* of services include both the shortage of primary care providers in the low-income neighborhoods most often inhabited by recent immigrants, as well as the distance to specialists and acute care facilities. Immigrants are more likely to live in health professional shortage areas (HPSA), which means that they are more likely to have difficulty finding an available physician within their community. Even for those living in HPSAs that are served by a community health center (about half of HPSAs in the USA have a federally funded community health center) or public clinics, specialty care and specialized testing can still be difficult to obtain.

Hospitals in low-income immigrant communities have difficulty surviving because of the high rates of uncompensated care that the communities require (due to the low rates of health insurance, see below). As a result, a number of well-known safety-net hospitals have closed in recent years, such as M.L. King Hospital in South Los Angeles, leaving the immediately surrounding community with few acute care beds. South Los Angeles (Service Planning Area 6) includes over one million residents; half of nonelderly adults in the area were born abroad, most commonly in Mexico. In 2006, South Los Angeles had 1.14 hospital beds per 1,000 residents compared to 2.21/1,000 county wide and 3.22/1,000 in the wealthiest part of town ("Westside"). Those hospitals contained about five emergency room treatment stations per 100,000 residents in South Los Angeles, compared to 15 countywide and 23 in the Westside. Outside of hospitals, South Los Angeles had 7.7 pharmacies per 100,000 population versus 15.1 countywide and 21.8 in the Westside. Some public hospitals that survive, such as Grady in Atlanta, are cutting back on critical services like dialysis units in an attempt to reduce budget deficits. The October 2009 closure of Grady's dialysis unit left their mostly uninsured and immigrant patients without an affordable source for that life-sustaining treatment. These data indicate that there is a shortage of available health services in low-income immigrant communities, which is a significant barrier to obtaining needed care.

Accessibility can also be impaired when immigrants seek to use the few providers that exist in communities where immigrants settle. Common barriers to access include lack of knowledge of available care, high out-of-pocket costs, inconvenient service hours, and fear of the authorities.

Any newcomer takes a while to learn about health care and other services that are available in a new neighborhood. International immigrants have the additional disadvantage of having come from countries where the health care system is organized very differently (regardless of their country of origin). Without prior knowledge of the intricacies of public program eligibility and benefits in the USA, often combined with limited English proficiency and low levels of education, finding appropriate services and programs can be daunting. Community services that are free or low cost, such as community health centers, often run at capacity, constraining their ability to conduct outreach and publicity for to immigrants.

The barrier of cost is significant because immigrant workers have low rates of health insurance as well as low rates of coverage for sick leave from their employer. Noncitizen immigrant Latinos have low rates of health insurance coverage due to the fact that their employers have the lowest rate of offering insurance. In California, for example, only 49% of undocumented Latino workers (i.e., those without a work permit, or "green card") were offered insurance by their employer, compared with 82% of citizen Latinos. The proportion of workers who were offered insurance who enrolled in the health insurance plan offered was somewhat higher among the undocumented (84% vs. 72%), indicating that there is a clear desire for health insurance when it is available and affordable. In addition, documented immigrants are ineligible for federally supported Medicaid for their first 5 years in the country, even if they would otherwise qualify. And undocumented immigrants are not eligible for any public assistance for health care through Medicaid except in life-threatening emergencies. It is worth noting that California provides Medicaid coverage to all documented low-income immigrants in families with children, supporting those in their first 5 years in the country with entirely state funds. Several California counties also have programs that provide health insurance to low-income children who are not otherwise eligible for insurance, who are primarily undocumented children. Despite these additional programs, according to the 2003 California Health Interview Survey only 47% of undocumented Mexican immigrants had health insurance, compared to 67% of legal permanent residents, 80% of Mexican immigrants with U.S. citizenship, and 85% of U.S.-born Mexican-Americans.

While California and the USA are unique in the developed world in not providing universal health insurance, they are not unique in creating financial and other barriers to some classes of immigrants, especially undocumented or irregular immigrants. According to the United Nation's 2009 Human Development Report, 60% of developed nations restrict preventive care benefits to irregular immigrants and almost 30% restrict emergency care benefits to them. Restrictions on temporary legal immigrants are less common, and for permanent immigrants the least common.

As a result of the lack of benefits in the occupations that employ large numbers of immigrant workers in the USA, they often have to pay twice when they seek medical care – once to pay for the doctor visit and a second time in lost wages when they take unpaid time off work to seek care. One study found that half of undocumented workers in California worked at firms that did not offer sick leave. Partly as a result of these trends, immigrants also have low rates of preventive service use, including cancer screenings (e.g., mammography, colonoscopy), adult immunizations, and well-checks. For example, according to the 2007 California Health Interview Survey, 50% of noncitizen immigrants age 50 and over had never had colon cancer screening compared to 22% of US-born persons age 50 and over. The exception is Pap tests for cervical cancer, where noncitizen women ages 18–64 have had a recent test (within the past 3 years) at about the same rate (83%) as US-born women (87%). The difference with Pap tests is that both the federal government and the state of California have special programs to pay for Pap tests and cervical cancer treatment that is available to all women, regardless of their immigration status. Pap tests are also performed in community clinics and other outpatient sites that immigrants commonly use. Colonoscopy does not receive this level of government support, which results in reduced access for persons without insurance and a regular source of medical care.

Another barrier to access to existing services is fear about immigration status. Policy initiatives at the local, state, and federal level continually target undocumented immigrants in attempt to limit their use of public services, even when there is no evidence that they are commonly using the services. Other policies are designed to frighten or make life more difficult for undocumented immigrants by preventing them from obtaining driver's licenses, ordering landlords not to rent to them (which the courts routinely overturn), or requiring the police to check the immigration status of everyone arrested. While these latter laws are not directly related to health care, they create a hostile climate that extends to the use of health services. In 2009, the National Conference of State Legislatures identified 353 new laws and resolutions that were passed related to immigrants. Some helped immigrants, such as laws allowing undocumented immigrants who attended high school in the state to pay in-state tuition in public colleges. The majority involved restrictions on the undocumented.

The continual media coverage of the deportations of undocumented immigrants further creates fear in immigrant communities that leads many to avoid contact with any public authority to the extent possible. Even if a person is a legal permanent resident, some fear that their ability to gain citizenship or sponsor other family member to immigrate the USA could be compromised by using publicly funded services. There are also "mixed status" families where one or both parents are undocumented but their children were born in the USA and are therefore automatically citizens. While the children qualify for public health care programs, the parents often hesitate to enroll their children in the programs because of the fear that the use of those programs will make it difficult for the parents to regularize their status in the future. A published government directive states that the use of government-supported health care cannot be used as evidence that an applicant for legal immigration could be a "public charge," but the same directive allows the use of cash assistance to be evidence of a public charge. The resulting confusion and mistrust in many immigrant communities creates barriers to seeking low-cost and free health services for which they may be eligible. While some politicians claim that most immigrants are motivated to come to the USA to obtain social welfare benefits, such as free health care, the evidence is that this is rarely a consideration.

Discrimination against immigrants in policy and actions is common throughout the world during periods of high unemployment and economic crisis. Western Europe experienced growing anti-immigrant sentiment and policies during the economic crisis that peaked in 2009, such as France deporting many Roma immigrants and anti-immigrant political parties gaining influence in the UK, Italy, the Netherlands, and Sweden. Heavily publicized deportations, police harassment, and heightened surveillance of immigrant populations will have a similar chilling effect on the use of government-sponsored health services and programs in all these countries, as it has in the USA.

Even when immigrants use the services available in their communities, the care provided may not be *acceptable* and discourage further timely use or compliance with recommended courses of treatment. Language barriers between providers and patients are a significant problem in both building trust and communicating information. In the 2005 California Health Interview Survey, 13% of adults with limited English proficiency (LEP) who had a doctor visit reported that they had difficulty understanding their doctor. The US Office for Civil Rights published a guidance in 2001 stating that the Civil Rights Act requires all federal programs provide "meaningful access" to those programs to persons who have LEP by providing translation services (www.lep.gov). In practice, this requirement applies only to institutional providers and public health programs that serve a significant number of persons with LEP. This leaves out all private providers as well as those institutional providers with smaller LEP caseloads. There are also National Standards on Culturally and Linguistically Appropriate Services (CLAS) that are also oriented primarily to institutions and not individual providers. There are frameworks, therefore, to guide health care providers, but they are unevenly and incompletely implemented.

Other acceptability barriers result when workers move locations frequently, such as those following crop harvests. Continuity of care is lost when migrant laborers use multiple clinics in different states or even countries. This is particularly important for migrants with chronic conditions that benefit from careful monitoring such as diabetes, diseases that have long courses of treatment such as tuberculosis, and for maintaining health records that are needed for later medical encounters such as information about previous caesarean section births. The fragmented nature of the US health care system and the low level of exchangeable electronic medical records work against an adequate continuity of care for migrant families with these types of health needs.

Perceived discrimination is a further barrier to acceptable care. Some studies suggest that immigrant Latinos are more likely to report racial discrimination in health care more than US-born Latinos, independently of language ability, income, and health insurance status. They also commonly report discrimination based on their health insurance (if on public insurance), or lack of insurance. When combined with other barriers, the perception of poor treatment due to their race/ethnicity will discourage Latino immigrants from seeking timely health care and is likely to reduce their willingness to follow medical advice.

Barriers Leading to Lower Health Care Use and Spending

The multiple barriers to health care use are reflected in the consistent findings that immigrants use fewer health care resources, even after adjusting for need and other standard predictors of use. In California, only one-third of noncitizen Mexican immigrants have a usual source of care; they are 30% less likely than US-born Mexican-Americans to have a usual source of care even after controlling for other determinants including insurance, age, poverty, and health status. Noncitizen Mexican immigrants report 2.4 doctor visits per year, 1.5 fewer than US-born Mexican-Americans after sociodemographics and need are considered. And 14% of noncitizen Mexican immigrants had an emergency room visit in the past year, *half* the adjusted rate of their native peers. Recent Mexican immigrants are also less likely to have received preventive services such as a mammogram, colonoscopy, or influenza immunization.

It is important to distinguish between rates and numbers in this context. Some hospitals complain that uninsured immigrants are overflowing their emergency rooms and creating a financial burden. This can happen, even though the rate of emergency room use is exceptionally low among immigrants, if the hospital is one of the few facilities in an area with a large number of immigrants. The undersupply of health care noted earlier is the cause of the problem, not immigrants since the emergency rooms would be even more overcrowded if the same neighborhood housed low-income native-born persons who are more likely to use emergency rooms. Another result of having an undersupply of facilities in dense communities are long waits that further discourage use even when needed. In September 2010, it was reported that the largest public hospital in Los Angeles, with a high immigrant census, had an average wait of 12½ hours in the emergency room from the time the patients are triaged until they are seen and then admitted or discharged.

It is logical that barriers to health care that result in lower levels of use also result in lower spending for immigrant health. An analysis of US health care spending in 2003 found that immigrants who had been in the USA under 10 years were 39% less likely than US-born persons to have any medical expenditures after controlling for sociodemographic differences, health status, and health insurance. Immigrants with longer stays were 25% less likely than the native-born to have any health care expenses. For those who did have health care costs, immigrants had substantially lower expenditures (14–20% after adjustments for population differences) than US-born persons. Even immigrants with full-year health insurance had lower spending than natives, both for total spending as well as out of pocket expenses. It is possible that immigrants obtain lower-cost insurance that exposes them to more restricted provider networks and/or higher copayments that act as barriers to care. Other availability, accessibility, and acceptability barriers discussed above may continue to serve as barriers to immigrants even when they have health insurance. Since the study controlled for self-assessed health, chronic conditions, and functional limitations, most of the health advantage enjoyed by immigrants was taken into account. The low medical expenditures for immigrants suggests that they account for a disproportionately small share of the US health care budget and create no significant financial burden on the country's health care system.

Health Care Reform Limitations

The central goal of the 2010 US health care reform, the Patient Protection and Affordable Care Act (ACA), was to expand health insurance coverage and reduce the number or persons without insurance by over half. It is estimated that under the ACA about one-third of all those in the country who will remain without health insurance will be undocumented immigrants since under half of undocumented immigrants nationally have any form of health insurance. The undocumented are explicitly excluded from public health insurance (Medicaid), new federal subsidies to purchase private insurance, and from participation in the new purchasing exchanges that should provide more affordable insurance. Low-income persons without immigration documents will continue to be eligible only for federal government payment for emergency services in life-threatening situations and for the delivery of babies (who are US citizens as a result of being born on US soil and therefore eligible for public insurance).

In addition to insurance, the USA has a network of primary care clinics (community health centers, or CHCs) that offer services based on the patients' ability to pay. Immigrants, both undocumented and documented, can access those clinics and the federal funding for the clinics increased under health care reform. It is possible that access to health care for all immigrants might increase with the expanded CHC presence since 57% of all recent immigrants to California use CHCs as their usual source of care, if they have one.

The lack of insurance is a key, but not the only, barrier to health and health care for immigrants. In addition to reducing health risks that immigrants face because of the type of jobs that they are recruited for, barriers to equitable health care put the long-term health of immigrants at risk. Equitable health and health care for immigrants require new efforts to assure that the full range of medical care facilities and providers are available in immigrant communities, that those resources are accessible to community members, and that the services provided are acceptable. While these types of barriers exist for many different groups in the USA, immigrants face a unique set of barriers that will require targeted interventions to address.

Conclusion

The concentration of immigrants in low-paid jobs with above average occupational health risks is not unique to the USA, as noted by the World Health Organization's 2010 consultation on immigrant health. The organization and financing of the medical care system in the USA are unusual, but the underlying issues of barriers for immigrants to the availability, accessibility, and acceptability of services can be found in health care systems throughout the world. These issues are fundamental to the WHO immigrant health consultation that identifies "avoid disparities in health status and access" as one of the four pillars of a public health approach to migrant health. The other pillars include ensuring migrants' health rights, which are integral to accessibility; minimizing the negative impact of the migration process, which is related to the vulnerability of immigrants in the labor market as well as social exclusion that serves as a barrier to health care; and reducing excess mortality and morbidity, where health barriers are implicated.

In taking a public health approach to immigrant health internationally, there is a tendency to emphasize linguistic and cultural barriers to care as particularly important for immigrant populations. While improving the ability of health care systems to communicate with diverse populations important, making that the lead immigrant health issue diverts attention from the even harder task of improving the availability of services in immigrant communities and making those services accessible. A clinic with providers who speak the same language as the immigrant community where it is located will not be accessible if the community is afraid that showing up at the clinic could lead to deportation. In all nations, therefore, reducing health barriers that immigrants face requires a multisectoral effort to change policies and systems to decrease occupational and other barriers to health, while improving the availability of health care, assuring that the available care is accessible, and enhancing the acceptability of the care that is accessed. Human mobility will continue to increase worldwide as a result of globalization, making these issues relevant across nations for many years to come.

Acknowledgment

Steven P. Wallace was supported in this work in part by the NIH through the National Institute on Aging grant P30-AG021684 for the Resource Centers for Minority Aging Research, and the National Institute of Environmental Health Sciences grant RC1ES018121.

E. Richard Brown was supported in this work in part by funding from the NIH National Cancer Institute and The California Endowment.

The content of this entry does not represent the official views of the NIA, NIEHS, NCI, the NIH, or The California Endowment.

Related Topics

► Access to care
► Discrimination

- ▶ Health determinants
- ▶ Health services utilization
- ▶ Healthy immigrant
- ▶ Language barriers
- ▶ Limited English proficiency
- ▶ Public health insurance
- ▶ Undocumented

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Health Beliefs

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Health beliefs are what people believe about their health, what they think constitutes their health, what they consider the cause of their illness, and ways to overcome an illness it. These beliefs are, of course, culturally determined, and all come together to form larger health belief systems. Different cultures have different definitions of what constitutes health and what causes illness. Culture itself can be defined many ways, but it is basically the characteristics that comprise a group of people's way of life, such as attitudes, beliefs, practices, etc.

Our thoughts and emotions follow our beliefs and create the attitudes, assumptions, expectations, and behaviors that determine how we react to life events and what we think is possible. These underlying belief systems drive our behavior. Similarly, health beliefs influence health behaviors and health outcomes. Results of clinical trials show that participants who received placebos have favorable responses to alleviating many health conditions and symptoms (30–90% of the time) based on their beliefs in the effectiveness of medical treatment. Several other examples include success in the use of hypnosis to control or eliminate a wide variety of unpleasant symptoms based on the power of expectation and attitude toward health. Cancer patients also show spontaneous remissions when their beliefs change or when patients reinterpret their symptoms and alter their attitudes about their lives.

Health beliefs also have a profound effect on the health of the community since beliefs and traditions of community members influence behavior changes targeted through community awareness and intervention programs. The beliefs of those in a community regarding specific health behaviors such as smoking or exercise can influence policy, for example, on whether or not funds will be spent on antismoking legislation, no-smoking ordinances, bike trails, or highway infrastructure. These beliefs also influence the types of food, recreational activities, restaurants, and health services available in a community.

Health-related beliefs and practices among different ethnic groups can produce positive health and well-being and beneficial health outcomes, have serious and harmful health outcomes, or result in no harmful health effects and hence are harmless. Examples of each are provided below.

The popular Western belief, "an ounce of prevention is worth a pound of cure," aptly illustrates the value of prevention – the planning for and taking action to prevent or forestall the occurrence of an undesirable event. Prevention is more desirable than intervention, which is the taking of action during an event or after the event has already occurred. Preventive activities include immunization for childhood diseases, the use of protective clothing or sunscreen to prevent skin cancer, health education and health promotion programs, the use of automotive passenger restraints and bicycle helmets, chlorination of a community's water supply, and safe housing projects.

Cigarette smoking, the largest preventable cause of death and disability in developed countries (and a rapidly growing health problem in developing countries), is a classic example of a behavior for which an ounce of prevention is truly worth a pound of cure. Despite thousands of conclusive studies establishing cigarette smoking as a cause of cancer, and despite the resulting coughing, odor, facial wrinkles, skin discoloration, ostracism, and increasingly socially unacceptable nature of this behavior, smoking rates remain high in certain population groups. Among US youths, in the late 1990s, more than one third of high school seniors reported having smoked during the preceding 2 weeks. Unfortunately, because the debilitating effects of smoking are not visibly present for many years following initiation of the behavior, most individuals are not willing to do the "ounce of prevention" part of the adage.

A different story emerges for those who do quit smoking. Smokers who have quit for up to 5 years soon regain positive health benefits, such as less coughing, better breathing, and life expectancies equivalent to individuals of the same age who have never smoked. An additional benefit to society is purely economic: for every dollar invested in a smoking cessation program, society gets back $10 in terms of decreased rates of tobacco-related morbidity and mortality (or a cost savings of over $50 billion per year at current rates of investment).

Some health beliefs do not themselves lead to negative or positive health outcomes. For example, many cultures equate balance with health and imbalance with illness. Cambodians and Asian Indians, two of the Asian Americans subgroups in the United States, believe that imbalance caused by natural forces or changes in the environment is the basis of illness. They also believe that illness can have spiritual causes. Bangladeshis in London believed the absence of sweating (due to the cold British climate and lack of physical labor) was the cause of diabetes among immigrant Bangladeshis and a reason why the condition improved or disappeared upon return to hot countries. In the same study, 14 out of 18 immigrants agreed that if they returned to Bangladesh, their diabetes might be cured. Such beliefs do not by themselves affect the course of the illness. Rather, their impact depends on whether the individual refuses recommended medical treatment in favor of using only an unproven remedy, such as sweating.

Similarly, some Hispanics or Latinos believe that physical or mental illness may be attributed to an imbalance between the person and their environment. Influences include emotional, spiritual, and social states, as well as physical factors such as humoral imbalances expressed as too much "hot" or "cold." "Cold" conditions are treated with "hot" medications and "hot" with "cold" medications, thus bringing the individual back into balance. Problems that are primarily spiritual in nature are treated with prayer and ritual. Some Hispanics who follow these beliefs may not express them to health professionals. However, Hispanics who use traditional or an ethnomedical approach of treating illness may be troubled by simultaneously using cosmopolitan treatments such as antibiotics, antihypertensive, etc.

Societies and cultures throughout the world are replete with traditional health beliefs and practices surrounding fertility. For example, pregnant women in many Asian cultures are advised that if they eat blackberries their baby will have black spots, or that if they eat a twin banana they will give birth to twins. Such beliefs have their foundation in folklore and traditional practices. Some Vietnamese traditionally believe that disease is caused by an imbalance of the humoral forces of yin and yang. When ill, many Vietnamese may use herbal medicines and a set of indigenous folk practices referred to as "southern medicine" in an effort to restore the yin/yang balance. These practices, from the Western viewpoint, were once thought to pose barriers to health. Recent investigations, however, revealed that certain beliefs and practices predicted neither lack of access to, nor underutilization of health services. In fact, individuals should not be discouraged from placing faith in such beliefs as they may result in positive health outcomes.

Individuals from different religions also hold beliefs that relate to the cause and treatment of illness. For example, some Hindus have a strong belief in astrology and believe that the movement of the planets has a major influence on human life. Many Hindus are strict vegetarians and connect this dietary choice to spirituality. Eating beef is prohibited since cows are considered sacred as they are believed to symbolize fertility and represent life and the sustenance of life. Other meat is not eaten because it involves harming a living creature. In the case of pork, the pig is seen as a scavenger and, therefore, the meat is considered unclean. Chicken and fish may be acceptable to some Hindus. However, food prepared in a medical facility may not be accepted because it may have come in contact with a forbidden food. Similarly, many refuse medication by capsule as cows and pigs are a source for the manufacturing of some capsules. In fact, past research has demonstrated that individuals who maintain vegetarian diets may experience lower rates of heart disease, obesity, and other unwanted health conditions.

However, certain health beliefs and practices result in physical harm or negative health outcomes. Female circumcision, or female genital mutilation as it is known in many industrialized countries (FMG), is a graphic illustration of a health belief and practice with a negative health outcome. Mostly practiced in Africa, the belief is that the practice of FMG ensures virginity and family honor, secures fertility, and promotes the economic and social future of daughters. FMG is also believed to preserve group identity, help maintain cleanliness and health, and further marriage goals, including enhancement of sexual pleasure for men. Some proponents of FGM justify the practice by asserting it “attenuates sexual desires in girls and protects their morals,” while others maintain that it is a “religious tradition.” In fact, it is not a requirement of any religion. The practice of FGM may lead to a range of complications that may occur immediately after the practice or in ensuing years; these complications range from disability to premature death. The practice is also believed to play a significant role in facilitating the transmission of human immunodeficiency virus (HIV) infection through numerous mechanisms. Hence, it is shunned by many international health organizations including the World Health Organization (WHO), and the practice of FGM is currently outlawed in the United Kingdom, Sweden, Belgium, the United States, Canada, Switzerland, France, Denmark, and in some African nations, such as Egypt, Kenya, and Senegal.

Conclusion

Health professionals often experience difficulties in providing care to ethnic minorities because of the disparity between minority and immigrant health beliefs and Western medical systems. The distance between the immigrant and minority health beliefs and Western health belief system appears to magnify the difficulties encountered in any cross-cultural health service delivery setting. It is important that doctors know about the traditional or ethno-medical treatments in order to compensate for affects of these treatments and to foster trust between them and their patients. The belief of many of the Asian and Hispanic subgroups regarding the causation of illness emphasizes social and spiritual dysfunction as causal factors. Management strategies such as preventive care, traditional and ethnomedicine, and the role of traditional healers should be considered for positive health outcomes.

Related Topics

- ► Acculturation
- ► Acculturative stress
- ► Alternative and complementary medicine
- ► Assimilation
- ► Cross-cultural health
- ► Cultural competence
- ► Culture-specific diagnoses
- ► Herbal medicines

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Health Care

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Background

There are over 185 million persons worldwide who live outside their countries of birth. In the USA, immigrants number 33 million or 11.5% of the total population. This level of immigration is unprecedented; even at the highest peak of immigration in the early twentieth century, the number of immigrants was only 40% of what it is today. International migration has also had a major impact on other developed countries. While the USA has the largest number of immigrants, as a percentage of the total population, Australia has the highest foreign-born population, followed by

Canada, Sweden, USA, the Netherlands, Norway, United Kingdom, and Russian Federation. Thus, caring for immigrants has become a near-universal experience for health care professionals in developed countries around the world. To competently and compassionately care for foreign-born individuals, physicians and other health care providers need to develop and apply a specific set of skills. This entry provides an introduction to these skills and additional resources.

It is first important to distinguish between different categories of immigrants, as this affects their legal status and rights and responsibilities. Immigrants are individuals who migrate from their home country because of perceived economic advantages, professional advancement, a desire to join family members, or other reasons that generally do not involve extreme threats to safety or survival. However, many immigrants (especially from Mexico, Central and South America) have experienced war and political violence. The Immigration and Nationality Act (INA), created in 1952, is the basic body of immigration law in the USA. Immigrants are permitted entry through one of many different types of visas. Far larger numbers of immigrants enter without documents, and primarily emigrate for work opportunities. Immigrants, whether documented or undocumented, are not guaranteed the same benefits and services as are refugees.

Refugees are a unique subset of immigrants. A refugee is defined as any person who is outside any country of such person's nationality or, in the case of a person having no nationality, is outside any country in which such person last habitually resided, and who is unable or unwilling to return to that country because of persecution or a well-founded fear of persecution on account of race, religion, nationality, membership in a particular social group, or political opinion. The 1951 Geneva Convention, written in the aftermath of World War II focusing mainly on Europe's displaced population, is the main international instrument of refugee law. The Convention defines who a refugee is and the kind of legal protection, other assistance and social rights he or she should receive from the countries who have signed the document. The Convention also defines a refugee's obligations to host governments. The 1967 Protocol expanded the scope of the Convention as the problem of displacement spread around the world. In the USA, this commitment was codified and expanded with the passing of the *Refugee Act of 1980* by Congress. It also provided for the establishment of an Office of Refugee Resettlement (ORR) within the US Department of Health and Human Services (HSS) to help refugees begin their lives in the USA. The structure and procedures evolved and by 2004, federal handling of refugee affairs was led by the Bureau of Population, Refugees and Migration (PRM) of the US Department of State, working with the ORR at HHS. Each year, the President of the USA sends a proposal to the Congress for the maximum number of refugees to be admitted into the country for the upcoming fiscal year, as specified under section 207(e) (1)–(7) of the Immigration and Nationality Act. In recent years, the number of refugees admitted to the USA has ranged between 40,000 and 80,000 individuals. Worldwide, the number of refugees is estimated to be 16 million, in addition to 26 million internally displaced persons.

There are clear differences in the services provided to refugees and immigrants in the USA. Other countries will vary in the services provided. In the USA, refugees are provided relocation services, including but not limited to housing, job placement and skills training, cash and medical assistance with school enrollment for children, English language training, and aid for victims of torture. Refugees are entitled to free health screening and immunization services that are usually provided at a local health department, English as a Second Language (ESL) classes, and Medicaid (for 8 months). Immigrants who are not refugees are not guaranteed any of these services but may be eligible for some services, primarily related to public health protection, such as screening and treatment for tuberculosis at local health departments. In countries with universal, government-sponsored health insurance, access of immigrants to health care is more favorable.

Health Needs of Immigrants

The health needs of immigrants – both medical and psychological – will vary depending on where the immigrant was born and where he was living before arrival in the "third country," that is, the country of resettlement: the conditions under which he was living, and his access to health care, clean water, shelter, food, and other support at that location. Refugees, because they do not make a voluntary choice to leave their country, generally have been living under more extreme physical and emotional conditions and thus require more intensive screening and health care services upon arrival and for months or years to follow. Immigrants from developing countries will also need screening for certain diseases, such as tuberculosis and HIV.

Clinical Evaluation

A complete history and physical exam should be conducted for every refugee. Patients should be reassured that all information is confidential and is being asked in order to better understand their health status to provide appropriate care. In addition to the usual elements of a history and physical, the history and physical examination should include:

1. Immigration history: country of origin, country of departure, and dates for each move; reasons for leaving the country of origin; history of torture or physical or emotional violence
2. Nutritional status, including growth and development, especially in children
3. Infectious diseases, including screening for diseases common to the refugee's country of origin or transit
4. Mental health, including screening for depression, anxiety, posttraumatic stress disorder, somatization disorder, and substance abuse
5. Health promotion and screening, including cancer screening (Pap smears, mammograms, colonoscopies, etc.)

Physical examination should include height and weight of both children and adults to assess nutritional status. Refugees should be assessed for physical signs related to traditional health practices, such as coining (rubbing coins over the skin), or to trauma and torture. Documentation of all findings is very important, as such documentation may be needed for asylum or legal proceedings. Identification of such findings may also facilitate discussion of this sensitive subject with the patient who otherwise may have denied prior abuse. Examination of the teeth is also important, as dental care among refugees is usually absent and referral to a dentist is a common need.

Laboratory and screening tests should include screening for common infectious diseases including tuberculosis, hepatitis B, intestinal parasites and HIV (adults and children of infected parents). Previous immunization with bacilli Calmette-Guérin (BCG) vaccine should not be considered when interpreting tuberculin skin test (PPD) results. Refugees are required by the Department of Homeland Security to be tested for tuberculosis and syphilis. HIV testing was required until recently. Other useful tests are complete blood count, comprehensive metabolic panel, thyroid-stimulating hormone, and urinalysis. Most refugees have had limited prior access to screening tests. Routine age-appropriate screening should be offered, including Pap smears, mammograms, and colonoscopy. Challenges to providing screening tests will be described in a later section.

Children and adults should be provided with age-appropriate vaccinations. Some refugees may come with vaccination records, but that is the exception rather than the rule.

Children should have additional evaluation for growth and development. Nutritional deficiencies are particularly common among children, including stunted growth and anemia. Additionally, children may have had limited exposure to formal education, and children with developmental delays would likely not have been identified and treated, or may have even been dismissed from school. This evaluation is particularly challenging, especially on initial assessment, and may require discussion with teachers and refugee agency staff over time after resettlement to determine if the child is delayed. Referral to a developmental pediatrician should be made early if there are any concerns.

Many refugees have been traumatized psychologically by their experiences at home and through dislocation and relocation. Common situations include loss of spouses, parents, or other family members to violence or illness; experience personally or through a close relative of torture or physical abuse; loss of home and possessions; and separation from family members and friends. Once resettled in the USA or other final destination, they are faced with a whole set of other stressors, including learning a new language and culture, obtaining a job, earning enough income to provide for their family, and for children, going to school in a new environment. Refugees often come from countries where discussion of emotional distress is considered taboo, and thus identification and treatment of refugee patients with any of these conditions pose considerable challenges. Patients will often present with multiple physical complaints, and once "medical" etiologies are investigated and ruled out, it is necessary to address the psychological basis for the symptoms with the patients, in a culturally sensitive way. It may take several visits to gain the trust of patients with psychological distress and emotional disorders and to negotiate acceptable treatment regimens. Consultation with and referrals to mental health specialists, including psychologists and psychiatrists, should be done when the primary care physician feels such expertise is required. Specialized clinics are available in some cities with large refugee populations, including centers for victims of torture. Often, patients are less interested in "psychological" treatment than in assistance with meeting socioeconomic needs, such as obtaining better employment, and thus the assistance of social workers is essential.

Initial screening of refugees is generally done by health departments, and treatment of some diseases, such as active or latent tuberculosis, may be done by them also. It is important for physicians to learn what services are provided to refugees and immigrants in their communities by the health department and other agencies. Collaboration and sharing of information is the most beneficial approach to providing high quality as well as cost-effective care.

Barriers to Health Care Access: The Patient's Perspective

There are many potential barriers to accessing health care services from the immigrant's perspective. In the USA, refugees receive Medicaid (publicly funded insurance) for 8 months, which is generally extended for children to the age of 18. Unfortunately, some clinicians do not accept Medicaid, and dental care is excluded for adults with Medicaid. In most other developed countries, health care is provided universally, so this should not be a barrier per se. However, barriers to accessing health care extend beyond health coverage, including lack of language fluency and access to trained interpreters, limited education and literacy in their own language, lack of knowledge as to where to go for health care, lack of knowledge about what conditions require medical attention, when to use the emergency room versus going to a primary care physician, lack of transportation, and fear of losing employment to take time off from work to see the doctor. Seeking help for emotional problems is taboo for many cultures and thus presents unique barriers.

Barriers to Health Care Access: The Clinician's Perspective

Physicians and other health care providers often find caring for immigrants challenging. Much of the challenge is related to the more obvious communication barriers. Working with trained interpreters requires training and experience on the part of the clinician. In addition, interpreters are very costly. Larger hospitals and health systems are more likely to have access to interpreters, either in person, or through language lines, than smaller hospitals and practices due to the cost. All communication with limited English (or other dominant language of the respective location) proficient (LEP) patients requires more time, and more complicated exchanges, such as informed consent for procedures, will require even more time and patience. Follow-up communication (e.g., conveying lab results and instructions) is more difficult, and patient education materials in multiple languages may not be easily available for all conditions for which they are needed. Add to that the challenges of learning about different cultures, tropical diseases that the clinician hasn't thought about since medical school, and psychological and physical traumas that are painful to address. Physicians often identify caring for chronic diseases and health screening as particularly frustrating areas, as refugee and immigrant patients often have not had experience with chronic disease management or preventive screening and thus do not always accept these services or return for follow-up appointments. Finally, physicians do not always understand the legal rights and responsibilities of immigrants and refugees, or the services available to them in the community.

Cultural and Linguistic Standards and Laws

In the USA, title VI of the Civil Right Act (1964) states that "No person in the United States shall on the ground of race, color or national origin, be excluded from participation in, be denied benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance." In 2000, President Clinton signed into law an executive order "ensuring that LEP persons who are eligible for Federal programs and services have meaningful access to the health and social service benefits that they provide and that this access must be at no additional cost to the LEP person."

In 2001, National Standards on Cultural and Linguistically Appropriate Services (CLAS) were developed by the Office of Minority Health, US Department of Health and Human Services. The CLAS standards are primarily directed at health care organizations; however, individual providers are also encouraged to use the standards to make their practices more culturally and linguistically accessible. The principles and activities of culturally and linguistically appropriate services should be integrated throughout an organization and undertaken in partnership with the communities being served. The 14 standards are organized by themes: Culturally Competent Care (Standards 1–3), Language Access Services (Standards 4–7), and Organizational Supports for Cultural Competence (Standards 8–14).

Within this framework, there are three types of standards of varying stringency: mandates, guidelines, and recommendations. CLAS mandates are current Federal requirements for all recipients of Federal funds (Standards 4, 5, 6, and 7). These standards are:

Standard 4: Health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.

Standard 5: Health care organizations must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.

Standard 6: Health care organizations must assure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/consumer).

Standard 7: Health care organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.

Thus, interpreter and translation services must be provided, by law, at any health care organization receiving federal funding, without cost to the patient. Federal funding includes Medicare and Medicaid. Agencies in the community assisting LEP clients are generally aware of these requirements and will advocate locally for these services to be provided to patients receiving care.

Training and Licensure Requirements

The Liaison Committee on Medical Education (LCME) sets the standards for medical education in the USA; two standards are specific to working with patients from diverse cultures:

ED-21: The faculty and students must demonstrate an understanding of the manner in which people of diverse cultures and belief systems perceive health and illness and respond to various symptoms, diseases, and treatments.

ED-22: Medical students must learn to recognize and appropriately address gender and cultural biases in themselves and others, and in the process of health care delivery.

The Accreditation Council for Graduate Medical Education (ACGME) and Institute of Medicine have recommended that cultural competency education be part of residency training. A recent survey of over 8000 residency programs in the USA demonstrated that just over 50% of programs are now providing this education. A number of residency programs also offer specialized tracks in health disparities, global health, and care of immigrants, and new fellowship programs in immigrant and global health are emerging. In 2008, the State of New Jersey enacted legislation requiring all colleges of medicine in the state to provide cultural competency training as a condition of receiving a diploma. All license renewals will require continuing medical education training (6 hours) in cultural competency. Other states are following suit. This new emphasis on cultural and linguistic competency in medical education will assist new and practicing physicians in acquiring the skills they need to provide care to the growing number of immigrants they will serve.

Core Values in Immigrant Medicine

Patricia Walker and Elizabeth Barnett, in their introduction to *Immigrant Medicine* (2007), identify a set of core values that should be practiced by providers working with refugees and immigrants: global health equity, respect, trust, cultural humility, and compassion. Physicians can learn a lot from listening to their patients' stories, and develop mutual respect and trust that is essential for an effective therapeutic alliance. When the challenges of caring for immigrant patients seem overwhelming, stepping back, reflecting on their patients' traumatic experiences and enormous strengths in surviving adversity most Western physicians have never seen, will help the clinician in overcoming these hurdles and lead to a more fulfilling and successful partnership.

In addition to these core values, an important role for physicians and other health providers is that of advocate. For example, advocating for health insurance reimbursement for interpreter services leading to legislative changes can help cover the expense of interpreter services and contribute to better communication. Eleven states in the USA (as of 2005) allow reimbursement for interpreter services provided for Medicaid and State Children's Health Insurance Program (SCHIP) enrollees. These include Hawaii, Idaho, Kansas, Maine, Massachusetts, Minnesota, Montana, New Hampshire, Utah, Vermont, and Washington. Physicians can also advocate within hospitals for better interpreter services, cultural competency training, and translated education materials. There is no limit to what is possible with perseverance and imagination.

Collaboration is Essential in Immigrant Health Care

Finally, two desirable, if not essential, components to providing effective and compassionate care for immigrants are collaboration and teamwork. Ideally, the physician will be a member of a team of health care providers consisting of other physicians (e.g., psychiatrists, developmental specialists, infectious disease specialists), nurses, social workers, psychologists, community agencies and volunteers, public health department personnel, interpreters, health educators, and teachers. An example of this model is the International Family Medicine Clinic (IFMC), founded at the University of Virginia (UVA) in 2002. In partnership with the International Rescue Committee (IRC, refugee resettlement agency) and the Charlottesville-Albemarle Health Department, the IFMC provides primary health care services for all refugees resettled in Central Virginia by the IRC. The IRC, with informed consent by the patient, provides the overseas medical examination to the IFMC. The Health Department, which conducts the initial screening of refugees, sends all results of testing to the IFMC, where identified illnesses are treated (except for active and latent tuberculosis, which are managed by the Health Department). Quarterly meetings are held with these partners, plus the IFMC social worker, the UVA language office director, and other health and nutrition agencies that work with refugees in the community, to share information and optimize care. Resident trainees provide care to the refugees. An entire curriculum in refugee and immigrant health and cultural competence has evolved from this. Further, a new Global Health Leadership Track provides additional refugee and global health training for residents in Family Medicine and Internal Medicine. Physicians in smaller practices without access to a university can develop immigrant health collaborative teams using available resources in their communities.

Related Topics

- ▶ Cultural competence
- ▶ Cultural humility
- ▶ Immigrant visa status
- ▶ Immigration status
- ▶ Irregular immigration
- ▶ Limited English proficiency
- ▶ Medicaid
- ▶ Medical examination (for immigration)
- ▶ Refugee
- ▶ Refugee health and screening
- ▶ Refugee resettlement
- ▶ Refugee status
- ▶ Trauma exposure

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Health Care Access

- ► Access to care
- ► Health barriers
- ► Health care utilization

Health Care Seeking

- ► Health care utilization

Health Care Utilization

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Health status is a critical issue in defining the state of a society's welfare. Health status is dependent on numerous factors, including the availability and utilization of health services. In an ideal world, everyone would be able to access any kind of medical service, any type of medical procedure, treatment, or drug. However, in the real world in which we live, access to health care is mediated by factors such as the individual's or family's income, the availability of medical insurance, the patient's preferences and beliefs, culture, doctor–patient relations, patient education, institutional practices and policies, discrimination, and other factors. These factors, as well as others, may constitute barriers to accessing health care producing disparities across groups.

Immigrants often decide to leave their countries of origin due to the poor quality of living, reflected in their income, food availability and quality, health care availability and quality, life security, etc. They want a better life, better material conditions, and a safer and healthier life. Accordingly, immigrant utilization of health care services has become the focus of much discussion in recent years, particularly in those countries in which immigrants constitute a large proportion of the population or in which there is a large and growing influx of immigrants. For example, researchers reported that there were about five million immigrants to Canada during 2000–2001 representing approximately 18.4% of the population at that time.

Health status is strongly dependent on the utilization of medical services, of health care. Health care utilization can be primarily defined as the rate of accessing medical services by individuals. Health care utilization is often measured by the number of physician visits, hospital nights, and bed disability days, the use of home health services, and the use of other health professionals.

Several models have been proposed for use in examining health care utilization. A frequently utilized behavioral model developed by Andersen and colleagues explains health care utilization in terms of the propensity to use services. This model specifies that health care utilization depends on three sets of factors: predisposing factors, enabling factors, and need factors. Predisposing factors include sex, age, and social status. Enabling factors consist of the conditions facilitating or inhibiting the use of medical services, such as the distance to the health center, the type of municipality, the hours during which the health facility is open, and the family size. Need variables include the presence of disease or illness and psychological status.

Sociodemographic characteristics such as sex, race, residential area, geographical area, parental status, marital status, work status, income, education, insurance, and age may constitute barriers to health care utilization. Particular attention has been paid to the effects of race and ethnicity on health care utilization. It has been reported, for example, that Mexican Americans use medical services less often than White and Black non-Hispanics and other Hispanics.

Language is also a very important factor in accessing and utilizing health care after migration to a new country. As the welfare of the immigrant in the new country is often strongly dependent on the immigrant's ability to integrate into the new society, poor language skills in the language of the new host country is a barrier to the receipt of health care services.

The extent of similarities and differences between the immigrant's home culture and that of the receiving country is also an important factor in the extent of health care utilization. The extent to which the immigrant retains his or her own culture and adopts the culture of the new country, known as the process of acculturation, has been found to be associated with various health behaviors and with health care utilization. Past research has demonstrated a strong effect of acculturation on weight and diet, smoking, substance use, cancer screening, hypertension, AIDS risk, compliance with treatment, and alcohol use.

Women, in particular, may confront difficulties in accessing health care services. In some cultures, women are considered inferior and/or are expected to place the health concerns of their family members before their own. As a consequence, they may not seek out and utilize the health care services that they need, such as screening for particular diseases.

Health care service utilization requires a certain level of knowledge. That is, an individual may not utilize a service unless he or she is aware of its existence, its purpose, and its importance. As an example, researchers have found that immigrants may often rely on hospital emergency departments for their medical care in order to see a specialist, not understanding that, at least in the USA, access to specialist care often requires a referral from a primary care physician. As yet another example, immigrants may be less likely than native-born individuals to utilize preventive care services, such as disease screening, because they are not suffering from pain and do not have any symptoms.

An individual's income is an important determinant of health care utilization. Studies have shown that individuals' access to health care dramatically decreases with a decrease in income. The availability of health insurance is also critical, particularly in those countries in which access to government-funded health care is limited, restricted, or nonexistent. Immigrants may encounter greater difficulties in attempts to utilize health care services because of restrictions on noncitizens' access to governmentally funded health care and the unavailability of employment-based health care insurance.

Individuals may be reluctant to utilize health care services because of their immigration status. If they are present in a country illegally, they may fear that utilization of health care services will result in greater visibility and ultimately lead to their removal back to their country of origin. In some cases, immigrants may rely on more traditional healing remedies, such as plants, teas, and faith in lieu of Western medicine, specifically in order to avoid coming to the attention of immigration authorities. This fear may be exacerbated in smaller towns in which immigrants are more visible as a function of the lesser populace. Governmental legislation may also result in heightened fear of discovery among immigrants needing medical care. As an example, California's (U.S.) Proposition 187 had mandated that health care providers report to immigration authorities any patients who appeared to be present in the country illegally and also limited immigrants' access to health care. The passage of this law heightened immigrants' fears of deportation as a result of seeking health care and, as a result, potentially presented a threat to the public health because of the nontreatment of infectious disease. That legislation was later held to be invalid when it was challenged in court.

Related Topics

- ► Access to care
- ► Disease prevention
- ► Health beliefs
- ► Health care
- ► Health determinants
- ► Health literacy
- ► Health status
- ► Immigrant visa status
- ► Undocumented
- ► Women

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Health Disparities

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Researchers and practitioners have differing opinions on what constitutes health disparities and consequently a consensus definition has not been achieved. In the USA, the common terminology is health disparity while the terms "health equality" and "health equity" are used more frequently in other nations. Common characteristics of health disparities include a chain of events that signify a difference in (1) environment, (2) access to, utilization of, and quality of health care, (3) health status, or (4) a particular health outcome. Assessing the lack of quality of health care and the inability to access adequate care are the prominent measurements of health disparities. Disparity, inequality, and inequity often used interchangeably; however, keen differences exist between these important health terms. Health inequity refers to health differences that are unnecessary, unavoidable, unfair, and unjust. Disagreements concerning the definition of health disparity and the usage of other public health terms can hinder the development of health interventions.

Health disparities are usually determined by either structural biases or uncontrollable circumstances which inhibit vulnerable populations from receiving the care they need. These biases and circumstances can be noted in the seven determinants of health disparities; (1) natural or biological; (2) voluntary health-damaging behavior; (3) the health advantage of one group over another when a health-promoting behavior is adopted; (4) a health-damaging behavior that is chosen due to limited lifestyle choices; (5) exposure to unhealthy and dangerous living and working conditions; (6) inadequate access to health care and basic services; and (7) health-related social mobility. In order to eliminate health disparities, health care quality must be effective, safe, timely, equitable, and efficient. The health of a population can be measured by indicators that exhibit mortality, well-being, lifestyle behaviors, and health-related risk factors. These indicators are useful criteria for identifying health disparities among groups. Groups who suffer from health disparities include racial/ethnic minorities, uninsured individuals, and residents of rural areas.

Race and Ethnicity

Race and ethnicity have emerged as factors in identifying and remediating health disparities. Minorities when compared to their nonminority counterparts are at increased risk for mortality and morbidity. In 2005, African Americans had a higher rate of infant mortality than any other racial group at 13.63 infant deaths per 1,000 live deaths. They also undergo twice the number of outpatient department visits and emergency department visits (63.5 visits per 100; 79.9 visits per 100 persons) than Whites (31.3 visits per 100 persons; 36.3 per 100 persons). In 2007, 6.8% of African Americans were significantly less likely than Whites (14.7%) to receive mental health treatment or counseling.

African American patients also visited the emergency room within 7 days of discharge from the hospital more often than Whites. This could demonstrate distinct differences during inpatient care and/or follow-up care based on race. Hispanics, the largest immigrant group in the USA and one-third the population are the most likely of any racial minority group to be uninsured and low income, being 30% more likely to lack health insurance than Blacks or Whites. Sixty percent of Hispanics are known to be uninsured for a significant amount of time. In 2007, the overall mortality of African Americans was 25% higher than that of Whites, due to health concerns such as diabetes, heart disease, stroke, HIV, and cancer.

Minorities have long suffered from psychosocial stressors associated with racial and ethnic discrimination. Bias and discrimination occurs in any social system and the health system is not exempt. The Tuskegee Syphilis Study initiated in 1932 by the U.S. Public Health Service studied the progression of syphilis in African American men in Macon County, Alabama among 600 poor African American sharecroppers suffering from the sexually transmitted infections. This study, historically designated as unethical, serves as a case for examination of the detrimental effects of discrimination. This incident has influenced many minorities to have negative views toward public health services and preventative programs. Racial/ethnic health disparities continue to persist. Minority health disparities not only disclose the association between vulnerable populations and health care but also the link between racial discrimination and health status.

Reducing racial health disparities is a priority for The American Medical Association (AMA) and the National Medical Association (NMA). Despite their conflicting histories, they are committed to collaborating on eliminating racial injustice in health disparities. Many other organizations including the AMA have put forth great effort to recruit minority physicians by implementing math and science programs in certain communities and funding minority medical programs.

Gender

Health differences as they pertain to gender affect our perception of gender stereotypes and gender equality. Mental health is one area in which there is a major gender gap. Mental health disorders have affected women disproportionately. Depression and posttraumatic stress disorder (PTSD) have been known to affect women in larger numbers than men. Women are also predominately affected by a comorbidity of mental disorders. According to the World Health Organization, depressive disorders account for almost 41.9% of the disability from neuropsychiatric disorders among women compared to 29.3% of men. These disabilities can possibly result in physical ailments as well as a longer and stronger dependency on psychotherapy and medications. In 2007, it was reported that 53.3% of women were more likely to use prescription drugs than 43.2% of men. Men on the other hand are most likely to be diagnosed with antisocial behavior disorder and alcoholism than women. In addition to mental health, other health status indicators may show gender variations as well.

Health Insurance

The lack of insurance benefits is a major problem for majority of children, women, and elderly population. In 2006, there were 43.6% of Americans were uninsured, many of whom lived within an urban area, had lower incomes and were of minority status, or immigrants. The growth of the uninsured population consists mostly of individuals between the ages 18 and 64 who are employed. In 2007, one-third of people under 65 years of age, with a family income 200% below the poverty line, were uninsured for at least 12 months compared to higher income families, prior to being interviewed. Being uninsured compromises the health of millions and can lead to serious illness that could have been treated by early diagnosis and treatment. Those who are uninsured are more likely than insured individuals to be disproportionately affected by health disparities. Uninsured individuals are six times more likely to lack a usual source of care and four times more likely to be without a usual source of care due to financial reasons. Individuals with no insurance are twice as likely to visit the emergency room as insured individuals. Without a continuous source of care, uninsured individuals are the most likely to receive lower quality care and have illnesses difficult to manage. The lack of health insurance affects the delivery of emergency care, prenatal care, and childhood illnesses. Uninsured women and children may be at particular risk that causes many preventable and treatable illnesses to become chronic illnesses and even become fatal. Not only do those who are uninsured spend a higher amount out of pocket to cover health expenses, they are often charged full price for health care services. While other countries may have different mechanisms other than the US model of insurance to protect the population, not all groups can be assured of adequate and appropriate medical care and this variability may create disparities in access to care.

Geography and Residency

Residency is of great importance to public health and to the study of health disparities. Where vulnerable populations reside affects their access to health services, employment, and educational opportunities. Research of health disparities in urban, rural, and other subareas is an evolving area of study. Neighborhood studies have shown that those who reside in urban areas, for example, tend to reveal health disparities. Today the majority of the world's population lives in urban areas, in both high- and low-income countries. Most commonly seen in urban areas are issues of: air pollution, mental health disorders, communicable diseases such as tuberculosis, malaria, and whooping cough, and non-communicable diseases such as heart disease, diabetes, and obesity. Urban areas are most often associated with future technology, employment, and favorable lifestyle, thus are often chosen over rural communities as places to live. These benefits of urban living come with the cost of higher rates of mental illness, homicide, and physical health problems.

As urban areas continue to grow, so does the presence of urban dwellers. Urban dwellers are individuals who live in slum areas and are affected by the inadequate infrastructure and health issues of urban areas. There are more than a billion urban dwellers living in overcrowded areas heavily impacted by urban health issues such as traffic, violence, and crime. Ethnoburbs are suburban areas that emerge around large cities where there are significant growth of immigrants or ethnic group. The increase in migration toward ethnoburbs are concentrated mostly in the South, Midwest, and the Plains states. They are a newly acquired settlement recognized in racial/ethnic urban studies. Suburban and rural communities are also seeing an increase in immigrants. Suburbs are seen as urban areas as well, however, they are comprised of two elements: rurban and exurban areas. Rurban areas are most often low class and near poverty areas while exurban areas are clusters of developments right outside of the city limits. Suburbs are highly variable due to its increase in ethnic diversity. Rural areas are most affected by geographical isolation and limited job opportunities. Rural areas make up 20% of the American population, have fewer practicing physicians, and are less likely to be insured. Rural areas are more likely to have higher mortality rates, higher rates of chronic health conditions and suicide. With their limited resources and declining population, rural areas are in need of more efficient strategies, such as lowering health care costs, improving access to health services, and the implementing advanced technology.

Immigrants

Immigration reveals a complex relationship to health disparities. Immigrants are often healthier than their counterparts in their country of origin; referred to as the "healthy immigrant concept." However, the length of immigrant residency has been shown to have a major impact on the health of immigrants. When immigrants arrive, their health is most likely to be equivalent those of their home country. As time of residency increases in a new country, health outcomes tend to shift toward those of the host country. Immigrants have a rather unique experience regarding health care. As immigrants arrive in new countries, they are presented with drastic lifestyle changes. They often face opposition in new countries, where they may be perceived responsible for straining the infrastructure of the host country and inappropriately using health resources. The vulnerability of immigrants is influenced by residential location, proficiency in the English language, and immigration status. According to a 2007 study, immigrants overall have lower rates of health insurance, use less health care, and receive lower quality care.

Health disparities related to immigrant status are much more distinct in the USA, as Latinos make up the largest immigrant population. Prior to 1996 immigrants were able to receive Medicaid health care benefits; however, since then the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) has restricted immigrants from applying. The law requires immigrants to wait 5 years after being granted permanent residence to apply for federal health benefits. As a result, this federal law exacerbates rates of the uninsured. The primary sources of care for immigrants are community health centers and public clinics. Even so, these particular clinics are sparse in suburban and rural areas which have an influx of immigrant populations. For the estimated 12 million immigrants who reside in the USA illegally, fear of deportation prohibits them from seeking appropriate health treatment. The lack of health services available to uninsured immigrants' increases overall health care costs for everyone as well as puts individuals at risk for diseases and infections. With a majority of immigrants being of Hispanic descent, race plays a major role in health disparities. Hispanic immigrants make up one-third of the US population, making them the largest growing immigrant group in the nation. However, this growing group of immigrants faces a problem in obtaining quality health care. Their immigrant status, especially when undocumented, has a detrimental effect on their ability to access health care and insurance.

Initiatives

Eliminating health disparities has become a great challenge to researchers, practitioners, and policy makers. Health policy, health literacy, and research are three main areas in which reforms are being sought to address nationwide health concerns. Health literacy is the capacity to obtain process and understand basic health information needed to make health decisions. It is not only the ability to read, but the ability to interpret and understand health issues. Health literacy allows the ability to accurately read prescriptions and calculate the dosage. Low health literacy has been linked to higher rates of hospitalization and emergency services. The American Medical Association, one of the many organizations addressing health literacy, has specific tools and techniques to improve health literacy and patient–provider communication. Further, the AMA is using its partnerships with other organizations to reach out to patients and provide health literacy resources.

Government initiated health policies are also working to impact health disparities. Healthy People 2010 initiated by the Department of Human and Health Services in 2000 profiles the health concerns of the nation. This report contains over 450 objectives to improve the health of people throughout the nation. Two of their overarching goals are to increase quality and years of healthy life and eliminate health disparities. This initiative has been successful in highlighting health disparities among groups across the nation and establishing goals for the nation's health. The World Health Organization adopted Health for All by 2000 in 1981, an initiative to address health disparities and improve the health of the most vulnerable groups through policy, economics, and direct services across the world.

Insurance retention policy is one factor in closing the gap to health disparities. Insurance retention requires the insured to pay a small portion of an insurance claim, which reduces insurance premiums. This established policy designs programs for vulnerable populations improving the quality and access to health care as well as ensure family care. Insurance retention reaches those in need and helps lower rates of mortality and chronic and acute illnesses. It allows those who are insured to stay insured and reaches out to those who are uninsured as well. With many of the uninsured being noncitizens, racial or ethnic minorities, or of low income, language, discrimination, and health expenses and are becoming significant barriers. It is important that health care providers provide translational services to help non-English speakers, racial and ethnic minorities, and low-income populations to receive the best care possible.

These initiatives are providing a foundation for stronger implementation of further policies and practices to eliminate health disparities. However, there is still more work to be done in order to achieve success in elimination of health disparities.

Conclusion

Health disparities affect millions of people worldwide. Health disparities are manifest in race, ethnicity, gender, insurance status, geographical location, and immigrant status. Public health practitioners, policy makers, and researchers working together to reduce the risks of health disparities in all populations demonstrate that multifaceted approaches are indicated to eliminate health disparities. These efforts command long-term and sustaining interventions. Immigrants worldwide experience multiple conditions that predispose them to health disparities and their circumstances deserves special attention. Elimination of health disparities requires long-term approaches that sustain local efforts in specific populations such as immigrants, countries, and social context.

Related Topics

- ► Built environment
- ► Discrimination
- ► Health determinants
- ► Health literacy
- ► Mortality and morbidity
- ► Poverty
- ► Race
- ► Racism

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Health Education

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Formal health education is any combination of planned learning experiences that help individuals, groups, or communities gain the information and skills they need to make informed decisions about their health, safety, or well-being and act on those decisions. It is an educational process with approaches that individuals, families, and communities can use in making voluntary and free choices regarding health-related behaviors or lifestyle matters. The decisions might involve individual lifestyle choices such as what to eat or they might involve ways to create changes that will make communities healthier and safer. Such changes might include policies such as tobacco-free public areas or community activism such as creating safe places for being physically active, ridding neighborhoods of illegal drug pushers, or improving the quality of foods served in schools.

Typical settings for the delivery of health education are schools, colleges and universities, community agencies, health care settings, workplace settings, and governmental and nongovernmental agencies/organizations at the local, state, regional, federal, and international levels. Regardless of setting, quality health education consists of the development, delivery, and evaluation of planned, sequential, and developmentally appropriate instruction, learning experiences, and other activities. The purpose of health education is to influence in a positive direction the health behavior of individuals and communities as well as the living and working conditions that influence their health.

Many people and systems provide health education. Families are one's first health educators. In schools, teachers, school nurses, and peers often provide health education. Sources of health education in the community include neighbors and friends, grocers, the media, and health care providers in addition to formal programs that might be conducted in community centers, places of worship, and worksites.

Professionally prepared and trained health educators draw from the biological, environmental, psychological, physical and medical sciences to promote health and prevent disease, disability and premature death through education-driven behavior change activities and policy interventions. Several organizations support the health education professional, including: the American Association for Health Education (AAHE), the American School Health Association (ASHA), Eta Sigma Gamma (ESG), the Society for Public Health Education (SOPHE), the International Union of Health Educators and others. The International Union for Health Promotion and Education, with regional offices across the globe, promotes global health and contributes to the achievement of equity in health between and within countries of the world.

The National Commission of Health Education Credentialing, formed in 1988, drew upon competencies identified through a role delineation project to create and implement a credentialing system for the profession. The competencies serve as the basis for the examination the Commission uses to determine who is eligible to be a Certified Health Education Specialist (CHES). The Commission introduced in 2011 a Master Certified Health Education Specialist (MCHES) designation that reflects advanced competencies in health education. The competencies expected of professional health educators are arranged into the following seven areas of responsibility: Area I: Assess Individual and Community Needs for Health Education; Area II: Plan Health Education Strategies, Interventions, and Programs; Area III: Implement Health Education Strategies, Interventions, and Programs; Area IV: Conduct Evaluation and Research Related to Health Education; Area V: Administer Health Education Strategies, Interventions, and Programs; Area VI: Serve as a Health Education Resource Person; Area VII: Communicate and Advocate for Health and Health Education.

Professional Preparation Programs

Professional health educators have a minimum of a bachelor's degree. An estimated 250 institutions of higher education in the USA offer professional preparation programs in health education. The names of the academic departments housing the discipline and the degrees they confer vary – health education, health communication, health science, public health education, and health promotion. Many larger universities offer masters or doctoral degrees in Health Education.

A typical course of study in Health Education includes content courses, such as: adolescent health, aging, consumer health, death and dying, fitness, human diseases, drugs and society, human sexuality, nutrition, and safety. In addition, Health Education majors take process courses such as: teaching health in secondary schools, community health methods, theory of behavior change, public policy, program planning, program evaluation, and research methods. Together, with a core of science and humanities, the required content and process courses provide graduates with both knowledge about health issues and skills for effectively facilitating learning.

The Promotora is a valuable collaborator with the professional health educator. Frequently found within Hispanic populations, the promotora shares a cultural bond and common language with a community. Thus, some immigrants are more receptive to and less skeptical of a promotora than the classic health educator. In some instances the promotora has training in specific health content or community education. A few community colleges in the USA offer an Associate's Degree for promotoras and states, such as Texas, license these paraprofessionals.

School Health Education

School health education addresses the physical, emotional, and social dimensions of health tailored to students' age and developmental levels. The ultimate goal is to motivate and assist students in maintaining and improving their health, preventing disease, reducing health-related risk behaviors, and being informed consumers of health services and products both now and when they become adults. Intermediate goals include developing students' health literacy and facilitating their acquisition of the knowledge and skills they need to make health-enhancing decisions. Health literacy involves being critical thinkers and problem solvers, responsible and productive citizens, self-directed learners, and effective communicators. School health education is one aspect of a school's health program that includes curricular, environmental, and support systems, programs, and policies that contribute to the health and safety of students and school employees.

Within elementary schools, classroom teachers, school nurses, and physical education teachers frequently provide instruction about health. At the secondary level, many schools offer separate health classes taught by professionally prepared health educators; other schools integrate health education into other subject matter; and some do both. Students receive more content and quality when a separate health course is taught by trained health education teachers than when health education is integrated into other subjects.

National standards exist for school health education; many states also have guidelines for what schools should teach about health. The US Centers for Disease Control and Prevention (CDC) reviewed school health education programs and identified characteristics of those that were effective in addressing behaviors that promote or compromise health, many of which would apply to health education provided in any setting. Those characteristics, among others, include being research-based and theory driven as well as incorporating learning strategies, teaching methods, and materials that are culturally inclusive.

Culturally inclusive curricular materials are free of culturally biased information, but also include information, activities, and examples that are inclusive of diverse cultures and lifestyles (such as gender, race, ethnicity, religion, age, physical/mental ability, and appearance). Strategies promote values, attitudes, and behaviors that acknowledge the cultural diversity of students, optimize relevance to students from multiple cultures in the school community, strengthen students' skills necessary to engage in intercultural interactions, and build on the cultural resources of families and communities.

Among immigrant families coming from non-Western cultures, school health education often introduces both the student and the students' family to Western concepts of disease and health promotion. Within immigrant communities, a disconnect sometimes occurs between the health understandings and messages of the originating community and those of the destination community, reflecting different understandings of disease causation, ways to protect oneself, and sources of healing. Culturally competent health education starts with the assumptions people have regarding health and healing and builds from there in helping them gain the knowledge and skills they need to make health-enhancing decisions and act on those decisions.

School Health Education Project – Bienestar – is an example of a school-based intervention found effective in reducing risks for developing diabetes that is tailored to low-income 4th grade Mexican American students is the *Bienestar* curriculum, consisting of a bilingual parent education and involvement program, a classroom health and physical education curriculum, a student after-school health club, and a school cafeteria program. The Health and Physical Education Program consists of 16 lessons with sections on physical activity, nutrition, wellness, and diabetes. The purpose of the curriculum is to develop knowledge and skills necessary to engage in moderate and vigorous physical activities and adopt healthy dietary behavior. The *Bienestar Health Club* involves after-school learning activities for students aimed at rehearsing and reinforcing the knowledge and skills learned through *Bienestar* classroom-based instruction and promoting leisure time moderate to vigorous physical activity. The parent involvement program reduces the disconnect between health education in the school curriculum and family messages and practices.

Community Health Education

Health educators assist communities in identifying needs, drawing upon problem-solving abilities, and mobilizing resources to develop, promote, implement, and evaluate strategies to improve health. Such strategies include, but are not limited to: community organizing, grant seeking, coalition building, advocacy, and health communication. In a clinic setting, health educators provide patient education, counseling individual patients and helping them understand their health conditions and what they need to do to improve their health and care for themselves and their families linguistically as well as culturally and within their social/familial context. They also provide group educational programs and materials that patients can access while waiting for appointments.

Community Health Project: A Smoke Free Paso del Norte Initiative

The Smoke Free Paso del Norte Initiative is one example of an initiative with multiple programs designed to complement one another for a common health benefit and that is relevant to Mexican American Immigrants. Established by the Paso del Norte Health Foundation 1999, the initiative triangulates health education programs that provide smoking cessation, ones that address prevention of tobacco use among youth, and advocacy for clean indoor air policies. Central to the initiative is a coalition of tobacco control advocates.

The following illustrates how this successful initiative used the seven responsibilities of health educators:

Area I: Assess Individual and Community Needs for Health Education

To determine what exists and what is desired, the project started with a needs assessment that included a survey using a modified version of the Adult Tobacco Survey (ATS) and a review of data from the state's Behavior Risk Factor Surveillance System (BRFSS). By comparing these data (what exists) to *Healthy People 2010* goals (the desired), the coalition determined a need for both prevention and cessation services. The data also provided reference points for evaluation. An assessment of the policy landscape indicated the need and potential opportunity for a clean indoor air ordinance.

Area II: Plan Health Education Strategies, Interventions, and Programs

Over a period of 6 months, the Paso del Norte Health Foundation planned an overall health education strategy and placed it within an initiative strategic plan. The overall approach chosen for tobacco control was the social–ecological model. Planning involved setting region-wide tobacco control goals, and recommending an optimal mix of programs to achieve results.

Each partner agency planned a program to advance the initiative's goals related to the reduction of tobacco use among the primarily Mexican American population in the Paso del Norte region. Some partners custom-designed health education programs such as health communication campaigns for both prevention of initiation and cessation. Other partners adopted an evidence-based program such as the American Lung Association's NOT Program or modified evidence-based programs to fit the needs of Mexican American immigrants within the region.

Area III: Implement Health Education Strategies, Interventions, and Programs

Implementation required financial resources, collaboration, and culturally competent health educators. Skilled educators delivered smoking cessation programs for both adults and youth, produced advocacy materials about a clean indoor air ordinance for use with policy makers, and lead a coalition of partner agencies to leverage resources. An external advertising company implemented the media campaigns.

Area IV: Conduct Evaluation and Research Related to Health Education

The Foundation contracted with external health education experts who had experience in both tobacco control and evaluation. The external evaluators monitored ATS and BRFSS data; observed implementation of health education programs; conducted cost-analysis for cessation media and focus groups for prevention media; and evaluated the coalition's activities, including advocacy activity. The Paso del Norte Health Foundation and the partner agencies used the formative, process, impact, and outcome level data to improve programs, document success, and, when necessary, close ineffective programs.

Area V: Administer Health Education Strategies, Interventions, and Programs

Each program had budgets, timelines, and personnel. A health educator was responsible for the overall administration of a program including preparing periodic reports to funding agencies, adjusting program delivery, making human resource decisions, and overseeing the work of contractors. The health educator shared program administration with an accountant who tracked the finances.

Area VI: Serve as a Health Education Resource Person

The coalition for A Smoke Free Paso del Norte served as a resource for professional health educators to access the latest information about tobacco control. In turn, these health education partners served as resource people within their own agencies and with the public. Each health education partner knew where to refer smokers for cessation services and could provide information about other health education tobacco control programs.

Area VII: Communicate and Advocate for Health and Health Education

Health educators involved in the initiative shared the model used for and the results from A Smoke Free Paso del Norte with professional audiences at conferences and in publications. Partner agencies communicated with one another and received evaluation results, thus promoting continued dedication. The public received various messages in the newspaper and on websites about the initiative structure, results, and plans for the future. The Foundation and the partners designed special communications for key stakeholders, including policy makers and funders.

Culturally competent, professionally trained health educators impart knowledge, develop skills, and empower individuals and communities to take actions that will improve health and safety for individuals, families, and communities. For immigrant populations, cultural competence requires that the health educator identify the populations and subpopulations to include and key opinion leaders in those populations. Those opinion leaders can help the health educator understand the cultural beliefs about disease causation and find or create culturally appropriate interventions. The health educator, in turn, can help immigrants navigate the US health care system, understand how to care for their health conditions in a new environment, and interpret health messages so they are comprehensible.

Health education helps individuals, groups, or communities gain the information and skills they need to make informed decisions about their health, safety, or well-being and to act on those decisions. In addition to professionally prepared health educators, those who contribute to those planned experiences can include the media, promotoras, health care providers, public health practitioners, teachers and counselors, youth leaders, and key community opinion leaders such as clergy. Health education provides a mechanism for immigrant families to engage in healthy behaviors and healthy communities in their new country.

Related Topics

- ► Cultural competence
- ► Health literacy
- ► Health promotion
- ► Promotora
- ► Public health
- ► Tobacco control

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Health Insurance

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Health insurance is the primary payment for health services in the USA and is generally noted as private insurance or government insurance. The purpose of insurance is to provide protection against risk. Risk refers to the possibility of substantial financial loss from event of which the probability of occurrence is low. As a financing mechanism, health insurance helps protect individuals from devastating financial loss when expensive care is required. Health insurance also decreases the risks of costly delay in seeking treatment for conditions that might advance to a more severe, complicated, and expensive condition. Health insurance simply provides some level of payment for medical care. The systematic process of selecting, evaluating, predicting, and rating the risk for determining what will be covered and the extent to which it will be covered is referred to as *underwriting*. The individual protected is the *insured*; the insuring agency is the *insurer*. The historical understanding of insurance is that the *insured* pays the *insurer* a sum of money in advance to a pool of payments from others who are also insured. This pool of funds offsets the costs of the risk for a rare event which can be determined based on the group. This pooling of risk helps determine the rates of payments and also keeps the individual costs reasonable.

Initially, this concept was used to insure workers against wage loss resulting from injuries. In the 1930s, health insurance emerged in its current form. Throughout the 1930s and 1940s, hospital group prepayment plans were common and hospitals became highly dependent upon these plans with 70% of hospital income from individuals.

During this time, Blue Cross-Blue Shield, a private, not-for-profit insurance model was established and dominated the health care industry for decades. This plan reimbursed providers for the costs of the medical care and provided coverage to individuals, including care for routine events. Early financing from the American Medical Association supported the proliferation of Blue Cross-Blue Shield across the country. By 1940, the Blue Cross movement represented a major financing alternative to the arguments for national health insurance. Prior to World War II, commercial insurance companies showed little interest in adding health insurance to their portfolios, but following WW II, labor contracts added benefits and financial incentives encouraged commercial companies to enter the health insurance arena. This growth is evident today with many companies competing for health insurance contracts.

Private insurance, also referred to as "voluntary health insurance," is a plan provided through an employer, union, or purchased by an individual through a private company. *Group insurance* (insurance through an employer, union, or association) comprises approximately 66% of those with health insurance. Although early private policies were often inadequate, major medical coverage to cover catastrophic events was added in the 1950s and since the 1970s, most private policies included major medical and comprehensive coverage. *Self-insurance,* another form of private insurance, is made available by employers who determine they are large enough with sufficient risk diversification to fund their own health insurance for employees. Federal tax policies provided incentives to make this an attractive and economical option for some companies. As managed care plans (plans by providers) appeared, self-insurance became less economical and many companies adopted managed care plans. *Individual private insurance* is an important source of coverage for many Americans. While most Americans obtain coverage through their employer, early retirees, employees of businesses that do not provide insurance, and self-employed individuals rely on individual insurance. In this case, the risk is determined as individual risk rather than group risk and may be more expensive.

Government insurance accounts for approximately 30% of those with insurance and refers to the federal programs such as Medicaid, Medicare, Children's Health Insurance Program (CHIP), military care, and individual state programs. These programs provide specified health benefits for eligible populations. Medicare provides benefits for elderly and disabled; CHIP benefits low-income children; Medicaid provides care for low-income, elderly, disabled, women, and children. Increasing reliance on these programs has occurred as the number of uninsured has increased. The uninsured population has become a major national priority that stimulated the recent Patient Protection and Affordable Care Act (March 21, 2010). This Act is designed to expand health benefits to those without health insurance either through government or private plans.

Health insurance is a major component of health financing in the USA. Internationally, individual countries vary substantially in their governmental and private finding of health care. Immigrants in most circumstances will not have access to necessary care designated for citizens. Legal immigrants who are employed, however, may have access to health coverage in different countries. The risk remains that the health insurance model may preclude care for immigrants who experience delayed treatment and often increased disease burden due to lack of necessary care.

Related Topics

- ► Access to care
- ► Health care
- ► Health services utilization
- ► Medicaid
- ► Medicare
- ► Public health insurance

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Health Literacy

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Introduction

Health literacy, together with language and culture, is fundamental to the success of health communication. In the United States, health literacy began to emerge as a field in the early 1990s when the US Department of Education released the National Adult Literacy Survey (NALS) showing that over 50% of US adults were not able to use everyday prose and documents to find answers to questions. Results indicated that 23% of US adults had very limited, and 25% had limited functional literacy skills. Although researchers and practitioners in the developing world had long been aware of the challenges illiteracy and limited literacy presented to health communications, in the developed world, where illiteracy is rare, scant attention had been paid to the role of literacy in health. The startling results of the NALS had a powerful effect, especially on clinicians who became concerned about the effect of limited literacy on care. At the same time, Adult Basic Education Programs were including health in their community empowerment efforts. It is from these two fields, health care and adult education, that much of the early work in health literacy developed, with public health sometimes serving as a bridge between disciplines.

In the years since the NALS galvanized the field, research has shown limited literacy, and when measured, health literacy, to be associated with a variety of health outcomes. In patient populations limited health literacy has been associated with later stage diagnosis of cancers, poor glycemic control in diabetes, improper use of asthma medications, and poor knowledge of disease and self-management skills for hypertension and diabetes. Research has also explored how health literacy impacts adherence to treatments, the informed consent process, health care costs, and access to entitlements.

Definitions and Models

The most commonly cited definition of health literacy is the one used by the US Department of Health and

Human Services in *Healthy People 2010* and the Institute of Medicine (IOM) report *Health Literacy: A Prescription to End Confusion – the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.* The definition is broad and does not specify the form the health information takes (written, verbal, numbers, pictures), nor does it define the skills and capacities. Generally, reading, writing, listening, speaking, and numeracy are considered basic literacy skills, and become health literacy when applied in a health context. With this definition health literacy is determined by the skills possessed by the individual and measured against a clinical standard expressed in the term *appropriate decisions.* A variety of developments in health literacy have pushed thinking beyond this narrow individual skills-based focus.

Despite accepting this definition focusing on individual skills, the IOM report includes discussion of the emerging conceptualization of health literacy as arising from the intersection of demands of a situation and an individual's skills. In addition, the IOM report asserts that culture and language are central to health literacy. Thus health literacy is a complex social determinant of health. Efforts to address health literacy must take culture and language into account and focus not only on improving the skills of individuals, but also on developing the skills of providers and the simplification of procedures, forms, and even signage used by organizations and institutions, such as hospitals, social service agencies, and insurance companies.

The public health field has recognized that health literacy serves not only the individual, but also public health. Donald Nutbeam has proposed three levels of health literacy: functional health literacy, interactive health literacy, and critical health literacy. Functional health literacy is the basic skills. Interactive health literacy is participatory and involves the provision of appropriate and usable information, individuals' ability to assess and carry out the recommendations in the information, and their participation in mutual decision making. Critical health literacy is the ability to analyze information from a variety of sources in order to act. Attention to aspects of health literacy beyond basic skills is necessary, both because it allows individuals to participate more effectively in their care and develop skills necessary to take collective action to address community health. Another valuable expansion of health literacy is the multidimensional model developed by Christina Zarcadoolas, Andrew F. Pleasant, and David S. Greer in which there are four central domains: fundamental literacy, scientific literacy, civic literacy, and cultural literacy. In this model literacy skill in one domain can aid in the development of skills in another, and competencies in one area may help compensate for weaknesses in other areas. The hope is that by explicating the domains of health literacy they can be taken into account to provide guidelines for better health communication.

Measurement

Measuring health literacy is a complex undertaking and at this time there are no comprehensive measures of health literacy. This is partly due to multiple models of health literacy, as well as the myriad skills that make up even basic literacy. Research has been based on a variety of measures, although these measures do not capture all of the skills (reading, writing, speaking, listening, and numeracy) inherent in the most basic definitions of health literacy nor do they delve into broader domains of health literacy.

Much of the research linking health outcomes to health literacy has relied on the Rapid Estimate of Adult Literacy in Medicine (REALM), a word recognition test, or the Test of Functional Health Literacy in Adults (TOFHLA), a cloze test which includes tasks to assess reading and numeracy skills. A Spanish language version of the TOFHLA has also been developed. The REALM and the TOFHLA are general measures of health literacy most appropriate for clinical settings. There are also several disease-specific measures that have been developed for clinical settings. Health contexts vary across diseases, cultures, life course, and settings, making the development of measures for specific purposes appealing. At the same time, many researchers are calling for agreement on definitions and theory to facilitate the development of comprehensive measures that will apply across clinical and public health settings, as well as take a broader skill set into account.

Prevalence

In 2003 the US Department of Education commissioned the National Assessment of Adult Literacy (NAAL) and included health items to assess health literacy. The measures used are not publicly available. Respondents in this nationally representative sample were asked to demonstrate that they could use materials culled from health-related settings. The survey indicated that in terms of health literacy skills 12% of adults were proficient, the majority (53%) had intermediate skills, 22% had basic skills, and 14% had below basic skills. Someone with basic skills would be able to read a pamphlet and find two facts, while someone with intermediate skills could read a prescription label and determine what time to take a dose. Although limited health literacy skills affect adults across all age, racial, ethnic, and educational groups, the NAAL identified vulnerable populations: elderly (65+), ethnic and racial minorities, immigrants, those with low income or limited education, and people with chronic mental or physical health conditions. Reasons for limited health literacy skills include lack of educational opportunity, learning disabilities, cognitive declines in older adults, and lack of practice (literacy skills of any kind tend to erode if they are not practiced).

Future Directions

The development of health literacy as a field has had a profound effect on our understanding of the literacy demands of printed health education materials. Many of the new developments are directed toward seeking to extend the insights to other communications and the delivery of services. Practitioners have been extending best practices developed in health literacy, as well as plain language and communications into new areas. However, to fully understand the processes by which changes to practice will affect health literacy and health outcomes measures that assess health literacy skills beyond reading. In addition, as measures to assess health literacy practices of providers and the health literacy demands of organizations and institutions must be developed. Such measures will likely result from efforts to develop health literacy theory.

Some in the field are working to develop health literacy into a complete theory of health behavior. The theory would provide a framework to examine how people move from finding information to understanding it, evaluating it and communicating about it, to finally using the information to make health behavior changes. There is also interest in exploring how social networks relate to health literacy, as people rarely pursue health information in a vacuum.

Related Topics

- ▶ Communication barriers
- ▶ Cultural competence
- ▶ Education
- ▶ Health determinants
- ▶ Health disparities
- ▶ Health education
- ▶ Literacy
- ▶ Low literacy level
- ▶ Physician–patient communication
- ▶ Vulnerable populations

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Health Outcomes

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For any sample population, health outcomes are measured by tracking morbidity and mortality. Morbidity represents disease or ill health within a given population, and mortality measures deaths and causes of death within that population. Morbidity and mortality measures give an overarching view of a population's health, but offer limited insight into the root causes of health outcomes. For this reason, researchers track additional health indicators to gain insight into likely causes associated with illness and death in a given population.

Beginning in 1996 the Healthy People project, led by an interagency group within the US Department of Health and Human Services, developed a standard list of leading health indicators to help focus national health outcome research. The project's leading indicators for 2010 include physical activity, overweight and obesity, tobacco and drug use, sexual behavior and sexually transmitted infections, mental health, history of violence, environmental quality, and access to health care, among others. The project database, available publicly online and updated with the latest available data, provides tables that track leading health indicators and outcomes using a variety of national and state population survey data. Policy makers at all levels of government and community service rely on such data to guide health service program assessments and highlight areas for program improvement.

The health outcome data available through the Healthy People 2010 project serve as a rich information source intended to guide policy development. Federal and state policy makers use health outcome data to develop policies and programs focused on large scale service areas and initiatives. At the local level, policy makers use health outcome data to build on federal and state programs, filling gaps and tailoring services to the needs of communities. For example, the US Congress currently uses the Healthy People 2010 project objectives and leading health indicators to assess the progress of certain federal block grants. Likewise, the indicators have been used at a local level by cities, counties, school districts, foundations, and nonprofits to track and assess local health outcomes, and inform program development.

Immigrant Health Outcomes

More than 37 million immigrants currently live in the USA, with the majority born in Latin America, Asia, or the Pacific Islands. A legal immigrant to the USA might be a student with a visa, a permanent resident with documentation, a naturalized citizen, a refugee, or a person seeking political asylum. An undocumented immigrant may have originally immigrated legally, but overstayed the expiration date of his or her documents, or may have avoided inspection when crossing the border. Due to the innate diversity of this group researchers must account for vast differences in baseline health, education, socioeconomic and family status at every stage of information gathering and analysis.

Historical research on immigrant health outcomes has yielded paradoxical results. The health outcomes of recent immigrants are better than those of native-born US citizens when results are controlled for socioeconomic factors. However, as immigrants live and work in the USA, their health outcomes deteriorate and begin to mimic the less-healthy outcomes of native-born citizens. Recent studies also highlight the fact that patients with limited English proficiency, regardless of citizenship, tend not to seek or receive preventive medical care, and are more likely to experience serious medical errors and drug complications when seeking treatment.

Current research indicates that immigrant health outcomes vary both across and within ethnic groups. For instance, Latino and Black male immigrants have shown reduced morbidity risks associated with chronic heart and lung conditions compared to other immigrant and native-born populations, but the same groups show increased risk for stomach or brain cancer and infectious diseases. Conversely, male and female Latino populations have proven more susceptible to diabetes than other populations, regardless of citizenship status. Health outcomes also vary within broadly defined racial and ethnic categories. Pacific Islanders and people born on the Asian continent differ significantly from each other not only in their health outcomes but also their socioeconomic and demographic characteristics. Broad racial or ethnic definitions captured in survey data tend to minimize evidence of significant disparities in health outcomes of certain subgroups.

According to the Pew Research Center, between the years 2005 and 2050, an estimated 117 million people will be added to the US population as a direct result of new immigration. This rapidly growing population and its US citizen descendents represent 82% of projected population growth during that time period. In light of the size and diversity of this population, research into immigrant health outcomes must span multiple language barriers and cultural differences to effectively inform policy development.

Policy Implications

Understanding the paradoxes of immigrant health outcomes can help researchers and policy makers better understand overall health outcomes, refine disease prevention strategies, and assess health care programs. Accurate data allow for the development of targeted programs and policies that improve health care access, quality, and outcomes. The Patient Protection and Affordable Care Act of 2010, also known as the US health care reform bill, improves health data tracking for racial and ethnic subpopulations. The Act authorizes oversampling of historically underrepresented groups, including immigrants, to increase the accuracy of data collected.

In seeking to improve the accuracy and application of health outcomes data, health practitioners and researchers promote community-based participatory research. Characteristics of successful community-based participatory research include the following:

1. The research is designed to increase community resources and supports long-term improvements.
2. It uses a range of methods, both quantitative and qualitative, from multiple disciplines, including culturally distinct models.
3. Its findings are relevant to the needs of both policy makers and advocates, using standard metrics that allow for comparison across studies.

Conclusions

Health outcomes are measured by tracking morbidity and mortality along with certain lifestyle indicators intended to highlight root causes of disease and death within a population. However, many factors other than the current leading health indicators influence health outcomes, including country of origin and native language proficiency. Any successful policy or program aimed at improving health outcomes relies on standardized, current data to establish a baseline, track changes over time, and demonstrate results. With a growing immigrant population in the USA, current health reference points and regular information updates accurately reflecting target populations are key elements to successfully gauging the progress of programs and policies at every level.

Related Topics

- ► Community-based participatory research
- ► Culture-specific diagnoses
- ► Epidemiological paradox
- ► Health policy
- ► Healthy immigrant
- ► Mortality and morbidity

Suggested Readings

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Health Perception

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Health perception encompasses both physical and mental well-being, and for some, even spiritual fulfillment. For the newly arrived immigrant, health perceptions may focus on immediate survival rather than long-term health status. Health perception is influenced by the health care system in the country of origin. For example, a study of women who immigrated to the USA after the fall of the former Soviet Union found that when the women received health care services in their homeland, they had relied on their physicians to refer them for health screenings and to provide health education, as this was customary. When the women immigrated, they expected physicians to again take the primary role in directing their care; they were not accustomed to being proactive and requesting health information or tests.

Generally, countries accepting immigrants require medical examinations to be performed prior to entry. Immigrants told at the time of screening that they are in good health may continue to believe that their health status has not changed until a problem is diagnosed. Length of time in the host country can also influence health perception, as immigrants may have a difficult time transitioning to their new home and may face numerous stressors not previously experienced, including finding employment and earning enough income to support their families, feelings of loss and social status, and loneliness and social isolation.

Immigrants may face several barriers to receiving health care services including language differences, lack of translation services, and lack of culturally appropriate health services. Cultural competence and educational programs for health professionals can orient the professionals to the potential importance of cultural rituals, use of traditional remedies (e.g., teas and herbs) and cultural norms. Understanding the multiple meanings and perceptions of health and their influence on interactions with health care professionals can lead to improving immigrants' access to health care, compliance, and satisfaction.

Related Topics

- ► Cultural competence
- ► Health care
- ► Health determinants
- ► Health disparities
- ► Health status

Suggested Readings

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Health Policy

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While there is controversy over the relative contribution of health care to population health and longevity, it is clearly not the most important factor. In every society, social and economic status are strongly associated with life expectancy, health status, and the prevalence of disability, even where there is universal and equal access to health care. In addition to these disparities within societies, it is now generally held that societies with more inequality tend to have worse population health than societies of comparable aggregate wealth but less inequality. Population health is also strongly affected by environmental conditions such as water and air quality; culturally and economically influenced behaviors such as tobacco and other substance abuse, diet, and physical activity patterns; and social conditions associated with psychological stress and violence.

So the subject of health policy is impossibly broad. All public policy is relevant to health, even if it is not explicitly justified or discussed in those terms. This entry will therefore focus primarily on health care policy, but readers should keep in mind that health care is only a small corner of the broad field of human health. Additionally, a component of public policy is explicitly labeled as "public health" – in the United States, representing about 5% of the spending on health care – and we will touch on these policies as well.

Among the wealthy countries other than the United States, there is little relationship between aggregate spending on health care and population health. But the United States is an outlier. Despite not having universal coverage, the United States spends far more per capita on health care than any other wealthy country. Nevertheless, life expectancy and health status indicators in the United States are the worst among the wealthy countries, although the poorest countries are far worse off.

To understand this seeming paradox, and health care policy more generally, we must begin by reviewing some of the basic economics of health care, which in many ways do not resemble the idealized portrait of the market as presented in standard introductory texts.

First, health care is characterized by unusually large externalities, meaning that large costs or benefits to society are not captured in the transaction between consumer and provider. This is actually true of essentially all economic transactions; it is a difference of degree. There are some negative externalities to health care, such as the carbon and other emissions associated with manufacturing of medical devices, or contamination of water by excretion of pharmaceuticals and their metabolites, but at least from a human point of view there are much larger positive externalities. An obvious example is communicable disease control. Successfully treating people with infectious diseases prevents transmission to others. Vaccination that produces herd immunity is even more cost-effective. To the extent that health care can prevent or reverse disease and disability, it keeps more people economically productive, and also more capable of non-monetized contributions to society such as dependent care and volunteer work.

Less tangibly, people care about each other and are gratified when loved ones enjoy better health or have their suffering relieved. More diffusely, many people feel distress knowing that people they do not know are suffering, or abandoned in need. An affluent society simply will not tolerate allowing people to die at the door of the hospital when a modestly expensive intervention would save them. (Note that we nevertheless do tolerate a great deal of avoidable suffering and death, a matter I will discuss under the heading of the Rule of Rescue.)

In summary, health care is a mixed good. If we depended on people to pay for it out of pocket, it would be underproduced from the standpoint of society. Or more precisely, it would at least be misallocated.

A second way in which markets for health care violate standard assumptions is the extreme informational asymmetry between consumer and provider. When we shop for ordinary goods, we generally have a pretty good idea of what we are buying, its quality, and how it compares to competitors' offers; our information can be improved by labeling requirements, warranties, and simply by experience. If we spend a few dollars on a product we find we do not like, we will not do it again. With health care, however, we may not get a second chance. The product consists largely of expertise. People consult physicians because they expect the physician to know much more than they do about their health condition and how to improve it. Most of us, most of the time, cannot assess whether the physician's judgment is correct.

One consequence is that the government must provide quality assurance in the form of a licensing regime. Physicians and other health care professionals must meet requirements of training and demonstrated competence, maintain up-do-date knowledge, and continually satisfy standards. The medical schools and training programs which produce physicians must in turn meet standards of accreditation. This has the effect of restricting the supply and raising the price of physician services, and placing the supply under control of public policy.

Another profound consequence is that demand for medical services is not fundamentally controlled by consumers. While conventional views of the market hold that consumers are "sovereign" in that they choose how to allocate their spending, this is not true for health care. We depend on providers to tell us what we need. This combines with another feature of markets for health care, which is the extreme diversity of need. Most people, most of the time, have roughly comparable basic needs for nutrition, shelter, and other necessities. Beyond that of course we may have discretionary income that we allocate as we please, but to the extent that health care addresses necessities – which it surely would seem to do if life or functional status are at stake – our needs are not at all comparable. They may change dramatically over time as well as differing among individuals.

This means that a hypothetical "free market" in which people spend out of pocket for all of their health care cannot possibly produce socially optimal allocation of resources by any standard, including not only justice but also the material well-being of all. Clearly misfortune can strike anyone – be it a natural disaster, an infectious or congenital disease, an act of violence – leaving someone with a need for health care that he or she may be entirely unable to pay for. To the extent this reduces labor force participation or has other negative externalities we have discussed, it is costly to everyone.

Not only can ill health or physical trauma befall anyone, they likely will befall *everyone*, increasingly with age. They are *unpredictable* and only moderately *controllable*. Hence, the purpose of health insurance is to even out the financial risk of ill health and assure access to those who face high costs – in other words, to make the world more predictable and more just, as well as more prosperous.

This is why, with the exception of the United States, all of the wealthy countries, in one way or another, provide what is called "universal health care" to all of their citizens, and in some cases to other eligible residents or visitors. This means that everyone has access to basic, if not comprehensive medical care, and often dental and mental health care as well, regardless of their financial resources. Many of the less wealthy countries also provide some degree of universal access although limited resources mean people may not receive services which are considered standard in wealthier countries. Such policies are redistributive in that they require subsidies for people who could not otherwise afford comprehensive health care insurance, but the progressivity of financing varies considerably.

There are innumerable variations on how countries achieve this. I will describe only a few paradigmatic examples. In the United Kingdom, health care is largely socialized. Physicians are paid by the state, and hospitals are publicly owned. The constituent countries of the United Kingdom have separate organizations and control through their national governments. In each country, administration is decentralized to regional "Strategic Health Authorities" and local primary care and hospital "Trusts." The system is entirely tax financed. People can purchase additional private insurance for specialist services beyond what the NHS covers, but only about 4% of health care spending is private.

Canada has what is called a "single payer system," which is publicly funded, but has most services provided by private entities. The system is administered at the provincial level, and supported largely by income taxes. Every citizen is insured by the provincial fund, which physicians bill for services. Provinces vary somewhat in the services they cover. While pharmaceutical costs are for the most part covered only for the elderly or poor, the government negotiates with suppliers to keep costs low.

Many European countries have mixed systems in which private insurers are allowed to compete with a publicly sponsored program; or private insurance plans are very tightly regulated and funded through arrangements that make them affordable for lower income people.

Middle income countries such as Mexico, Brazil, and India generally have mixed systems in which a publicly run or subsidized system is available to poor people, at least in principle, but more affluent people generally have private insurance. The quality, accessibility, and true universality of health care in these countries vary. There may in effect be rationing by inconvenience in the form of long waiting times, difficult travel for rural people, and poor amenities in public clinics, and services may simply be overburdened. In India, for example, it has been reported that 700 million people lack access to specialty care because specialist providers are concentrated in the cities.

In the poorest countries, including much of sub-Saharan Africa and some Latin American and Asian countries, the resources to provide any form of universal health care are lacking. Specific health care services may be extended to poor people through internationally sponsored programs focused on particular diseases, such as HIV, tuberculosis, or malaria, and immunization campaigns. There is often controversy as to whether these resources would be better spent building a permanent, comprehensive health care infrastructure, or may even have some counterproductive effects of draining personnel from the general health care system.

The situation in the United States is complicated and requires more extensive discussion. The United States provides a national publicly sponsored insurance plan, called Medicare, to people aged 65 years and older and to people with qualifying disabilities. Medicare pays physicians for outpatient services on a fee-for-service basis, using funds from a payroll tax on workers with a small contribution from premiums paid by participants. Prescription drugs for outpatients are now partially paid for, with substantial cost sharing by consumers above an annual threshold. This cost sharing will be greatly reduced by recent legislation. Hospitals are reimbursed for episodes of care based on patients' diagnoses, funded out of general tax revenues.

Poor people, up to income thresholds that vary by state, may be covered by state-sponsored plans called Medicaid, supported partly by state tax revenues and partly by federal payments to the states. Generally, recipients must either be Medicare eligible, in which case Medicaid pays for services not covered by Medicare and for cost sharing; or be minor children, custodial parents of minor children, or pregnant women. Some states have extended eligibility to others, and the recent reform legislation will eliminate these "categorical eligibility" requirements nationwide for people making up to 133% of the federal poverty level. Children may also be covered at somewhat higher income levels with partial contributions from the federal government to the states through a program called the State Children's Health Insurance Program (SCHIP). Medicaid programs usually contract with private insurance plans to provide coverage.

The rest of Americans are covered by private insurance companies, most of them profit making corporations; or they are not covered at all. An odd feature of the US system, essentially a historical accident arising out of the emergency economic policies imposed during World War II, is that most Americans who have private insurance receive it from their employers who purchase coverage on their behalf. The benefit is a cost to employers, and hence deductible from their taxable income; but is not taxable income for employees. The value of this subsidy is greater for higher income workers, and hence largely regressive.

Some of these health insurance corporations are huge. The largest health insurance company in the United States, WellPoint, owns the Blue Cross/Blue Shield brand in 16 states. The mission of these companies is to make money for their owners and executives, just like any other corporation. Their premium revenues, in addition to paying for beneficiaries' health care, which they call "medical losses," go to profit, administration, marketing, and the cost of strategies to avoid medical losses, which are called "medical underwriting." These include refusing to sell to people with expensive health care needs, or charging them higher premiums; and canceling policies when people develop costly medical problems. As a result, people who do not have access to insurance through their employment may be completely unable to purchase insurance if they are not in good health.

The new legislation, if it ultimately takes full effect in 2014, will restrict these practices. It will also require all people who do not otherwise have insurance to purchase it, with subsidies offered to moderate-income people, or pay a tax penalty. Purchase of insurance will be facilitated through state-run "exchanges." However, the legislation does little to constrain growth in health care costs and it remains to be seen whether insurance will be affordable for many people even with the subsidies, and whether insurance companies will be able to evade the restrictions on medical underwriting, among other questions.

For international migrants, the most obvious issue is whether they can benefit from whatever system of health care organization and financing there may be in their host country. Not surprisingly, illegal migrants cannot normally obtain publicly provided or subsidized benefits legally, although wealthy countries generally have mechanisms for providing emergency critical care and labor and delivery services out of compassionate motives. In the United States, where sentiment against illegal presence in the country is currently very high, fear of deportation causes many to avoid presenting even for urgent problems, although Medicaid will pay for emergency care for otherwise eligible people and hospitals are required to provide it in any case.

For legal migrants, participation in host country health care schemes is normally possible, if not required. In the United States, however, there are limitations on eligibility for publicly subsidized programs even for legally present aliens. Legal permanent residents are ineligible for Medicaid or SCHIP during their first 5 years in the United States, with the exception of refugees and members of the armed services and their families. People with temporary work visas or student visas are generally not eligible for Medicaid or SCHIP. Immigrants who are legally able to work in the United States are at disproportionate risk of not being insured, because they are disproportionately likely to be in low-wage, temporary, or seasonal jobs that do not provide health insurance benefits, or in families supported by low-wage workers.

Resource Allocation

When the current systems of health care financing first developed in the twentieth century, health care constituted a relatively small proportion of national economies. Universal coverage was not very difficult for the wealthy countries to afford, and most Americans could afford their private premiums. On the other hand, the benefits of health care were fairly limited, and the most beneficial services – immunization, antibiotics, trauma care – were not very expensive.

By the late twentieth century, however, technological advances had simultaneously broadened the scope of medicine, produced effective new treatments for more and more disorders, and greatly increased the expense of providing the available medical services. The affordability and cost-effectiveness of medicine became a major concern. It may seem paradoxical, but the United States, the only wealthy country without universal coverage, has had the greatest problem with affordability. Whether through socialized medicine, socialized health insurance, or tight regulation of private insurance, universal systems impose a global budget cap on health care spending, whereas in the United States providers can for the most part simply bill for whatever services they provide, whether the payer is government or a private company. That outcomes are no worse, in fact somewhat better, in systems with capped spending demonstrates that more is not necessarily better when it comes to health care.

All wealthy countries nowadays require that pharmaceuticals, and usually medical devices, must go through a process to determine safety and effectiveness in order to obtain a license to be legally prescribed. However, these requirements do not ensure that a drug or device is safe and effective for all the situations in which it might be used, or that it is more effective or less expensive than existing alternatives. Furthermore, longer term experience with medical interventions often leads to discovery of problems such as adverse effects not found during the initial testing period. Finally, a small benefit bought at a very large cost may simply not be worth it compared to other possible uses for the money, given that our resources are finite.

In order to live within their budgets rationally, therefore, most countries have established agencies that make choices about how limited resources are to be allocated. New drugs that are not superior to less expensive alternatives may be licensed, but not paid for. Treatments that provide insufficient benefit in relation to cost may not be approved for payment, although wealthy people could buy them with their own funds. The United States has no such authority.

As the goal of medicine is not merely to extend life, but to improve its quality, evaluating the cost-effectiveness of medical interventions requires creating some common metric, which incorporates both. The most commonly used measure is called a Quality Adjusted Life Year, abbreviated QALY. One way to compute QALYs is called the Standard Gamble. What if there were a treatment that might cure your osteoarthritis, but it involved some risk of death? (Indeed there is such a treatment – joint replacement surgery, like any surgery, involves a small but nonzero probability of killing you.) The Standard Gamble asks at what probability of death versus certain cure you would be indifferent to the surgery. Often, these questions are not asked about specific conditions such as osteoarthritis of the knee, but refer to vague, general states such as pain, mobility, mental acuity, etc. You can ask these questions of people who actually have a disease or symptoms of interest, or you can ask them of the general public in an even more hypothetical way.

Once we have this information from a sufficient number of people – and how you define sufficient is an interesting question in itself – it is used to calculate QALYs for various states. Let us say that cancer Treatment A on average gains people ten extra years of life, but at 70% value based on the side effects of chemotherapy and the lack of a left lung. This can then be compared with another treatment – say you skip the chemotherapy in which case you can expect to live 8 years but at 90% value, which is worth 7.2 QALYs. And it can also be compared with its cost. For example, if surgery plus chemotherapy costs $250,000, the expenditure represents about $35,700 per QALY. National health care systems either implicitly or explicitly set approximate limits for the spending they are willing to make to purchase one QALY.

For several reasons, much of medical spending in the absence of such analyses and limitations is likely to produce little benefit for the cost, and often no benefit at all. We often do not have very good information about whether a treatment is beneficial, but we nevertheless have a bias to do something if we think it might help. Drug and device companies aggressively market their products and often promote overuse or use in inappropriate circumstances. And providers who are paid by the services they perform have an unconscious bias toward doing more. Limiting access to potentially beneficial treatments on the basis of cost is bound to be controversial, and public disputes do arise over these issues. In the United States, however, it has so far proved politically toxic even to propose undertaking such evaluations.

International migrants who do have insurance coverage may have some special interests in how available resources are allocated. One is whether services can be reimbursed to overcome language or cultural barriers that may hamper communication with providers, obtaining important health information, or accessing services. These include interpretation at the site of care, translation of written materials, patient "navigators" or benefits managers to assist people who are unfamiliar with the systems and procedures of the host country, and promotion of multilingualism and multiculturalism in the health care work force.

Another is whether resource allocation takes into account possibly differential health care needs of ethnic minority populations, who may have elevated risks for certain diseases. The United States sets decennial public health goals, and the goals for 2010 included eliminating racial and ethnic health disparities. Actually achieving this would require differentially allocating resources to disadvantaged populations, or to problems which disproportionately affect some groups, but this did not happen. Although progress toward the nation's public health goals was made in some areas from 2000 to 2010, disparities persisted.

Public Health Policy

Public health means the study and the promotion of health from the perspective of populations rather than individuals, which is largely the domain of medicine. While essentially all public policy has implications for population health, some publicly funded programs and regulations are explicitly labeled as having a public health justification or pertain to a public health department or authority. This line is somewhat arbitrary and changes over time. Delivery of potable water to cities, and the safe removal, treatment, and ultimate disposal of sewage, was labeled as a public health measure when it first became a standard government responsibility in the late nineteenth and early twentieth centuries. Nowadays, however, we generally take it for granted as part of the essential infrastructure of modern life, and do not commonly think of our water and sewer bills, or tax subsidies for these services, as public health expenditures.

The domain of "public health" as usually conceived of today includes sanitary regulation and inspection of food processors, restaurants, and grocery stores; public campaigns to encourage healthful behaviors; regulation of industry and motor vehicles to limit environmental contamination and promote safety for workers and the general population, although these activities are also justified using other labels such as environmental protection and occupational safety and health; and consumer product safety regulation.

Substance abuse prevention is usually thought of as a public health service, as are programs to reduce harm of drug abuse such as needle exchange. Substance abuse treatment is logically a form of individual clinical service but it is nevertheless usually part of a separate system from the medical institution and may be within the institutional domain of an agency otherwise charged with public health responsibilities. Enforcement of prohibition laws is not generally thought of as a public health service, and indeed may be contrary to the interests of public health in reality, although it is usually explicitly justified as a form of protection of public safety. Police protection and firefighting are not usually labeled public health services, although fire prevention and harm reduction such as sprinkler systems, and crime and violence prevention are certainly strong interests of public health researchers and advocates.

Quite evidently, war and peace, the distribution of income, education and the preparation of young people for the job market, criminal justice, land use planning, transportation infrastructure, energy policy – almost everything that government does or fails to do – has public health implications, but much of it is seldom discussed in those terms. On the other hand, while most of medicine is usually distinguished from public health, some kinds of medical services are often labeled as "public health," including immunization campaigns, screening for transmissible diseases, and outreach to the medically underserved, even when these are done by regular clinical providers. Regulation and inspection of hospitals and nursing homes is also usually the domain of public health agencies. So the term can be confusing.

For international migrants, there are often differential impacts of public policies, whether labeled as public health policies or not, and of public policy omissions. For example, economically disadvantaged people are more likely to live near localized sources of air pollution, notably major highways and industrial emitters. The most dangerous components of near highway pollution, ultrafine particles, are found at high levels within only a half kilometer or less of the highway, whereas air quality is usually regulated only at a regional level and so largely ignores such highly localized effects.

Immigrants and members of ethnic minority groups may face discriminatory treatment by the criminal justice system. In the United States, while they are no more likely to use illicit drugs than members of the dominant European settler culture, they are far more likely to be incarcerated for drug offenses, rather than be diverted to treatment programs. Some ethnic minorities have low average educational attainment and hence limited life opportunities, which directly affects lifelong health. Members of ethnic minorities may disproportionately work in dangerous jobs, live in unsafe housing – lead contamination is far more prevalent in the United States in the homes of African American and immigrant families – or lack access to healthy foods.

The Rule of Rescue

Public health is underfunded compared to medical services, on the basis of cost-effectiveness at the population level, for many reasons. One of the most powerful is called the Rule of Rescue – a moral intuition that many people have which demands that everything possible be done to succor an identifiable person in need. In contrast, public health measures that prevent injury and disease, while they may benefit far more people for the same or even less cost, do not benefit specifically identifiable individuals. We will never know who did not get cancer or heart disease because we limited motor vehicle pollution; who was not injured in an unsafe workplace; what child had a chance in life because we sent him to an early intervention program instead of a juvenile penal facility; what child did not start smoking because of a tobacco control program. The beneficiaries of these interventions can only be represented by statistics, not identifiable people.

The Rule of Rescue also operates most powerfully when the individual is in the most desperate straits. Hence the mass media of the entire nation may focus relentlessly on the plight of a single child who has fallen down a well, while hundreds of thousands of children may be suffering from poor nutrition, social deprivation, toxic air, substandard housing, or family violence. Health care is equivalent to pulling the child out of the well, and public health to putting a cap over it so children will not fall down it in the first place. But we feel far more urgency to do the former than the latter.

In summary, to the extent that international migrants may be socially and economically disadvantaged, their health will tend to suffer. A health care system that allocates resources equitably and is adaptive to the special needs of distinct populations can help ameliorate the consequences, but cannot make up for the damage done. Health policy, ultimately, is all of social policy.

Related Topics

- ► Access to care
- ► Barriers to care
- ► Child health care access
- ► Disease prevention
- ► Environmental health
- ► Health determinants
- ► Health insurance
- ► Kennedy, Edward
- ► Managed care
- ► Medicare
- ► Public health insurance
- ► Socialized medicine

Suggested Readings

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Health Promotion

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Health promotion, defined by the Joint Committee on Health Education and Promotion Terminology as "any planned combination of educational, political, environmental, regulatory, or organizational mechanisms that support actions and conditions of living conducive to the health of individuals, groups, and communities," is central to the practice of public health. Health promotion is an all-encompassing, ecological concept that attempts to account for how individual behavioral factors, sociocultural characteristics, and environmental resources shape health in order to develop, implement, and evaluate strategies that support positive health behaviors. Though health promotion has been conceptualized in various ways, common among most understandings is the objective of health promotion to engage individuals, groups, and communities in planned efforts to improve health status and quality of life.

Health promotion activities generally rest on the following assumptions:

- The health status of individuals, groups, and communities can be changed.
- The complex interactions between social, behavioral, biological, and psychological factors help shape health and disease status.
- The principles and theories that underlie the occurrence of disease can be understood.
- Individuals, groups, and communities must be motivated and ready to change in order to make a behavior modification permanent.
- Starting and maintaining a health behavior change can be complicated.
- Various prevention strategies that are culturally appropriate can be developed and implemented to address an identified health issue.
- A behavior modification can be made and that modification may influence an individual's, a group's, or a community's health status.
- There is an understanding of the level of individual responsibility regarding a person's health; however, it should not be viewed as victim-blaming.
- There are a variety of factors such as policies, resources, family, and community relationships that shape and influence health behavior modifications.

These assumptions undergird the goals and objectives of health promotion interventions. Central to these assumptions is the ecological premise that health status is informed by individual health behavior that is changeable and voluntary, but strongly influenced by interpersonal, organizational, and sociocultural forces. Thus, the purpose of a health promotion program is to help individuals, groups, and communities engage in health-promoting behaviors voluntarily.

Health Promotion Programs

Health promotion programs may be comprised of a number of interventions that aim to address intrapersonal, interpersonal, and sociocultural influences on individual health behavior. Health promotion programs can be implemented over several years, such as a tobacco control campaign that includes smoking cessation classes and smoke-free worksite policies, or can be one-time interventions such as a health fair that includes diabetes screening. The intent for health promotion programs is to impact individual behavior within a group or community context, thus the duration, format, and content of a health promotion program depend upon the population and health outcome targeted.

Ideally, the development of health promotion programs should be customized to the population they aim to impact, a process that requires a preparatory assessment of the needs of the target population. This initial needs assessment serves to inform health promotion programs by providing an initial inventory of the health status, concerns, and self-identified priorities of the target population. After this initial assessment, behavioral science theories and planning models are often used to design program interventions, materials, and activities. Through the development of a health promotion intervention, an intentional effort is made to ensure that all components of the program's interventions are culturally accessible, appropriate, and accurate for the target population. In keeping with the above principles, health promotion interventions have been designed for many different populations, including immigrant and voluntary migrant communities.

Health Promotion and Migrant or Immigrant Populations

Immigration to a new region is typically associated with a variety of behavioral, environmental, and lifestyle changes that may expose immigrants and voluntary migrants to a multitude of health related issues due to language, cultural, and social barriers. For example, dietary acculturation, or the adoption of the dietary patterns of the host country in which immigrants reside, may lead to differences in health outcomes (known as "health disparities") among immigrant populations. Food availability, affordability, preparation, and processing may be significantly different and less healthy in the host country than the immigrant's country of origin. Many developed countries, such as the USA, consume diets that are generally high in fat and low in fruits and vegetables. This has implications for immigrants adopting such dietary practices as a diet higher in fat typically leads to increased risk for the development of several diseases, including some cancers and diabetes.

Culturally appropriate health promotion programs have been developed to help reduce health disparities in immigrant and voluntary migrant communities. Health promotion interventions have been created to address health issues including: (1) diabetes, (2) obesity, (3) nutrition, (4) cardiovascular disease, (5) sexually transmitted infections, (6) HIV/AIDS, (7) tuberculosis, and (8) women's health (e.g., breast cancer screening, cervical cancer screenings, prenatal health).

Challenges of Health Promotion

There are many challenges and barriers when it comes to creating and implementing effective health promotion programs for immigrant populations. The variety and diversity of immigrant communities require tailored, specific programs that are culturally accessible; thus, health promotion interventions must be unique to the priority population. Despite this, some common considerations must be made for health promotion interventions targeting immigrant communities. In particular, the successful implementation of a health promotion program in migrant and immigrant populations requires attention to the language, culture, and social norms of the target population.

Language Barriers

The number and diversity of languages spoken by immigrants may serve as a barrier to health promotion. Health promotion interventions are maximally effective when they are culturally relevant, up-to-date, and specific to the target population. Ideally, health promotion interventions are delivered in the language spoken by the target population. However the large level of language diversity that can exist in even relatively small regions make this challenging. For example, in the USA an estimated 47 million people speak a language other than the national language of English. In the state of California, over 43% of the state's population speaks their native languages at home and even a single borough in New York City has approximately 138 different languages spoken.

Cultural and Social Barriers

Culture can be said to be made up of a collective of perspective attitudes, beliefs, and behaviors, essentially the normative values of a particular group. Immigrant and migrant populations' perspectives on health issues may promote or complicate the provision of health promotion interventions. Cultural stigmas in particular can pose unique challenges to health promotion interventions. For example, in some cultures mental illness is often considered to be shameful or humiliating disease that may reflect poorly on the individual and the individual's family. In such cultures, mental illness is not discussed outside of the family even during mental health crises. Understanding this cultural stigma is imperative when creating a mental health promotion campaign for this population as much of the intervention may need to focus on de-stigmatizing mental illness, or may have to center on the family unit as the focus for health promotion activities.

Health promotion interventions must take into account that cultural norms may also work to enhance health disparities precipitated by the immigration event. For example, cultural perceptions that being overweight indicates health may encourage individuals to adopt more high-calorie diets that are prevalent in the host country. Cultural perceptions that it is inappropriate for women to discuss health issues with men may lead to less help-seeking behavior and increased health disparities in host countries where health care providers are predominantly male. Thus, health promotion interventions must be tailored to identify and reinforce health-positive cultural beliefs and behaviors while working to manage cultural norms that encourage or amplify health disparities.

Conclusion

Immigrant populations are generally at greater risk of adverse health events and health promotion efforts can work to prevent health disparities between different groups. However, health promotion interventions must be tailored to the unique need and priorities of specific immigrant communities, with a special eye toward understanding and addressing the specific language, cultural or social norms that may create barriers to health promotion efforts. When this is undertaken intentionally, health promotion interventions can be an effective means for promoting health in migrant and immigrant populations.

Related Topics

- ▶ Acculturation
- ▶ Barriers to care
- ▶ Communication barriers
- ▶ Community health workers
- ▶ Community programs
- ▶ Cultural competence
- ▶ Cultural humility
- ▶ Disease prevention
- ▶ Health barriers
- ▶ Health beliefs
- ▶ Health care
- ▶ Health care utilization
- ▶ Health determinants
- ▶ Health disparities
- ▶ Health education
- ▶ Health literacy
- ▶ Health outcomes
- ▶ Healthy immigrant

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Health Services

- ▶ Health care utilization
- ▶ Health services utilization

Health Services Research

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Health Services Research was defined by the Board of Directors of the Association for Health Services Research (AHSR), a US-based research institution, as: “the multidisciplinary field of scientific investigation that studies how social factors, financing systems, organizational structures and processes, health technologies, and personal behaviors affect access to health care, the quality and cost of health care, and ultimately our health and well-being. Its research domains are individuals, families, organizations, institutions, communities, and populations.” Investigators who conduct health services research are interested in how health systems do or do not work, and the factors that change the effectiveness of health care.

Health services research in immigrant communities has focused on the topics of health services research in general.

Social factors impacting the health care of immigrants are wide-ranging. Frequently, immigrant communities have different values, attitudes, and beliefs about health care, and about what it means to access health care. Health services research attempts to look at why people do or do not access health care, and what forms of inequality can result from the social interaction of immigrants and the health care system. Additionally, social pressure may lead to immigrants being less likely to seek health care. Alternatively, immigrants may not wish to seek health care that they are entitled to, for fear of persecution or prejudice from health and state authorities. Much of the work of health services research is concerned with health disparities and access to care, both of which are topics that greatly impact immigrant health, usually poorly. Health disparities are the result of language, access, legal status, bias, race, economic status, sexual orientation, and many other factors affecting immigrants – understanding health disparities is a major component of health services research.

Financing systems impact immigrant health for multiple reasons. If the immigrant populations come from a country with a different health care system – less or more government coverage of health care – this may lead to confusion about payment or procurement of health care. In addition, immigrants may be reluctant to seek health care, and thus may only access health care when their health problems have evolved to very costly problems. The impact of immigrant health care on the financing of health care can be a controversial topic. In addition, different health care systems have different ways of financing the health of the population in general, and immigrant populations specifically; much contradictory research exists about how much exactly immigrant health care costs different health systems, and what the best methods would be to reduce this cost. There is much debate about how health systems should be doing preventive health care in immigrant communities, and what strategies work best.

Organizational structures and processes, that is, how an organization is organized, has a large impact on the ability of immigrants to access the system. Additionally, immigrants may not access institutions if they are not designed in such a way that will make institutions sensible to them. Additionally, there are documented health disparities in immigrant populations due to processes in hospitals. For example, "pain disparities" exist where hospitals are not staffed with translators, or when no staff members are fluent in the language of the immigrants. Additionally, when translators are not available, family members are often recruited to translate for each other, which may lead to poorer health outcomes.

Health technologies are an emerging field in health services research about immigrants. The major field of study about health technologies is about the electronic medical record, and how it can increase communication among health care providers and ultimately provide better care for patients. It is not certain if electronic medical records will eventually allow for international communication between the health systems of many countries. People are also using technology to help to reach out to immigrant populations in their own languages and customs, especially when fluent and otherwise culturally competent workers may be in short supply.

Related Topics

- ► Ambulatory care utilization
- ► Health care utilization

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Health Services Utilization

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Health services utilization can be defined as the consumption of health services or the extent to which health services are used. Common crude measures of health services utilization include *utilization of primary care services* (number of primary care visits by persons in a given population in a given year/size of the population) and *utilization of inpatient services* (number of inpatient days/size of the population). The immigration histories and immigration communities among countries differ greatly. To add to this, country-level health care delivery systems (including the financing, insurance, and delivery components) vary substantially. These differences make comparing health services utilization between the immigrant and nonimmigrant groups among different countries difficult. Few studies agree on the nature, direction, or extent of the differences in health services utilization between immigrant and nonimmigrant populations. Much evidence supports the idea of the “healthy immigrant” effect, that healthier people within a country tend to migrate while the less healthy remain in their native country. Additional evidence supports the idea that the longer an immigrant remains in a country, the more his or her disease risks and health services utilization approach resembles those who are native to the country.

The Organization for Economic Co-Operation and Development (OECD) represents governments of democratic countries with market economies working together to develop comparative statistics in order to evaluate and coordinate policy. The health section of the OECD provides comparable statistics in health. A systematic overview of existing research on differences in primary care utilization between immigrant groups and the majority population of seven OECD countries found that the United States more often reported a significantly lower use of primary care among immigrant groups as compared to the majority populations in other industrialized countries. In addition, a study of the strength of the primary care component of the health care systems among OECD member states describes a weak primary care system in the USA and relatively strong primary care systems in other OECD countries.

The USA and EU have the largest number of immigrants in the world, yet immigrants to those two locales face two fundamentally different types of health care systems. Immigrants to the United States encounter a largely market-driven system while immigrants to industrialized EU countries encounter universal, government-sponsored health care access programs. The following discussion addresses these two scenarios, borrowing from Aday’s *Framework for Studying Vulnerable Populations* to structure the utilization discussion. For each health services utilization scenario, (1) general characteristics and health care needs, (2) programs to meet needs (including financing and access), and (3) utilization trends are discussed.

Immigrants and Health Services Utilization in the United States

General Description and Health Care Needs

Although immigration is a global issue, the United States has the largest immigrant population at approximately 39,000,000, with approximately 12% of the population born outside the US. The immigration status of immigrants impacts their utilization of health services. Immigrants admitted for legal permanent residence in the United States are considered documented or legal immigrants and form approximately two-thirds of the foreign-born population. Persons who immigrate without applying for legal residence are considered undocumented or illegal immigrants and are an estimated one-third of the foreign-born population. About 80% of undocumented immigrants are from Latin American countries. Some evidence supports the “Hispanic Paradox” or the idea that, despite lower socioeconomic status, these immigrants have lower mortality rates.

The nature of the individual’s immigration experience contributes to his or her health care needs. For some immigrants, especially undocumented immigrants, the immigration context may increase the prevalence of posttraumatic stress disorder, depression, social isolation, lack of preventive care, and serious health problems. Once in the United States, undocumented workers are likely to find employment in lower paying and less desirable jobs that lack health benefits. Children from immigrant families are generally in worse physical health than children from nonimmigrant families and use health care services at a significant lower frequency.

Programs to Meet Needs

Access to medical care in the USA is affected by a combination of factors, including acceptability and adequacy of services to those in need of care, availability, and affordability of services. Acceptability and adequacy of health services can be affected by complex cultural and social beliefs, miscommunication, misinformation, misunderstanding, and mistrust between medical service provider and patient. Health care providers must be located in areas where immigrants are welcomed; facilities requiring proof of citizenship or residence status for eligibility discourage undocumented immigrants from seeking care. Facilities that fail to provide bilingual staff or translators may also decrease the availability of health care services.

US immigration policies contribute to affordability and utilization of health services. Payment for immigrant health care services comes from Federal programs, including Medicare and Medicaid. However, undocumented immigrants have the less access to these payment sources. Undocumented immigrants are not eligible for Medicare, Medicaid, or CHIP (Children's Health Insurance Program). Immigrants may therefore join the working poor who earn too much through employment to qualify for Medicaid, yet earn too little to afford private health insurance. Since the 1996 welfare reform, most newly arrived older immigrants with less than five years of residence are barred from using Medicaid benefits and are also ineligible for Medicare due to lack of work history. Uninsured and undocumented immigrants may seek care in free neighborhood clinics, clinics accepting cash payment, and emergency rooms. In 2004, the proportional distribution of private and public spending on national health expenditures was about 45% versus 55%.

Utilization Trends

Among populations with continuous private coverage and without coverage (uninsured), immigrants, especially noncitizens, are less likely to use preventive services than natives. The longer immigrants stay in USA, the closer their health care utilization approximates native-born persons. Among the publicly insured, immigrants' utilization is similar to natives, although noncitizen immigrants are significantly less likely to use preventive services. US-born adults have significantly more non-preventive visits than immigrants. The effects of education, having usual source of care, and having other public insurance were stronger among immigrants than natives. Lower utilization of both preventive and non-preventive services may result from a combination of better health and more limited resources. Among Latinos, patterns of access and use of health care services tend to improve with changing legal status. Immigrants with limited resources often seek care in emergency rooms rather than primary care clinics. Restricting immigrants' access to health care services costs the health care system more overall. Providing preventive and primary care is more cost effective than paying for emergency situations or problems resulting from lack of adequate health care services. A 2005 analysis of the 1998 Medical Expenditure Panel Survey shows that immigrants accounted for $39.5 billion in health care expenditures and per capita expenditures were 55% lower than those of US-born individuals. Expenditures for uninsured and publicly insured immigrants were half those of their US born counterparts. Immigrant children had 74% lower per capita health care expenditures than US born children. Emergency room expenditures were more than three times higher for immigrant children than for US born children.

Immigrants and Health Services Utilization in Other Industrialized Countries

General Description and Health Care Needs

As of 2007, 27 European countries form the EU, an economic and political partnership that seeks to harmonize social and economic policies. In 2008, the total number of non-nationals (persons not citizens of the country in which they reside) living in European Union member States was 30.8 million or 6.2% of the total European Union population. Approximately 40% of these come from countries outside of Europe. The EU emphasizes the need to integrate third country nationals into the EU system, giving them equal access to the rights of citizenship and social services including health services. As with US immigrants, the context of immigration contributes to the ease or difficulty in adjusting to the new society and these contexts may contribute to the prevalence of serious health problems. However, once in the EU, immigrants are offered social inclusion and the effective access to social protection. The EU recognizes that immigrants face a higher risk of poverty than the rest of the population and specific obstacles in accessing health care which may hamper their full participation in society. Specific initiatives seek to achieve full participation.

Programs to Meet Needs

Residence in an EU country is commonly the basis for entitlement to use of the health care system, resulting in near universal population coverage. Most of the EU countries have national health care programs, whether national health insurance systems, nationally owned health systems, or social insurance programs. The health systems provide comprehensive benefits, including preventive, public, primary, ambulatory, inpatient, prescription, mental health, and dental health services. Among countries, of course, there is variation in extent of cost sharing and range of benefits covered. The EU member States use a range of mechanisms, including public funds (tax and social insurance) for statutorily mandated benefits and private health insurance and out-of-pocket payments for services not covered in statutory benefits package. Public expenditures generally exceed private expenditures, although the proportion is falling and generally accounts for more than two-thirds of the health care expenditures.

The Council of European Union asserts the four core values of the EU member States' health care system: universal coverage, solidarity in financing, equity of access, and provision of high-quality health care. EU member States seek to provide universal coverage to all residents, including immigrants. Attempts to provide universal coverage may, in some cases, limit the breadth of coverage and therefore undermine financial protection of the insured. Increasingly, the fiscal sustainability of EU systems has been questioned. Response strategies have included increasing public revenues, lessening benefit obligations so that they can be met from existing revenue, and improving the capacity of the health systems.

Utilization Trends

European studies comparing migrants' access to health services are made difficult by incomparability of data (diverging measures of ethnic origin/migration status), incomparability of outcomes, and varying adjustment across studies for socio-economic and health status. The Migrant and Ethnic Minority Health Observatory Project (MEHO), funded by the EU, maps migrant health services to assist researchers and administrators to coordinate data collection and make more valid comparisons. Initial studies show that migrants tend to have lower attendance and referral rates to mammography and cervical cancer screening, more personal contacts per patient with general practitioners, and the same level of use for specialist care compared to nonmigrants in the EU. Emergency room utilization varied (lower, equal and higher across countries) and hospitalization rates were higher than or equal to nonimmigrants. This underscores the importance of understanding utilization of services among immigrant populations and the accompanying health outcomes.

Related Topics

- ► Access to care
- ► Acculturation
- ► Barriers to care
- ► Communication barriers
- ► European Union
- ► Health barriers
- ► Illegal immigration
- ► Immigration status
- ► United States

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Health Status

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The World Health Organization (WHO) defines health as a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity. The WHO definition, introduced in 1947 is broad, leaving much room for discussion and interpretation. Some believe that health should be more narrowly defined providing more specific guidelines to help identify who is healthy and who is not. Others believe that the definition inspires users to explore possibilities and challenge conventional notions about health. In practice, there has been little effort to develop ways to measure health using this WHO model. On the other hand, the definition is responsible for efforts to develop better conceptualizations of health. It emphasizes that in addition to the physical dimension, there are mental and social aspects of health. This model promotes progress toward higher functioning in several domains: energy, comfort, and integration of mind, body, spirit and social interactions. Social well-being, social health, and mental health appear to be linked.

There are many different ways to measure the status of health populations. Internationally life expectancy, overall mortality rate, healthy life expectancy, and the prevalence of HIV are used to measure health status across counties. In industrialized countries, more specific measures such as disease-specific mortality, low birth-weight births, and self-rated health status are available for analyzing differences in health status. The relationship between health status measures and income and education has been documented and studied for decades. In the last 15–20 years, conceptions of health and the factors that affect health status have become more nuanced. Reports from the Whitehall study in England have led the quest to understand contributions of social determinants to health. These studies are helping to develop a better understanding of health and the factors that influence how it is maintained.

Models of Health

In addition to the WHO definition of health, there are other models used to guide thinking about health. The *medical model of health,* promoted by scientific medicine, focuses on the presence or absence of disease or disability. This emphasis works well for clinicians and those who focus on symptoms. This view restricts health to the sphere of professional knowledge and experience in an illness treatment system. This results in most health resources being used to treat the signs and symptoms of disease. Often, treatment is centered on the individual and devoid of social or cultural context. While the medical model is prominent in industrialized societies, many health professionals are beginning to incorporate social and cultural context into their practices.

The *wellness model of health* has foundations in health promotion. Primary prevention plays an important role in developing efforts to promote wellness. While the wellness model has an individual focus, it can easily provide a context for community wellness. There is increasing interest in assessing lifestyle and personal health behaviors in a community context. Critics of the wellness model point out that many of the components of the model are difficult to measure. The *environmental model of health* adapts health to include the influence of physical and social surroundings. The built environment, air and water quality, damage to the environment as a result of the actions of man are all factors that can influence health of individuals that can be measured only at geographic level (e.g., neighborhood, county, state). Individuals who are well adapted to their environment are less likely to experience stress and disease. How individuals and communities adapt to their social and physical environments is the essence of the environmental model. Proponents of this model are interested in how well individuals and communities harmonize with their ecology. In this model, the healthy individual who is comparatively free from undue pain, discomfort, or disability is in balance with his environment.

Social and Environmental Health

The social aspect of health has started to receive attention in research studies conducted in the last 10–15 years. Studies have associated health status with the social and physical environment in which people work, live, and age. People's health is impacted by the amount of social support and how socially connected they are. Social capital, a concept popularized by Robert Putman, is based in mutual trust, reciprocity among member of the group, and patterns of social engagement. Collective efficacy measures how well members of a community work together for common good. Social capital and collective efficacy have been demonstrated to be supportive of health after controlling for the effects of socioeconomic status in advantaged neighborhoods. Research conducted across a broader range of neighborhood environments has been less conclusive. It is important to continue efforts to understand how connections with our social environments affect health.

Health is determined in large part by individual health behaviors. Many health behaviors are established early in life in the context of family and cultural values. Some behaviors are influenced by knowledge learned in formal education settings and informal circumstances. Individual behaviors also may be influenced by the physical and built environments in which people live. Neighborhoods that contain or have access to parks and sidewalks may be more physically active. Community access to fresh foods may help maintain healthier eating behaviors. Understanding how to support people in modifying unhealthy behaviors is an important focus of health promotion efforts. Stress is another noteworthy influence on health. The way people live and work produce stress that can have a negative impact on health and well-being. Differences in socioeconomic status, race, and ethnic groups can expose individuals to varying levels of stress. Racial discrimination is another stressor that may have a negative impact on health.

Measures of Health Status

There is a wide array of measures of health status. Mortality data are the most universally available health statistics and a consistent resource to monitor changes in leading causes of death. Worldwide, the most common health status measures are life expectancy, all-cause adult mortality, and mortality under 5 years of age. Mortality data are not necessarily the best measure of health; many conditions that result in illness or disability do not result in death. There are many web-based resources that identify and monitor health status measures; the Community Health Status Indicators (CHSI) report is one such tool. This resource allows community advocates access to statistics that can assist in creating a healthy community. The CHSI Project is a partnership between several United States government, nonprofit, and academic agencies. The web-based reports supplied by CHSI give information about how to measure health status and statistics for recommended measures for all counties in the United States. Ten broad categories of health statistics are provided: demographics, summary measures of health, national leading causes of death, measures of birth and death, relative health importance, vulnerable populations, environmental health, preventive services use, risk factors for premature death, and access to care. The variety of the health measures provided by the report helps to understand the breadth of indicators that have been developed to measure health status. Summary measures for health status in the United States supported by CHSI are: life expectancy, all-cause mortality rates, self-rated health status, and average number of unhealthy days in the last month.

Healthy People 2010 is a national health promotion and disease prevention initiative that challenges individuals, communities, and professionals to ensure good health and long life for all. The leading *Healthy People 2010* health indicators are: physical activity, overweight and obesity, tobacco use, substance abuse, responsible sexual behavior, mental health, injury and violence, environmental quality, immunization, and access to health care. It is interesting to note that most of the recommended summary measures are measures of physical health. The information technology that supports measurement has not caught up with the science that acknowledges the significance of the role of the social and physical environmental in health.

Health Status and Socioeconomic Status

For almost every measure of health the more advantaged individuals are, the better their health. Socioeconomic status is a measure of an individual's social standing in the community. The core concepts of socioeconomic status are captured by combining measures of educational attainment, income, and occupational standing. Because these three measures are highly correlated, many studies use only income or education to measure socioeconomic status. Similar associations with health status have been found no matter which socioeconomic status indicator is used. The evidence shows that as rates of osteoarthritis, hypertension, cervical cancer, and all chronic diseases decrease, socioeconomic status increases This is true, too, for rates of unhealthy behaviors such as smoking, sedentary lifestyles, and exercise.

Prior to the mid-1980s, researchers considered only the relationship between poverty and health. It was believed that incomes above the poverty line would not have a significant contribution to improved health. Research published between 1985 and 1995 shows a changing comprehension of health being affected along the continuum of socioeconomic status. Reports by Michael Marmot and colleagues from the Whitehall study in England presented strong evidence showing that among British civil servants, 10-year mortality rates decrease as occupational grades increased. Many studies conducted in this period showed similar results, although they used different measures of mortality and different measures of socioeconomic status; findings clearly showed a gradient between levels of socioeconomic status and mortality.

A direct relationship between socioeconomic status has been identified in most industrialized nations. The strength of this relationship is not uniform; the strength of the association between socioeconomic status and health is weaker in more egalitarian countries such as the Scandinavian countries. Studies of income inequality report that states in the United States with more unequal distribution of income are more likely to have adverse health outcomes.

Social Determinants

As evidence is developed that confirms understanding about relationships between health and socioeconomic status, interest moves to improving knowledge about other factors figuring in the relationship between health and socioeconomic status. There are multiple pathways by which socioeconomic status determines health; a comprehensive analysis must include macroeconomic contexts and social factors as well as more immediate social environments, individual psychological and behavioral factors, and biological predispositions and processes.

A variety of conceptual models have been designed to explain the relationships between various ways that biology, genetics, and social and environmental factors contribute to health. Race, ethnicity, socioeconomic status, and other demographic measures have an impact on health; the impacts are direct, indirect, and interactive. The Institute of Medicine emphasizes that health is a concept for which there are linkages and relationships among the multiple determinants of health. This ecological model assumes that health and well-being are influenced by the interactions that occur among the determinants. The interactions occur in community and are supported by social activities that create community cohesion. Community cohesion is built through social interaction with neighbors that builds trust, such as reciprocal actions of providing support for others and accepting assistance from others. Using an ecological model requires knowledge of the determinants that influence health under the circumstances (e.g., childhood obesity, exercise and nutritional habits at home, access to safe outdoor environments in which to play, schools with physical education class and programs that provide healthy meals). In *Social Determinants of Health Second Edition: The Solid Facts*, Michael Marmot and Richard Wilkinson discuss how social determinants impact health status in populations across the world. This report building on evidence from the Whitehall Study and other research about the social determinants of health provides ten messages about social determinants based on: the social gradient, stress, early life, social exclusion, work, unemployment, social support, addiction, food, and transport.

Health Disparities

Reduction of health disparities is one of the goals *Healthy People 2020*. In the United States, there are documented disparities in income and education between race/ethnic groups. It is critical to the understanding of the role of race/ethnicity in health to examine the extent to which differences in health status may be attributed to socioeconomic differences. Studies that analyze race/ethnicity make it clear that not all differences in health among race/ethnic groups are due to socioeconomic differences. The influence of race and ethnicity on health is not yet understood.

Immigrant Health Status

Immigration plays a significant role in the health status of racial and ethnic minorities. Studies of immigrant health status document differences in health status of immigrants and their native-born American counterparts with the same racial and ethnic origins. Immigrants arrive in the United States healthier than their native-born counterparts, but over time this advantage disintegrates. The "healthy immigrant effect" explanation posits that people who are healthy choose to immigrate, then over a period of years assimilate into the dominant culture, adapting eating habits and other behaviors that impact weight gain and other aspects of health. Research evidence based on self-reported health status, health conditions, activity limitations, and mass body index (BMI) measured over time substantiates this explanation.

Future Directions

Health is more than the absence of disease or infirmity. Research over the past several decades suggests that health is a complex concept. While much of health status research focuses on mortality-related indicators, increasing emphasis is being given to issues related to health and wellness, oral health, and mental health. Current thought is that health is influenced by environmental and social determinants, behavior, genetics, and biology, in addition to the health care system and social policy. Increasingly, measures of lifestyle and behavior are being used to monitor changes in health status. Researchers continue to extend the understanding of how individual and community health interact with the social and physical environment. Differences within and across race and ethnic groups are influenced by differences in genetic makeup and biology and complicated by diverse social and environmental circumstances. Health disparities research strives to understand the influences of individual mechanisms that contribute to illness and disabilities and how those mechanisms are influenced by membership in different subpopulations in society. To understand the causes of disparities in health status will require revised and new research approaches that include basic, clinical, behavioral, epidemiological, translational, and health services research. Determining health status of immigrants will require that in addition to considering the topics addressed above, researchers will need to take into consideration the origins of the immigrants and their circumstances and health prior to immigration.

Related Topics

- ► Access to care
- ► Built environment
- ► Health determinants
- ► Health disparities
- ► Healthy immigrant
- ► Life expectancy
- ► Mortality and morbidity
- ► Poverty
- ► Social capital
- ► Stress

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Suggested Resources

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Healthy Immigrant

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On average, newly arriving immigrants are healthier than natives of similar ethnic backgrounds. This is known as the "healthy immigrant effect." It is also referred to as the "healthy immigrant paradox" because immigrants often have high risk factors, such as higher rates of poverty, lower education, and poorer work and housing conditions than native-born residents, and because many immigrants arrive from countries that have lower standards of living, yet still have better health outcomes and lower mortality from the same causes of death. This effect has been widely studied for immigrants to Canada, Australia, Western European countries, and the United States.

Canada and the United States serve as valuable settings for healthy immigrant studies as both countries passed immigration acts – the Immigration Act of 1976 in Canada, and the Hart-Celler Act of 1965 in the United States – that affected the nature and volume of immigration. Prior to the immigration Acts, immigrants mostly arrived to these two countries from European nations such as the United Kingdom, France, Spain, Sweden, Denmark, Italy, and Greece. Subsequent to the passage of the immigration Acts, immigrants began arriving from Asian, Latin American, and Caribbean countries. Immigrants now originate from numerous countries around the world. This expanded pool provides researchers diverse immigrant populations for healthy immigrant studies.

Immigrants are found to be healthier than native populations across a variety of health conditions and indicators. Some studies show that immigrants have significantly lower incidences and risks of mortality from chronic diseases such as cardiovascular disease, hypertension, lung and prostate cancer, chronic obstructive pulmonary diseases, liver cirrhosis, and asthma. Immigrants tend to have lower rates of infectious diseases such as pneumonia and influenza, as well as unintentional injuries and suicide, and higher life expectancies. Pregnancy outcomes such as preterm births, low birth weights, and infant deaths also tend to be better for immigrants as compared to native-born populations. In self-reported surveys of health, immigrants report higher levels of satisfaction with their health status than their native-born counterparts. These trends persist when ethnicity, sex, and age at immigration are controlled variables.

Researchers offer several explanations for the phenomenon. Some posit that the requisite health screenings immigrants must undergo allow only the most physically able and fit for entry into a country. For example, Canada's Immigrant Act of 1976 broadened the criteria for "prohibited classes" of people that were denied entry into the country. People are denied entry if they suffer from an existing disease, disorder, disability, or other health impairment that is likely to be a danger to public health or safety, or will result in excessive demand on the Canadian health care and social services system, as deemed by a medical officer. That is, there is a selection bias in the system and immigrants to Canada and the United States are a healthier group than those who remain in their country of origin. Similarly, there is a self-selection bias as immigrants who are healthier and wealthier tend to be those who are migrants. Third, the healthy immigrant effect is believed to be a consequence of health and social factors. Many immigrants originate from regions of the world where lifestyle-associated behaviors that contribute to chronic diseases, such as inactivity, smoking, alcohol consumption, poor diet, and obesity, are less prevalent than in the developed world. Some posit that high human capital and strong social networks among immigrant families and communities provide a protective effect against ill health. Finally, though less-well studied, the "hygiene" hypothesis and vitamin D hypothesis are possible explanations of the healthy immigrant effect.

Healthy immigrant studies are usually conducted in several ways. Some studies compare health characteristics or outcomes in a cohort of immigrants with those in a demographically similar component of the host populations. A few longitudinal health studies were undertaken where researchers followed immigrant populations through time to ascertain changes in health outcomes. Researchers may also observe the effects of migration by comparing a group of immigrants with nonimmigrant counterparts who remain in their country of origin, although this is less common.

It is unclear for how long the healthy immigrant effect lasts. There is consensus that the health advantage diminishes, and the gap between native health and immigrant health closes the longer an immigrant lives in his/her adopted country. A longer length of residence is associated with health status, mortality patterns, and health behaviors that are convergent toward that of native-born populations. Little is understood of the behavioral and sociocultural factors that may be protective of good health in immigrants. Researchers are still attempting to determine the contribution of acculturation and assimilation on the healthy immigrant effect. Furthermore, questions remain as to whether, or to what extent, the healthy immigrant effect persists for children of immigrants, and how ethnic origin, country of birth, and environmental exposures predict or explain the health and mortality differentials between native and foreign-born populations. In order to fully understand immigrant health, it is also important to disaggregate studies of "immigrants" as this is a heterogeneous group with distinct differences in characteristics among subgroups of foreign-born peoples.

Related Topics

- ▶ Acculturation
- ▶ Air pollution
- ▶ Alcohol use disorders
- ▶ Allergies
- ▶ Assimilation
- ▶ Asthma
- ▶ Behavioral health
- ▶ Birth weight paradox
- ▶ Built environment
- ▶ Cancer
- ▶ Cancer health disparities
- ▶ Chinese Exclusion Act of 1882 (U.S.)
- ▶ Chronic disease
- ▶ Community
- ▶ Cross-cultural health
- ▶ Culture-specific diagnoses
- ▶ Dietary patterns
- ▶ Emigration
- ▶ First generation immigrants
- ▶ Health determinants
- ▶ Health outcomes
- ▶ Health status
- ▶ Hypertension
- ▶ Immigration and Nationality Act Amendments of 1965 (U.S.)
- ▶ Immigration in the global context
- ▶ Immigration processes and health in the U.S.: A brief history
- ▶ Infant mortality
- ▶ Liver cirrhosis
- ▶ Obesity
- ▶ Occupational and environmental health
- ▶ Racial disparities
- ▶ Smoking

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Heat Stroke

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Heat stroke is the most severe manifestation of a spectrum of illness, and as such represents an immediate threat to life. Even if not immediately fatal, the complications of heat stroke can include renal (kidney) failure, rhabdomyolysis (muscle breakdown), and severe metabolic derangements. Heat stroke is better prevented than treated, and is of particular concern for undocumented immigrants attempting to enter the United States along its southern borders. In Pima County, Arizona, alone there are over 100 heat-related deaths per year, and the risk of death has been demonstrated to increase predictably with rises in the ambient temperature.

Particular Risks for Undocumented Immigrants

Undocumented immigrants are at a particularly high risk for heat-related illness. Increased efforts at securing the United States' southern borders have led to undocumented immigrants seeking out increasingly remote areas to cross. Individuals crossing the border may have a limited ability to carry water or other liquids, and may not have access to shelter from the sun. Some individuals use stimulants such as caffeine in order to stay awake in an attempt to speed their journey. However, these substances may aggravate dehydration by increasing water loss. Individuals may not accurately assess their risk of crossing, or may be abandoned by their *coyotes* (guides/smugglers), leaving them vulnerable in the desert.

The Spectrum of Heat Illness

Heat stroke is generally the last stage of progressive heat illness brought on by progressive exposure to a hot environment, and is preceded by heat cramps, which progress to heat exhaustion. Heat cramps are generally the initial presentation of heat illness. Brought on by continued activity in a hot environment, mild dehydration, and inadequate electrolyte replacement, victims may complain of muscle cramping and aches, and feeling mildly unwell. Left untreated, heat cramps will progress to heat exhaustion. Heat exhaustion is a more severe stage of illness, generally accompanied by an increasing feeling of illness. Individuals with heat exhaustion are frequently nauseated and may vomit and are generally still sweating profusely. While the body is under tremendous physiologic stress, these individuals are still compensating for that stress, and generally still have a normal or mildly elevated body temperature and a normal mental status.

Heat stroke is the terminal event in the progression of untreated heat-related illness. The body's compensatory mechanisms have failed. The victim is sufficiently dehydrated that sweating has slowed or ceased (leading to the classic characterization of hot, dry, red skin), and the body temperature is no longer controlled, and can be as high as 108°F. Unless treated immediately and aggressively, heat stroke will be fatal in a short time.

Treatment of Heat Illness

The progression of heat illness can easily be reversed early in its course with relatively straightforward interventions. Removal of the patient from the hot environment is crucial. The provision of water and food will suffice for relatively mild cases. It is important first and foremost to replace lost body water, but with progressively severe dehydration the use of electrolyte replacement drinks can be considered, so long as they are not sufficiently concentrated to make the victim more nauseated or induce vomiting. Individuals with more severe heat-related illness who cannot tolerate oral fluids may require intravenous (IV) fluids. Again, replacement of body water and electrolytes (essential elements found in the blood) is important for resolution of the illness.

The treatment of heat stroke requires immediate and aggressive therapy. Not only must fluids be replaced and electrolyte derangements corrected, but the body must be rapidly cooled to avoid progressive organ damage. Removal of the patient's garments and the use of evaporative cooling (fans and water sprayed upon the patient) or immersion in ice or ice water have been documented. Patients may develop hemodynamic instability (dangerous fluctuations in heart rate and/or blood pressure), rhabdomyolysis, or progress to multi-organ failure, and are generally best treated in an intensive care setting.

Prevention of Heat Illness

Common-sense measures can help prevent heat-related illness. Adequate hydration is important, especially when exercising or working in a hot environment. Individuals should drink water before, during, and after activity, as the thirst reflex lags behind water loss. Light-colored clothing that reflects heat will reduce the absorption of radiant energy, as will a shaded area. "Sweat suits" or rubberized exercise or work gear should be avoided. Humid environments pose a particular risk, as the body depends on the evaporation of sweat for effective cooling.

Conclusion

Heat illness ranges from relatively mild heat cramps to life-threatening heat stroke, in which the body's cooling mechanisms completely fail. Undocumented immigrants are particularly at risk, as they may face harsh environments and lack of access to shade and water. Treatment may range from simple oral rehydration for heat cramps to intensive care unit admission for severe heat stroke. Prevention requires simple, straightforward measures, such as attention to hydration and the avoidance of prolonged activity in a hot and humid environment.

Related Topics

- ► Access to care
- ► Border
- ► Border health
- ► U.S.-Mexico border
- ► Undocumented

Suggested Readings

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Suggested Resources

The American Red Cross. Retrieved from http://www.redcross.org/

US Customs and Border Protection. Retrieved from http://www.cbp.gov/

Helicobacter pylori

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Background

Helicobacter pylori (*H. pylori*) is a bacterium that infects approximately half of the world's population. Infection is acquired typically during childhood and is much more common in the developing world where poverty, crowded living conditions, and poor sanitation increase the risk of infection. Within developed countries, these same risk factors make infection more common among immigrants. Without treatment, infection is lifelong. In most cases the infection causes no symptoms, but it is associated with chronic irritation and inflammation of the stomach (gastritis) and can have serious consequences. Infection with *H. pylori* is associated with the development of anemia, peptic ulcer disease, and two types of cancer – gastric adenocarcinoma and gastric mucosa-associated lymphoid tissue (MALT) lymphoma. The prevalence of infection with *H. pylori* and serious consequences associated with the infection make it an important topic for persons immigrating from resource-limited to resource-rich settings.

Geographic Rates of Occurrence

The incidence of *H. pylori* infection and gastric cancer varies tremendously by geographic region. While the occurrence of gastric cancer is declining in developed countries, it is increasing globally. *H. pylori* infection is thought to be responsible for more than 5% of the current global burden of cancer. *H. pylori* infection and gastric cancer are most common in East Asia, Eastern Europe, and South America, while they are less common in North America and Western Europe. In countries where infection is less common, tremendous ethnic disparities can still exist. In the United States, for example, 26% of non-Hispanic Whites are infected, whereas 62% of Hispanic-Americans are infected. For reasons that remain poorly understood, *H. pylori* infection is exceedingly common in sub-Saharan Africa, but the incidence of gastric cancer remains relatively low.

Clinical Manifestations

H. pylori is adapted uniquely to thrive in the human stomach. It is a curvilinear Gram-negative rod with a flagellum that allows it to swim through the viscous mucus that coats the inside of the stomach. It creates chemicals that alter the composition of the stomach contents, creating an environment that is more favorable to bacterial survival. The bacteria do not invade any tissues, but produce toxins that cause an inflammatory response that leads to tissue damage and release of nutrients for the bacteria to consume. This inflammation can lead to ulceration and, in a smaller proportion of cases, gastric cancer. These clinical manifestations develop typically decades after acquisition of the infection. Earlier in infection, children are at risk for the development of iron-deficiency anemia that is refractory to iron supplementation; this may be associated with malnutrition and growth retardation.

Screening and Treatment

The potential for serious complications of this extremely common infection raises questions about screening and treatment; however, this topic remains controversial because of the limited data on cost-effectiveness. Several methods of screening exist, but the definitive method for diagnosing active infection remains upper gastrointestinal endoscopy with gastric biopsy. This procedure involves sedating a patient, passing a camera through the mouth and into the stomach, removing a small piece of the stomach, and evaluating it under a microscope for evidence of infection. While definitive, this method is costly and exposes the patient to risks associated with anesthesia and instrumentation. It is usually reserved for patients with symptomatic disease. In Japan, all individuals over the age of 40 are offered radiologic screening for gastric cancer. This is costly, exposes the patient to risks associated with radiation, and identifies malignancy only after it has developed. Blood tests can detect antibodies to *H. pylori* and can be a useful screening test for adults without a history of infection. These tests are not approved for use in children and can remain positive even after treatment for the infection; therefore, they are not useful if a patient has been diagnosed and treated previously. The urea breath test is a noninvasive test utilizing a radioactive isotope to detect *H. pylori* metabolism in the gut; this can be used to monitor response to therapy in adults. Since infection with *H. pylori* is very common, but the most serious complications of the infection remain relatively rare, screening is reserved generally for patients in countries with a high incidence of gastric cancer and is begun in adulthood. Screening is not performed on children because of the increased risk for reinfection and the lower likelihood of clinically relevant disease. Children presenting with symptomatic disease such as peptic ulcer disease or unexplained refractory iron-deficiency anemia should undergo upper gastrointestinal endoscopy with gastric biopsy.

Eradication of *H. pylori*

Eradication of *H. pylori* is accomplished usually via a combination of antibiotics and proton-pump inhibitor medications that decrease the acidity of the stomach contents. Often the regimen includes three drugs that must be taken two times daily for 10–14 days. This regimen is very effective, but increased use of these medications and poor adherence to prescribed regimens have contributed to a rise in drug resistance that eventually may make treating *H. pylori* more difficult. Treatment is indicated in children with symptomatic gastritis, peptic ulcer disease, unexplained iron-deficiency anemia, or a first-degree relative diagnosed with gastric cancer. Any adult found to be infected should receive treatment. Eradication of *H. pylori* can correct associated iron-deficiency anemia in children, prevent recurrence of peptic ulcer disease, and lead to clinical regression of gastric lymphoma in up to three-fourths of patients. Additionally, eradication decreases lifetime risk for the development of gastric adenocarcinoma. Transmission among adults is rare, making reinfection in adulthood unlikely.

H. pylori is an extremely common infection of the stomach that can cause a broad spectrum of pathology, from asymptomatic colonization to peptic ulcer disease and malignancy. Immigrants from resource-limited settings are at an increased risk for having this infection and remain at increased risk for developing complications of infection even after settlement in low-risk countries. The role of screening for infection remains a topic of debate, but once detected *H. pylori* often can be eradicated with a 2-week course of medication. Eradication is associated with improvement of symptomatic disease and decreased risk of gastric adenocarcinoma and MALT lymphoma. While worldwide eradication of the organism is unlikely, implementation of appropriate screening and treatment strategies are likely to decrease the burden of infection among those currently at highest risk, including residents and immigrants from the developing world.

Related Topics

- ► Cancer
- ► Child health and mortality
- ► Hepatitis
- ► Nutrition
- ► Risk factors for disease
- ► Screening
- ► Serologic tests

Suggested Readings

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Suggested Resources

For the World Health Organization (WHO). http://www.who.int/en/

For information on cancers and risk factors worldwide. http://www.who.int/nmh/publications/fact_sheet_cancers_en.pdf

Helsinki Declarations

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The Declaration of Helsinki (DoH) is a document issued by the World Medical Association (WMA) that provides ethical guidance for research involving human beings. The Declaration was developed almost 20 years after World War II, as a response to the abuses by Nazi physicians and to complete the Nuremberg Code. This document was developed to offer protection from harm and exploitation of the most vulnerable categories of research subjects. While the Nuremberg Code emphasized the need for voluntary consent, the Helsinki Declaration started from the premise that the very mission of the physician is to safeguard the health of the people. The Declaration aimed to add further provisions to Nuremberg Code, especially aimed at safeguarding population lacking legal capacity for consent, such as children, mentally ill, temporarily incapacitated, when participating in research. Furthermore, it introduced the concept of therapeutic versus nontherapeutic research.

The Declaration was first adopted in 1964 and, since then, it has been revised several times in order to reflect current practices. Significant additions to the initial version were made in 1975, followed by minor additions in 1983 and 1989. One notable change appeared in the 1996 version, when a paragraph from the previous version saying that: “In any medical study, every patient including those of a control group, if any should be assured of the best proven diagnostic and therapeutic method," was followed by a paragraph stating that: "This does not exclude the use of placebo, or no treatment, in studies where no proven. . .method exists." This paragraph was to create controversy and debates the following years due to placebo-controlled, mother-to-child HIV transmission trials carried out in developing countries when concerns were raised by some who publicly criticized such research, since the Declaration of Helsinki prohibited the use of placebos when a proven "prophylactic, diagnostic or therapeutic" method exists somewhere in the world. As these HIV trials have been also strongly defended, pressures for another revision of the Declaration of Helsinki were made.

It took WMA several years to produce a significantly revised version of the Declaration, in 2000. This version was not spared for its share of controversy, mostly because of the new Paragraph 29, which reiterated the same statement from the 1996 version: "The benefits, risks, burdens, and effectiveness of a new method should be tested against those of the best current prophylactic, diagnostic, and therapeutic methods. This does not exclude the use of placebo, or no treatment, in studies where no proven prophylactic, diagnostic or therapeutic method exists."

The following years, as the controversy over this paragraph arose, WMA published "notes of clarification": in 2002, on placebo studies, yet no change to the requirements have been made and in 2004, when it stated that patients are entitled to be informed of the outcomes of the research and to share any benefits that come from the study and that arrangements for patients to benefit from the research after the end of the study should be made. Even if the Declaration did not provide information about who should fund these arrangements, it stated that these are to be included in the protocol and reviewed by an ethics committee. In case such post-study arrangements are judged as inappropriate by the ethics committee, then the study should not be approved.

There have been many calls for a new revision, and 3 years later another revision process was initiated that ended in the latest version which was issued in 2008. According to many, the latest version strengthens previous versions in some areas but it weakens some of the initial provisions in other areas.

The 2000 version was strongly opposed by the US Food and Drug Administration (FDA) that supports the use of placebo controls in the studies which are submitted to the agency for drug approvals. As a result of the changes made, FDA abandoned its previous rule that foreign studies must comply with the provisions of the Declaration of Helsinki. In 2008, the American regulatory agency issued new regulations that basically replaced the Declaration with the International Conference on Harmonization (ICH) Good Clinical Practice Guidance (GCP), as these documents contain weaker provision regarding the use of placebo controls in clinical studies.

While the first version of the Declaration was intended to guide physicians who were engaged in research involving human participants, its latest version urges other categories and organizations which are involved in research with human participants to adopt its principles. Nowadays, the Declaration is considered a fundamental document in the ethics of health care research and its principles have been embodied in national and international guides and regulations. In order to conform to the standards included in the Declaration, researchers that are involved in studies with human subjects need to respect the autonomy of each individual, promote and safeguard his/her health, provide informed consent without coercion, take special measures with vulnerable populations, compare new therapies against best available ones, have a sound scientific knowledge of the subject, assess risks against benefits, engage in studies that would provide a benefit to the population involved, disclose the results of their studies accurately, and fully disclose any ethical concerns in their study protocols.

The relevance of DoH in relation to vulnerable population, such as immigrants, relies on the introduction of principle of distributive justice. Therefore, the Declaration requires that researchers make sure that the risks and benefits of their inquiry are evenly distributed to participants in research, as well as to the communities to which the study participants belong. Furthermore, it calls for the minimization of the use of placebo controls, insists that populations to which the study participants belong benefit from the research, and requires that therapeutic agents be made available to all trial participants, even after the trial has been completed.

Related Topics

- ► Council for International Organizations of Medical Sciences
- ► Informed consent
- ► Nuremberg Code
- ► Vulnerable populations

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Hepatitis

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Introduction: The Impact of Global Migration

The impact of worldwide immigration has implications at many levels. This includes those at the public health level which has resulted in a shift in infectious disease epidemiology. In developed regions of the world, many infectious diseases have fallen to historical low levels of prevalence or have overall eliminated endemic transmission. However, as a consequence of migration patterns, immigration of individuals from areas of high incidence of infectious diseases such as tuberculosis, hepatitis, and HIV have brought a resurgence of these diseases into areas of low prevalence and incidence. Thus, infections that have been well controlled in immigration-receiving nations are now increasingly observed in the foreign-born population. With this growing public health challenge facing these host nations, it will be critical for health care providers, both at the primary care level as well as specialty care, to be able to recognize, diagnose, and manage such diseases. This entry will focus specifically on the viral hepatitis (A, B, C, D) which remains a global public health challenge facing immigrant-receiving nations today.

Viral Hepatitis

The term "hepatitis" is a non-specific one, and is simply defined as inflammation of the liver. Hepatitis can be acute and self-limiting, or chronic and progressive, leading to cirrhosis and end-stage liver disease. Hepatitis results from a wide range of causes, not only from infectious diseases, such as from viruses, but also from drugs and toxins as well as metabolic and autoimmune causes. Viral hepatitis can be caused by infection from any of the six viral agents: hepatitis A (HAV), hepatitis B (HBV), hepatitis C (HCV), hepatitis D (HDV), and hepatitis E (HEV). All of these human hepatitis viruses are RNA-based with the exception of hepatitis B, which is a double-stranded DNA virus. Although each virus has its distinct molecular and antigenic properties, the clinical manifestations after infection of any of these viruses are similar. However, route of transmission may vary. Individuals infected can be asymptomatic or present with fulminant liver failure. Typical symptoms include jaundice, right upper quadrant abdominal pain, fever, nausea, vomiting, and poor appetite. Some of these viruses can lead to chronic infection.

Hepatitis A

HAV is transmitted through the fecal–oral route, through person-to-person spread and in the setting of poor personal hygiene and overcrowding. Infections typically occur during childhood in areas of poor sanitation and crowded living conditions. However, with improvement in sanitation and hygiene, this has resulted in delay of infection. Therefore, the number of persons susceptible to the infection increases. The infection typically occurs in large outbreaks as well as sporadic cases with the source traced to contaminated food, water, milk, various fruits and vegetables imported from endemic countries. HAV is self-limiting and does not progress to chronic infection.

The prevalence of HAV infection varies worldwide, and correlates with socioeconomic conditions, particularly hygienic and sanitary conditions. Developing countries with poor sanitary and hygienic condition that are considered areas of high endemicity include parts of Africa, Asia, and Central and South America. In these geographic areas, infection is acquired often during childhood. Developed countries of low endemicity include Northern and Western Europe, Japan, Australia, New Zealand, USA, and Canada due to good sanitary and hygienic conditions. Although infection rates are very low in these countries, disease may occur among specific risk groups such as travelers to HAV endemic areas, migrant workers, and migrants from developing countries where HAV is endemic.

In the USA, the number of foreign-born persons began to steadily rise in the 1980s, increasing the number of foreign-born US citizens from approximately 9–32.5 million. The largest number within this group originated in Mexico, at 9.8 million (approximately 30% of the population), followed by Asia at 8.5 million (26%), and 7.3 million (23%) from other parts of Latin America. Based on these data, the majority of the foreign-born populations in the USA originate in countries considered highly endemic for hepatitis A. In one study by Weinberg et al., among Hispanic children who lived along the US–Mexico border in San Diego County from 1998 to 2000, hepatitis A cases were seen in 132 cases. The children were matched by age group and exposure period to 354 control subjects of Hispanic children who tested negative for anti-HAV. Of the exposed patients, 67% of them had traveled outside the USA during the incubation period compared to only 25% of children who did not have HAV infection. All but one of the children with infection had traveled to Mexico. It was during the summer months and Christmas holidays that travel had occurred the most frequently with the number of cases peaking 1–2 months after peaks in travel, reflecting the incubation period for hepatitis A. It was found that children with travel-acquired HAV infections were much more likely to have eaten food from street vendors and were more likely to have eaten salad or lettuce during travel compared to control subjects. Other studies have also described the association between pediatric travelers, hepatitis A infection, and the role of travel back to the country of origin.

Because hepatitis A is a potentially serious but vaccine-preventable disease, in 2006, the Advisory Committee on Immunization Practices of the US Public Health Service recommended routine hepatitis A vaccination of all children. In other countries, hepatitis A vaccination may not be included in their national childhood immunization schedule, and may only be recommended in children living in regions or communities with high rates of HAV infections. In the USA, with the implementation of a national hepatitis A immunization recommendation for all children, the goal is to prevent future community-based outbreaks in higher risk areas of the country, particularly in new immigrant growth centers.

Hepatitis B

The World Health Organization has called HBV a major global public health problem. It is estimated that two billion people worldwide have been infected with HBV with more than 350 million with chronic infection. It is estimated that 620,000 persons die annually from HBV-related liver disease. Approximately 25% of adults who become chronically infected during childhood later die from liver cancer or cirrhosis. HBV is 50–100 times more infectious than HIV. Despite causing significant morbidity and mortality, HBV infection is preventable with a vaccination that is safe and effective.

HBV is transmitted by percutaneous or mucosal exposure to infectious blood or body fluids. This most often occurs through injection drug use (IDU), sexual contact with an infected person, or from an infected mother to her infant during delivery. Primary acute HBV infection can be self-limited with subsequent lifelong immunity against reinfection. However, this can progress to chronic infection with continuing viral replication. The risk of developing chronic infection is inversely proportional to the age of exposure. Among those exposed to hepatitis B during birth, 90–95% will go on to develop chronic infection, and those exposed during childhood, 20–40% will develop chronic infection. In contrast, only 5% infected in adulthood will develop chronic infection. The progression from acute to chronic infection occurs when the immune system is not able to effectively destroy and clear virus-infected cells. Immunosuppressed persons, such as hemodialysis patients or persons infected with HIV, are at increased risk for chronic infection. Those chronically infected can remain asymptomatic for years until the development of cirrhosis and end-stage liver disease or advanced cancer. Moreover, those chronically infected often are unaware of their infection and their risks for transmitting the virus.

Worldwide, the transmission patterns of HBV and the seroprevalence of chronic infection vary significantly, although there are limited seroprevalence studies in many countries. Approximately 45% of persons worldwide live in regions where HBV is highly endemic (i.e., HBSAg prevalence is $\geq$8%). Historically, >90% of new infections occurred among infants and young children as the result of perinatal or household transmission during early childhood. Infant immunization programs in many countries have led to marked decreases in incidence and prevalence among younger, vaccinated members of these populations. Countries of intermediate HBV endemicity (i.e., HBSAg prevalence of 2–7%) account for approximately 43% of the world's population. Regions of the world with high or intermediate prevalence of HBSAg include much of Eastern Europe, Asia, Africa, the Middle East, and the Pacific Islands. In countries of low endemicity (i.e., HBSAg prevalence of <2%), such as the United States, and Northern and Western Europe, the majority of new infections occur among adolescents and adults and are attributable to high-risk sexual activity and injection drug use exposures. However, in these areas of low endemicity, prevalence of HBV infection is high among certain foreign-born groups.

In the United States, after the stepwise implementation of the national vaccination strategy to eliminate HBV transmission, the incidence of hepatitis B infection began decreasing in the mid-1980s. In 2007, the rate of infection was the lowest recorded at 1.5 cases/100,000 population since surveillance began in 1966. This represents an estimated decline of greater than 80% from rates reported in 1990, which was the year before the national strategy was implemented. Although the United States is considered a region of low endemicity, the prevalence of chronic HBV infection is high in various parts of the country. In 2006, approximately 800,000–1.4 million US residents were living with chronic infection, with 47–70% of these persons foreign-born. Chronic infection is more likely to occur in high-risk groups such as Asian Americans and emigrants from areas of the world where HBV is prevalent. This includes China, Korea, Southeast Asia, the Indian Subcontinent, Africa and Micronesia. In 2005, a seroprevalence study was conducted in New York City in order to assess the prevalence of chronic HBV infection among the Asian/Pacific Islanders. Among the 925 participants, 137 (14.8%) were found to be HBSAg-positive. The prevalence of chronic infection was highest in those less than 30 years of age. The majority of participants were immigrants, with 46% having lived in the US for less than 10 years. Other screening programs have also been conducted in other cities in the US, including Chicago, Philadelphia, and California, with results showing that 10–15% of Asian/Pacific Islander immigrants to the US have HBV infection.

Similarly, in other areas of the world with low HBV endemicity, immigration of groups from high risk areas has also resulted in increasing prevalence of chronic HBV infection. Various studies from Europe have reported a high prevalence of chronic HBV infection among various immigrant groups. The United Kingdom, in recent years, has experienced a massive influx of migration of groups from areas of intermediate to high endemicity. It is estimated that 325,000 in the UK have chronic HBV infection, and is nearly double the Department of Health's 2002 estimate of 180,000. Moreover, these estimates may be higher due to underreporting.

Spain is currently the main recipient country of immigrants in Europe with an increase from 0.5 million immigrants in 1995 to 5.2 million in 2008. This represents 11.3% of the country's total population. One Spanish study by Monge-Maillo et al. evaluated health characteristics of the two most common immigrant groups, sub-Saharan Africans and Latin Americans. Out of the 2,198 immigrants referred to their clinic over a 20-year period, the prevalence of chronic infection with hepatitis virus was higher among Sub-Saharan Africans with prevalence of HBSAg positivity in 9.8% of the patients.

Hepatitis C

HCV was initially referred to as hepatitis non-A, non-B, and was later identified in 1989. Prior to the introduction of anti-HCV screening tests for blood donors in 1992, HCV represented a major cause of transfusion-dependent hepatitis. The virus is primarily transmitted through blood exposure. The most frequent modes of transmission in the US, Europe, and Australia are from previous or current use of illegal drugs, predominantly injected drugs, and to a lesser extent, intranasal cocaine. On a global scale, cases of infection are often related to unsterile practices in medical procedure, such as in blood transfusions, the use of contaminated vaccination needles, and in hemodialysis. Egypt, for example, is among the countries with highest reported HCV prevalence of at least 15% due to reuse of needles during a national program of schistosomiasis vaccination from the 1950s to the early 1980s. Practices relating to folk remedies and other community-based needle practices, including acupuncture, have also been linked to transmission.

In acute HCV infection, only 25–35% of individuals are symptomatic, thereby making detection and diagnosis of acute infection difficult. Approximately 85% of those infected will go on to develop chronic infection. Among those chronically infected, approximately 20% will progress to cirrhosis over a 20-year period. Similar to chronic HBV infection, the majority of those with chronic HCV infection are asymptomatic until progression to advanced disease has occurred. Annually, 3–6% of patients with cirrhosis will progress to end-stage liver disease, and therefore, may be potential liver transplant candidates. Chronic HCV infection is associated with the development of hepatocellular carcinoma in 1–5% of infected persons, predominantly in those with cirrhosis. In the US, Europe, Australia, and Japan, HCV infection is the leading cause of chronic hepatitis and death from liver disease. It is also the leading indication for liver transplantation.

Worldwide, HCV is the second most common cause of chronic liver disease and hepatocellular carcinoma behind hepatitis B. HCV is a global public health problem with approximately 3% (170 million) of the world's population infected. The prevalence of HCV is relatively low in the US, northern Europe, and Australia, ranging from 0.3% to 1.8% of the population. An increased prevalence of HCV ranging from 1.5% to 9% has been reported in Southeast Asian and the Indian subcontinents, with the highest rates (2–14%) present in northern and central Africa, the eastern Mediterranean, and the Ukraine. There are up to 5–10 million in Europe who are infected, approximately 12 million infected in India, and an estimated 38 million infected in China. The majority who are infected do not know they are. Furthermore, the true prevalence of HCV worldwide is likely underestimated given the lack of appropriate screening and case identification.

HCV infection among the Asian population has often been underappreciated, particularly as HBV infection has long been recognized as a major cause of morbidity and mortality in this population group. However, the prevalence of HCV infection in China alone at approximately 3% and likely higher is greater than the overall US prevalence of 1.8%. Moreover, Southeast Asia is an area with higher hepatitis disease burden than the rest of Asia, with disease prevalence of 5.6% and 6.1% in Thailand and Vietnam, respectively.

HCV is a highly heterogenous virus. Six major genotypes of HCV have been identified worldwide with more than 50 subtypes described. A distinct geographic distribution of these genotypes can be seen: Genotype 1 is the most common type worldwide, and particularly dominate the US, Europe, Australia, and Japan. Genotypes 2 and 3 are less common in these areas. Genotype 3 is most common in India, the Far East, and Australia. Genotype 4 is most common in Africa and the Middle East. This genotype, however, is being identified more frequently in Europe and North America among native injection drug users and immigrants from endemic areas. Genotype 5 is most common in South Africa, while Genotype 6 predominates in Southeast Asia (Vietnam, Thailand, Burma, Malaysia, and Singapore), south China, and Hong Kong. Genotype 6 has also been identified in both the US and Australia among the Southeast Asian immigrant population who are infected. HCV genotypes have not been clearly associated with virulence or pathogenicity of the disease; however, they are an important predictor in treatment outcome.

Hepatitis D

Hepatitis D is largely acquired through parenteral exposure. Because it is a defective RNA viroid, it requires HBSAg for transmission, and therefore, occurs only in individuals who are positive for HBV surface antigen (HBSAg). HDV and HBV coinfection is associated with accelerated progression to cirrhosis, early liver decompensation, and an increased risk for the development of hepatocellular carcinoma. Therefore, those with coinfection are at higher risk for severe liver disease compared to individuals infected with HBV only. The Mediterranean countries, the Middle East, Central Africa, and northern parts of South America are considered areas of high endemicity for HDV. In Western countries, there is a high prevalence of HDV infection in intravenous drug addicts with HBV infection. More than 350 million people worldwide have chronic HBV infection. Of these, 15–20 million individuals are thought to be co-infected or superinfected with HDV. In southern Europe, HDV infection has been highly endemic. However, with the implementation of HBV vaccination programs in the 1980s, the incidence of infection decreased significantly to 5–10%. In Turkey, a wide range in prevalence of HDV infection has been observed. In western Turkey, the prevalence is <5% in contrast to southeast Turkey with prevalence of 27%. In southeast Turkey, almost half of all cases of cirrhosis and hepatocellular carcinoma are due to HDV infection. Mongolia is also a country considered to have high prevalence of HDV infection where up to 1/3 of chronic hepatitis infections are caused by HDV.

Although the prevalence of HDV infection has declined in southern Europe, the infection still remains a significant health problem in Central Europe. Prevalence in this area has been attributed to immigrants from highly endemic areas. At a referral center for liver diseases in Hanover, Germany, approximately 8–10% of HBSAg-positive patients test positive for anti-HDV antibodies. In this patient population, more than three quarters of those infected were foreign-born. Up until the mid-1990s, the majority were from Turkey. Since that time, a significant increase in HDV infection is being seen in patients originating from Eastern Europe and the former states of the Soviet Union. An increasing prevalence of HDV infection is also being observed in England. At King's College Hospital in London, 82 (8.5%) of almost 1,000 consecutive patients with chronic hepatitis B were tested positive for anti-HDV antibodies between 2000 and 2006. Many of these infected patients were born in Africa or Eastern Europe. Similar to Germany and England, a high prevalence of HBSAg-positive individuals with anti-HDV antibodies has been observed in immigrant populations in France, particularly in the African community.

Conclusion

The impact of global migration has affected immigration-receiving nations at many levels. This includes a significant impact at a public health level with a global shift in infectious disease epidemiology. Infections, including viral hepatitis, are increasingly observed in the foreign-born population who come from nations of high prevalence for these infections. With importation of these infections to low prevalence host nations, clinicians in these host nations will be confronted with the challenge of diagnosing and managing these diseases. Both commitment to education and training relating to such diseases pertaining to foreign-born groups and the use of tools and resources relating to international public health will be essential in order to provide appropriate and adequate medical management of these population groups.

Related Topics

- ► Asia
- ► Asian Americans
- ► Asians
- ► Immigrant health disparities
- ► Immigration processes and health in the U.S.: A brief history
- ► Immigration in the global context
- ► Infectious diseases
- ► Liver cancer
- ► Liver cirrhosis
- ► Public health

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Herbal Medicines

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Herbal medicines, also called botanical medicines or phytomedicines, are preparations of herbs used for healing. An herb is any form of plant or plant product, such as leaves, seeds, roots, bark, and flowers. The World Health Organization (WHO) recognizes four categories of herbal medicines: raw herbs, herbal materials, herbal preparations, and finished herbal products. Herbal materials include a plant's juices, gums, oils, resins, and dry powders. Herbal preparations include extracts and tinctures of herbal materials produced by biological and chemical methods such as extraction, fractionation, purification, and concentration. For example, a tincture is made by soaking an herb in a solution of water and alcohol, producing a concentrated, preserved liquid product. Herbal preparations are the basis for finished herbal products, which may contain inactive compounds that facilitate dilution or delivery of the active ingredient. Finished herbal products may contain a single or multiple herbal ingredients. Some, including many Traditional Chinese Medicine (TCM) formulations, may include natural ingredients not of plant origin, such as animal products or minerals. Based on this definition, herbal medicines may not contain chemically defined substances, including synthetic compounds and chemicals isolated from herbs.

Herbal medicines often contain complicated mixtures of organic chemicals that work together to produce an effect on the body. In many cases, it is unknown what specific ingredient in a particular herb works to treat an illness. Herbal medicines are drugs in the sense that they clinically modify bodily processes and can have therapeutic or harmful effects, depending on their use. However, there are a few general differences between herbs and conventional drugs. While conventional drugs often consist of a single purified active chemical, herbal medicines may have multiple active chemicals. For example, the opium poppy contains over 30 active chemicals, or constituents, called alkaloids. Morphine is one alkaloid that can be isolated and administered as a conventional drug, while opium is an herbal preparation made from the sap of dried opium seeds. Opium contains up to 12% morphine along with codeine and other non-narcotic alkaloids. Another difference between herbal medicines and conventional drugs is dilution. Herbal medicines tend to be more dilute than pharmaceutical drugs. For example, aspirin is derived from the bark of the willow tree. In order to get the same effects of the average dose of aspirin in pill form, one would need to consume up to

20 cups of willow bark tea. Nearly one-third of conventional drugs, including morphine and aspirin, are derived from plant sources. Morphine and codeine are still extracted from the opium poppy because it is more difficult and costly to synthesize them chemically. Digoxin, a drug used to treat congestive heart failure and abnormal heart rhythms which is derived from the foxglove plant, is another example of a commonly used conventional drug derived from a plant source.

Plants have been used for medicinal purposes since before recorded history and still account for over 75% of medical treatments in nonindustrialized countries. Ancient Egyptian writings indicate the Egyptians used garlic (*Allium sativum*), juniper (*Juniperus communis*), and myrrh (Commiphora molmol) for their healing properties. Over the centuries, diverse cultural groups developed traditional medical systems, such as Ayurveda and TCM, which included the use of herbal medicines. Dandelion (*Taraxacum officinale*) and goldenseal (*Hydrastis canadensis*) have been used in Native American healing traditions for their antimicrobial and other properties. Hoodia (*Hoodia gordonii*), a plant native to the Kalahari Desert in southern Africa, has been used by the Kalahari bushmen to reduce hunger and thirst during long hunts. With the invention of the printing press in 1440 AD, herbalists began to spread the word about effective herbal medicines. Researchers began to discover that people in different parts of the world tended to use the same or similar plants for like purposes. In the early nineteenth century, scientists began to use chemical analysis to extract and modify the active ingredients from plants. Later, chemists began making synthetic versions of plant compounds, and over time the use of herbal medicines declined in favor of conventional drugs in most industrialized countries. In contrast, many nonindustrialized countries never abandoned medical herbalism and continued to develop their existing traditional medical systems. In some countries, such as France and Germany, herbal medicine continued to coexist with modern pharmacology, though at a lower level. Today, herbal medicines fall under the umbrella of complementary/alternative medicine (CAM) in most industrialized countries. CAM refers to a collection of diverse approaches to healing other than those intrinsic to the politically dominant health system of a particular society or culture.

In the past several decades, public dissatisfaction with the cost of prescription drugs, combined with an interest in returning to natural or organic remedies, has led to an increase in herbal medicine use in the industrialized world. However, there is very limited scientific evidence from randomized, controlled trials to support the safety and efficacy of the vast majority of herbal products. Although herbal medicines are commonly perceived as safe because they are natural, many side effects, some potentially lethal, have been reported. For example, the herb *Aristolochia fangchi*, marketed for weight loss, was found to damage the kidney. Herbal medicines may also contain contaminants which cause side effects. A study examining the contents of 260 Asian patent medications found that 25% contained high levels of heavy metals, including lead and mercury, and another 7% contained undeclared pharmaceuticals, added to produce a desired effect. In countries where herbs are not subject to regulation as drugs, it is difficult to determine the true nature and frequency of side effects because herbal manufacturers are not required to record, investigate, or forward information to regulatory bodies of reports or inquiries of adverse events associated with the use of their products.

Quality control has also become an important concern for both health authorities and the public as many studies have shown that existing herbal products vary widely in the amounts of active markers in the product. Variability in the content and concentrations of constituents of plant material, together with the range of extraction techniques and processing steps used by different manufacturers, results in marked variability in the content and quality of commercially available herbal products. While some countries such as Germany and China regulate herbal medicines as pharmaceuticals, herbs are unregulated in most places around the world. In the United States, herbal medicines are sold over-the-counter as dietary supplements, and thus subject to a very limited form of regulation and oversight. Some preparations claim to be standardized, meaning the preparation is guaranteed to contain a specific amount of the active ingredients of the herb; however, there is often no regulatory body enforcing this standardization.

There is good evidence from systematic reviews, including Cochrane reviews, of randomized, controlled trials for the efficacy of certain standardized herbal medicines in particular clinical conditions. Examples include standardized St. Johns wort in relieving symptoms of mild to moderate depression, saw palmetto extract in treating benign prostatic hyperplasia, and standardized ginkgo leaf extract in symptomatic relief of dementia. There are many herbal medicines with reputed therapeutic value that have not gained acceptance in mainstream medicine due to a lack of research. However, some of these are currently undergoing scientific study, specifically to identify their active chemical components, physiological effects, pharmacologic properties, and clinical efficacy.

Herbal medicine is used to prevent and treat many medical conditions. Among the most commonly used herbs are echinacea, ginkgo, garlic, valerian, and ginger. Echinacea may improve the body's immune system while ginkgo has traditionally been used to enhance memory and treat circulatory disorders. Herbs are sold in many forms: as fresh or dried products; liquid or solid extracts; and tablets, capsules, powders, and tea bags. They also come in the form of topicals, including salves, balms, oils, poultices, and compresses. Herbal medicines are best taken under the guidance of a trained healthcare provider as they may cause allergic reactions, interact with conventional drugs, or affect existing health conditions in addition to producing side effects. Some are toxic if used improperly or at high doses. For example, evening primrose may increase the risk of seizures in people with epilepsy, while garlic, ginkgo, and feverfew may increase the risk of bleeding. St. John's wort should not be taken with prescribed antidepressant medication as this could cause serotonin syndrome, a potentially life-threatening condition. In general, individuals aged 65 or older and those with liver or kidney problems are more likely to experience interactions between conventional drugs and herbal medicines. Herbal medicines may be prescribed by traditional herbalists, chiropractors, naturopathic physicians, pharmacists, medical doctors, practitioners of TCM, and others. Typically, naturopathic physicians receive four postgraduate years of training in both conventional and herbal medicine and are recognized as licensed providers in several countries.

The WHO estimates that 80% of people worldwide rely on herbal medicines for some part of their primary health care. On the basis of current trends in market research data, it is likely that the sales of herbal medicines will continue to increase. Evidence-based research can help to validate traditional uses of herbs and to facilitate new drug development. Despite the complexity of herbal products, investigations of efficacy and safety are feasible. The WHO recognizes herbal medicines as valuable and readily available resources and states it is necessary to develop a systematic inventory of medicinal plants, to introduce regulatory measures, apply good manufacturing practices, and include herbal medicines in the conventional pharmacopeia of each nation.

Related Topics

- ► Alternative and complementary medicine
- ► Traditional Chinese medicine
- ► World Health Organization

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Suggested Resources

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Heroin

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Heroin (diacetylmorphine) is a semisynthetic opioid drug synthesized from morphine, which was discovered in the laboratories of the Bayer Company, initially as a remedy against cough. Street language for heroin includes the terms H, white stuff, powder, Hairy, smack, horse, white lady, joy, and boy. Currently, heroin is on the banned substances lists in almost all countries. It is a legally prescribed drug in the United Kingdom and it is also available by prescription for long-term users in the Netherlands, Switzerland, and Germany, as part of the harm reduction programs.

Heroin can be taken by injection (intravenous, intramuscular, subcutaneous), inhalation, smoking, or snorting. The most frequent administration pathway is via intravenous injection, because in this way the "flash," "high," or "rush" as it is variously known, i.e., an intense, sudden orgasmic pleasure, can be reached. In his book "Les toxicomanies," Porot shows that in order to obtain an even more intense or a repeated high, a special method called "tirette," also known as backloading, can be performed. This involves pulling the blood into the syringe and then the mixture of blood and drug is rapidly injected intravenously. There are several methods for smoking heroin, such as: "the dragon pipe," used mostly in Hong-Kong, whereby a mixture of heroin and phenobarbital is boiled and the vapors are collected; or the "Ack-ack," referring to smoking a mixture of heroin and tobacco mixture.

Short-term effects resulting from heroin consumption are related to the high experience, followed by a relaxation period that is often referred to as "the planet," characterized by psychomotor relaxation and "search of the self." Although heroin's effects are extremely powerful, they last for only about 2–3 hours; this is the reason why it has to be frequently administrated to achieve the desired high. Long-term effects include physical and psychological dependence, which occur in 97% of individuals within the first 21 days following the first administration of heroin. Long-term heroin consumption also induces tolerance, i.e., the consumer needs higher doses of drug in order to feel its effects. Heroin use produces symptoms like: disorientation, drowsiness, delirium, slow heart rate, decrease of blood pressure, shallow breathing, and respiratory failure. The chronic use of heroin over a period of 6–7 years may lead to malnutrition or various complications such as HIV/AIDS, hepatitis, cachexia, or severe psychiatric disorders (paranoia, dementia, etc.). The most risks to the heroin addict include overdose, HIV infection, hepatitis, and other chronic complications.

Despite the serious adverse physical and psychological consequences produced by heroin, it continues to be consumed because of the "high" that might help a person to forget about troubles and problems, offering her/him pleasure and euphoria. It has been suggested that immigrants who use heroin may do so in order to deal with the discrepancies that exist between their expectations and the realities they have to face in the host country such as low income, social stigma, and language and cultural differences.

Detection and quantification of heroin use among immigrants are difficult due to their low rates of seeking treatment, their lack of access to treatment, and their unwillingness to participate in research studies related to substance use. Immigrants may refrain from seeking treatment or participating in research for fear of possible legal consequences, including deportation.

A survey on heroin use among Russian immigrants in Israel (2002–2006) found a higher rate of hepatitis C and more heroin use via injection among immigrants as compared with native-born Israelis. In historical context, before 1989, in Israel, approximately 95% of the heroin addicts had come from the Middle East, mostly from Morocco and Tunisia. The profile of that heroin addict was: male, age 18–30, poorly educated, and of low socioeconomic status. After 1990, heroin use was attributed primarily to Russian immigrants, who currently represent 25% of individuals known to be addicted to illicit substances in this country.

A study that aimed at determining the drug use profile of immigrants in Spain between 2004 and 2008 found that 72.3% of drug users came from Latin

America, Portugal, and Eastern Europe. Most were men (80.8%) and the most commonly used drug was heroin (43.8%).

The key factors that may negatively impact on health of the immigrant drug users are: vulnerability to using drugs, low income, low educational level, a low rate of access for treatment due to the lack of health care insurance and/or illegal immigrant status, and cultural differences in perception of diseases. Immigrants who use heroin are doubly vulnerable, first because of their addiction and second because of the legal, political, and economic barriers to accessing treatment for their addiction.

The legal barriers include the possibility of deportation and/or imprisonment due to heroin use, illegal immigration status, or both. Legal provisions may also deny immigrants' access to treatment. Some of the health programs, e.g., Medicaid in the United States, may be accessed only by legal immigrants and only under certain conditions.

The economic status of immigrants is closely related to their health insurance status. Lack of health insurance and low income may limit immigrants' access to health care. Many immigrants are paid less than the native-born citizens and they are either uninsured or have a basic insurance (a mandatory one) that does not cover treatment for addiction.

Related Topics

- ► Addiction and substance abuse
- ► Barriers to care
- ► Drug abuse
- ► Drug use
- ► Health barriers
- ► Substance use
- ► Vulnerable populations

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High School

► Secondary education

Hijos de Crianza

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Although Latinos are a diverse population representing many different backgrounds and countries of origin, *familismo* is considered to be one of the most important cultural values across Latino populations. This value involves a strong identification and attachment with nuclear and extended family, along with a deep sense of family commitment, involvement, and responsibility. The family offers emotional security and a sense of belonging to its members and is the unit to which individuals turn for help in stressful or difficult situations. The expectation is that when a family member is in need, others will help, particularly those in stable situations. Similarly, when parents of young or minor children are experiencing challenges that affect their ability to adequately parent their children, it is expected that extended family will provide assistance. *Hijos de crianza* refers to children who are raised in the home of a relative within their extended family system in times of need. This practice is common among many Latino families, with relatives assuming full responsibility for the children as if they were their own.

Historically, many situations could result in children being raised by extended family, from a desire to improve the economic situation of the child to the need for additional care following the death of a parent. However, due to recent increases in immigration enforcement across the United States, *hijos de crianza* may be raised by relatives out of necessity following the apprehension and deportation of a noncitizen parent. For example, in 2006, more than 3,600 immigrants were apprehended by US Immigration and Customs Enforcement officials as a result of worksite enforcement operations, an increase of 700% since 2002. In many of these cases, parents were separated from their children for extended periods with no way of contacting them or deported to their country of origin while their children remained in the United States.

Although caring for these children is congruent with Latino cultural values, children who are informally raised by relatives in the United States may experience many barriers to adequately meeting their needs. For example, many public services are restricted to biological or formally adopted children and most eligibility determinations are based on the needs of biological or formally adopted children within a family unit. Even necessities such as obtaining appropriate medical care and enrolling children in school may be difficult due to the lack of a formal legal relationship. Thus, it may be beneficial for relatives to pursue some form of legal guardianship to facilitate access to necessary services for *hijos de crianza*, particularly when it is unlikely that children will be returned to their biological parents.

The need for extended family to be available to raise children is particularly important in times of increased immigration enforcement, as children who do not have available relatives to care for them following the apprehension and deportation of a parent may be at risk of entering the formal child welfare system. When this occurs, children in immigrant families face a number of unique challenges that threaten the child welfare system's ability to facilitate reunification with their biological parents. The achievement of reunification is largely dependent on the child welfare system's ability to provide services to families that reduce risk and ensure stability of the living situation. In families where parents have been deported, the ability to provide these services is considerably limited.

For children in the foster care system, the lack of culturally or linguistically appropriate services may also limit their ability to receive services needed to address both their physical and mental health needs. Further, when children are undocumented, funding for services may be limited due to restrictions within Title IV-E of the Social Security Act, which serves as the primary source of federal child welfare funding to states. This funding source allows states to receive federal matching funds for the care of children in state custody. However, the receipt of Title IV-E funds is restricted to children who meet eligibility requirements, which include immigration status. Immigrant children who are undocumented do not meet the eligibility requirement, and thus, states must bear the total burden of the cost of substitute care for these children. In times of shrinking resources for public child welfare systems, this may limit states' abilities to adequately care for ineligible immigrant children.

When reunification with parents or placement with relatives is not an option, undocumented immigrant children may be eligible for Special Immigrant Juvenile Status (SIJS), which makes them immediately eligible to apply for legal permanent residency in the United States. This status is available for undocumented children under the jurisdiction of a court due to dependency or delinquency. With this status, immigrant children become Title IV-E eligible and receive the other benefits of legal permanent residency, including the ability to live and work permanently in the United States. However, as SIJS is only available to children for whom reunification with their parents is not an option, the pursuit of SIJS must be done only after determining that reunification or placement with relatives in their country of origin is not in their best interest.

Related Topics

- ► Child
- ► Familismo
- ► Family
- ► Hispanics
- ► Latinos

Suggested Readings

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Migration and Child Welfare National Network. http://www.americanhumane.org/migration

Hispanic Health Paradox

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Research to date presents substantial evidence of a strong association between acculturation and health among the US Latino population. Generally, the research has found a negative effect on health outcomes and health behaviors with greater acculturation, whereby more optimal health outcomes have been observed among more recent immigrants to the USA from Latin America and less acculturated US-born Latinos, compared to the native-born or more acculturated members of the same ethnic/racial group or the White population. These highly provocative and controversial findings refer to the counterintuitive finding that more recent and less acculturated Latinos and immigrants in general have more optimal health, mental health, and more positive health behaviors, as well as better educational outcomes (a key determinant of health) than those who are more acculturated.

The Hispanic (or Latino) health paradox, also known as the immigrant paradox, is the phenomenon that greater acculturation to US culture, as marked by, for example, increased length of residency, and increased use of English is associated with poorer health and health behaviors, whereas foreign birth and less acculturation appear to be protective factors. Also referred to as the epidemiological paradox, the term was first coined in 1986 by Markides and Coreil in a literature review of the health status of Latinos in the US southwest. In their review they found that Latinos had lower infant mortality, a longer life expectancy, were less likely to die from cancer and cardiovascular diseases, and had better measures of functional health in spite of their low socioeconomic status and the presence of various risk factors.

Studies have found that Hispanic adults are at greater risk for cigarette smoking, alcohol and substance abuse, driving under the influence of alcohol, psychological distress, and depressive symptomatology. These paradoxical findings have been found among the larger and more diverse US immigrant demographic, not solely among Latinos. Numerous studies have documented fewer low-birthweight babies born to immigrant compared to US-born women. Similar findings have been reported for infant mortality. Immigrants are at significantly lower risk of death from cardiovascular diseases, lung and prostate cancer, chronic obstructive pulmonary disease, cirrhosis of the liver, influenza, pneumonia, unintended injuries, and suicide. More acculturated adolescents and adults have been found to have a significantly higher prevalence of overweight and obesity, perhaps a function of the increase in cardiovascular disease found with increased acculturation.

Self-selection among immigrants, that healthier and more capable people are more likely to immigrate/migrate, has been proposed as a possible explanation for the observed paradox. Nevertheless, the consistency of such findings is notable, especially considering the diversity of the populations and outcomes studied. Furthermore, studies that have examined people in the country of origin and/or across multiple generations in the USA have had similar findings and found evidence of a downward trajectory from the first generation (immigrants born abroad) to second generation (born in the USA to immigrant parents).

Similar to findings among adults, studies of adolescents from immigrant families have found they are physically healthier than nonimmigrant youth and have a lower incidence of significant emotional and behavioral problems. Youth from immigrant backgrounds as well as their parents report they are physically healthier compared to native-born youth, even though they are less likely to have health coverage or to see a health care provider on a regular basis. Second generation youth have been found more likely to engage in deviant behaviors compared to first generation immigrant youth. Similarly, marijuana and alcohol use have been found to be higher among the US-born youth compared to immigrant adolescents of similar racial/ethnic backgrounds. In education, perhaps the most important predictor of health behavior and health outcomes, studies have found that immigrant adolescents are more motivated toward school, work harder, and have higher educational aspirations, more positive academic attitudes, better academic grades, and higher math test scores compared to their peers born in the USA.

The evidence thus suggests that immigrants lose something over time in the USA and likely adopt mainstream US cultural ways that negatively impact health – for example, the loss of cultural practices, such as the consumption of traditional foods and home cooking, as they acculturate to eating highly processed and fast foods, as well as the increased stress that comes with acculturation and adjusting to life in a new country and cultural context. Research indicates that greater acculturation is associated with poorer health outcomes. These studies have observed better health outcomes among less acculturated Latino and immigrant adults and youth. These findings are important because they are contrary to dominant beliefs and are in conflict with traditional, prevailing theories of immigrant incorporation and assimilation; theories which state that immigrants who are more acculturated, those who speak English and adopt “American” cultural ways, will fare better in US society.

Although more recent and less acculturated immigrants are more likely to be poor/of low socioeconomic status, not well educated, and speak less English, evidence indicates they are healthier and engage in fewer risky health behaviors compared to immigrants or their children who have been in this country longer or are more acculturated and speak more English. That health outcomes deteriorate with greater acculturation, as length of residency in the USA goes up, is difficult to understand because as immigrants and their children acculturate to life in the USA they tend to use more English, develop social networks, acquire social capital, earn more money, and have better access to a health care provider – factors that would be expected to be associated with better health.

Foreign-born and US-born Latinos are racial/ethnic minorities in the US context, as are the vast majority of present-day immigrants to the USA who come from Latin America and, to a lesser degree, Asia. It is thus important to consider these paradoxical findings in light of the various socioeconomic and environmental factors that disproportionately impact US minorities in general, such as poverty, inadequate schools, poor access to quality health care, a lack of safe and stable housing, and exposure to hazardous environmental conditions and substances. These are contextual factors and determinants of health that disproportionately affect US minorities, which create pathways that contribute to the development and progression of disease as opposed to more optimal health.

Related Topics

- ► Acculturation
- ► Assimilation
- ► Healthy immigrant
- ► Hispanics
- ► Latinos

Suggested Readings

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Hispanics

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Background

In 2008, the US Hispanic population was 46.9 million, or 15.4% of the total US population. The term "Hispanic" is defined using the US government statistics classification, which is that of people who have ancestors from Cuba, Mexico, Puerto Rico, Spain, and countries of Central or South America where Spanish is the primary language. Race is not a factor in this definition and it does not include persons from places such as Brazil or Portugal, since Spanish is not the primary language in those countries.

Hispanics immigrate to various countries. Those from South America most often immigrate to Europe, specifically Spain, Italy, and Portugal. Mexicans and Puerto Ricans immigrate primarily to the USA. Puerto Ricans who are born in Puerto Rico and migrate to the US mainland are often referred to as migrants, rather than immigrants, because they are US citizens.

Approximately 60% of Hispanics residing in the USA were born in the USA and the remaining 40% were born elsewhere (i.e. not born as US citizens). The majority of Hispanics are of Mexican ancestry, almost 60% of the population. The remainder of this population consists of Puerto Ricans (9.7%), Central Americans (5.1%), South Americans (4%), Cubans (3.5%), Dominican (2.3%), and Spaniards (0.3%). Many Hispanics have settled in different parts of the USA based on their heritage. Almost 80% of Cubans live in the South, approximately 50% of Mexicans reside in the West and 60% of Puerto Ricans settled in the Northeast.

Hispanic health has been studied at all levels and has been included in several large national studies. One research flaw has been that often Hispanics are grouped together and not based upon their specific heritage. Newer studies have shown that often generalizations about Hispanics are not applicable to every subgroup.

Hispanics and Illnesses

It is well known that Hispanics, as a group, suffer from health disparities, which means that they have higher incidences of certain illnesses and have inequalities in the care they receive as well. They have higher mortality rates from Type II diabetes, gastric cancer, end-stage renal disease, liver disease, biliary disease, and HIV compared to all other groups in the USA. Further, they have higher rates of obesity, diabetes, and hypertension, as do both American Indians and Alaskan Natives, but at rates higher than those of non-Hispanic Whites. The top five causes of death for Hispanics in 2005 were heart disease, cancer, unintentional injuries, stroke, and diabetes. While four of these were the same for the non-Hispanic White population, diabetes was not in the top five and accidental injuries were the fifth leading cause of death. In comparison to the non-Hispanic Black population, the top five causes of death remain the same, however, not in the same rank order.

Diabetes

The rate of diabetes for Hispanics is 9.5%, which is higher than that for non-Hispanic Whites (8.7%), but lower than that of non-Hispanic Blacks (13.3%). More specifically, Mexican Americans are twice as likely to be diagnosed with diabetes than are non-Hispanic White adults. Compared to non-Hispanic White men, Hispanic men were 1.5 times more likely to start treatment for diabetic-related end-stage renal disease in 2002. In 2005, the death rate from diabetes was 1.6 times higher for Hispanics compared to non-Hispanic Whites. While it is unclear why the disparity in diabetes exists, it is likely contributed to by a combination of genetic, environmental, or metabolic differences in populations.

Heart Disease

Cardiovascular disease in Mexican American adults is found in 28.8% of males and 26.6% of females. It was found in 2007 that Hispanics as a whole were 10% less likely to have heart disease compared to non-Hispanic Whites. With regard to death rate from heart disease, Mexican American men were 30% less likely to die when compared to their non-Hispanic White male counterparts. In Mexican American adults, 4.1% of men and 1.9% of women have had a heart attack and 4.1% of men and 5.5% of women have angina, a condition of chest pain caused by reduction in blood supply to the heart muscle.

Cancer

The most common cancer found in Hispanic men is prostate cancer; however, they are 16% less likely to have this type of cancer compared to non-Hispanic White men. With regard to Hispanic women, breast cancer is the most common cause of cancer, and they are 33% less likely to have breast cancer compared to non-Hispanic White women. Both Hispanic men and women have colon and rectal cancer as the second most common type of cancer and lung cancer as the third most common cause. Hispanic men and women have higher rates of stomach and liver cancer, as well as higher mortality rates from these cancers, when compared to non-Hispanic Whites. Further, Hispanic women have twice the rate of cervical cancer compared to non-Hispanic White women.

Lung cancer is the leading cause of cancer death for Hispanic males, while breast cancer is that for Hispanic females. For non-Hispanic White women, lung cancer is the leading cause of cancer death. For the most part, the incidence and death rates from cancer in Hispanics is lower than that of non-Hispanic Whites. The exceptions are stomach, liver, cervical, acute lymphocytic leukemia, and gallbladder cancers, where Hispanics have higher rates.

In a Florida study, it was found that Hispanics living in the USA had an increased risk of cancer compared to their counterparts in the country of origin. Other than this study, the same risk factors that apply to the US population for cancer apply to the Hispanic population, such as tobacco use.

Stroke

The risk of stroke for Hispanics appears to have some variance based on age. For Hispanics between ages of 35 and 64, the relative risk of having a stroke is approximately 1.3 times greater when compared to non-Hispanic Whites. However, at age 75 or older, their risk is about half that of non-Hispanic Whites. It was found in 2005 that Hispanic men were 15% and Hispanic women were 25% less likely to die from a stroke when compared to their non-Hispanic White counterparts.

HIV/AIDS

In 2007, Hispanics made up 17% of the HIV/AIDS cases in the USA with much higher rates than that of non-Hispanic Whites. Hispanic men have almost a three times higher rate of AIDS and Hispanic women have an almost five times higher rate when compared to their non-Hispanic White counterparts. Further, Hispanic men and women have higher rates of death from HIV/AIDS, with Hispanic men being 2.5 times as likely to die and Hispanic women three times as likely to die when compared to their non-Hispanic White counterparts.

Infant Mortality

The 2005, infant mortality rates for the Hispanic subgroups varied from 4.4 to 8.3 per 1,000 live births, while the rate of infant mortality for non-Hispanic Whites was 5.8 per 1,000 live births. Puerto Ricans had an infant mortality rate that was 1.4 times that of non-Hispanic Whites. When including conditions related to low birth weight, the Puerto Rican infants were twice as likely to die compared to non-Hispanic White infants. Minimal or no prenatal care is another contributing factor for the increase in infant mortality. It was found that Mexican American women were 2.5 times as likely to begin prenatal care in the third trimester or not receive prenatal care at all, when compared to non-Hispanic White women.

Hispanic Paradox

In 1986, the concept of a “Hispanic Paradox” was first described in the literature. This concept is that while Hispanics are socioeconomically disadvantaged, they have overall better health and mortality outcomes – similar to those of non-Hispanic Whites, who do not tend to suffer from disparity in health care. This has been studied over the last two decades and the findings continue to show this mortality advantage, especially those in Mexican Americans. There are several hypotheses that attempt to explain this phenomenon. One hypothesis is that of a "salmon bias" effect, which suggests that unhealthy immigrants return to their country of origin to die, resulting in a lower mortality rate for those who stay in the USA. Another is that of a "healthy immigrant effect," in which persons in good health are able to migrate. And finally, there may be problems in how the data were collected using vital statistics records. Despite these possible explanations for the "Hispanic Paradox," none fully explain this finding.

Hispanics and Access to Medical Care

In the USA, Hispanics have the highest uninsured rate of any ethnic or racial group. Within the subgroups, 2004 data from the Centers for Disease Control and Prevention found that 37.6% of Mexicans, 20.4% of Puerto Ricans, 22.8% of Cubans, 32.3% of other Hispanic groups did not have health insurance. With regard to Medicaid coverage, 22.4% of Mexicans, 29.1% of Puerto Ricans, 17.9% of Cubans, and 20.8% of other Hispanic groups had this form of health insurance.

In 2004, a third of Hispanics in the USA did not have any health insurance, compared to 10.4% of the non-Hispanic White population. Over one fourth of Hispanic adults do not have a primary health care provider and Hispanics are much less likely to obtain health care when compared to non-Hispanic Blacks and non-Hispanic Whites. Further subgroups at higher risk for not having a usual health care provider include males, the young, those that do not speak English, the less educated, and those without health insurance.

Hispanics obtain their health information through a variety of sources. In one study, approximately 70% reported obtaining information through their physician. An equal number stated that they were able to gather this type of information through their social networks, which included friends, family, and church community. In this same study, 83% of Hispanics found health information through the media, with 79% of those acting on this information. It was found that a fourth of Hispanics felt that they received poor care during the previous 5 years and believed this to be secondary to their race, language ability, or financial situation. Despite that, 77% of Hispanics rated their health care as good or excellent.

Ethnic disparities and access to health care are influenced both by the characteristics of the person seeking care, such as language, citizenship status, sex, education, and health needs, and the characteristics of health care system itself, such as cultural competence, ethnocentrism, location, services provided, and bureaucratic barriers. Both individual factors and health system factors affect the Hispanic population.

Approximately 21% of Hispanics live at or below the poverty level for income. It has been found that poverty is a major deterrent to seeking out health care. Even when there is access to health care for minority populations, they still have worse health.

Preventive Care

Immunizations play an important role in the prevention of illnesses and Hispanics in general have lower rates of immunization. Hispanics over the age of 65 were 10% less likely to have received the flu shot in the previous 12 months and 50% less likely to have ever received the pneumonia shot when compared to their non-Hispanic White counterparts. While Hispanic children from 19 to 35 months of age have similar immunization rates for hepatitis, influenza, MMR and polio, they were slightly less likely than non-Hispanic children to be fully immunized.

Risk Behaviors

Tobacco

Approximately 24.1% of adult Hispanic men and 12.3% of adult Hispanic women are smokers. Hispanic high school students have a 34% and 31.5% smoking rate among Hispanic males and females, respectively. Further, the rate of smokeless tobacco use among Hispanic high school students is 6.1% in Hispanic males and 1.8% in Hispanic females.

Obesity

A total of 64.7% of Hispanic adult males and 56.8% of Hispanic adult females are overweight, and 18.2% of adult Hispanics are obese. Overweight is defined as having a body mass index (BMI) of 25 kg/m^2 or greater, and obesity is defined as having a BMI of at least 30 kg/m^2.

Mexican Americans have higher rates of being obese or overweight than the Hispanic averages. A total of 69.3% of both Mexican American men and women are overweight, and 24.8% of Mexican American males and 36.1% of Mexican American females are obese. In Mexican American children, ages 6–11 years old, 17.4% of males and 14.3% of females are overweight; in children 12–17 years old, 14.6% of males and 13.7% of females are overweight. There is an inverse correlation between weight and level of education for Mexican Americans. Those with less education tend to have higher BMIs (body mas index).

Diet plays a significant role in the weight status of Mexican Americans, with their average dietary cholesterol intake being 316.2 mg compared to the US average dietary cholesterol intake, which is 269.6 mg. They do have a lower average intake in saturated fat, with the US average of 27.9 g and for Mexican Americans consuming an average of 26.7 g. Mexican Americans consume more dietary fiber – on average 18.5 g, while the daily average for Americans is just 15.6 g a day, despite the recommendation of 25 g or more of daily dietary fiber intake.

Hispanics and Immigration Status

According to the 2008 census data, 28.2% of Hispanics are not citizens of the USA. It is difficult to track numbers of undocumented immigrants and it is currently believed that there are 11 million undocumented immigrants in the USA. Mexicans are estimated to make up 57% and Latin Americans 24% of the undocumented immigrant population in the US.

Hispanics and Language

The Pew Hispanic Center found that language fluency varies considerably among the Hispanic subgroups that live in the USA. Most Hispanics speak Spanish in the home, with the national level of Spanish-speaking households being 12%.

Hispanics and Education

Hispanics are less likely than non-Hispanic Whites to complete high school, with 61% of Hispanics having a high school diploma compared to 89% of non-Hispanic Whites. With regards to college, 12.5% of Hispanics have a bachelor's degree, while 30.5% of non-Hispanic Whites have a degree.

Hispanics and Occupation

A greater proportion of Hispanics live at or below the poverty level, 21.5% as opposed to only 8.2% of non-Hispanic Whites. Per the Census report of 2006, 24.4% of Hispanics work in service occupations, compared to 13.7% of non-Hispanic Whites. Hispanics hold 16.6% of management or professional occupations, while non-Hispanic Whites hold 39.9%. Fewer Hispanics earn as high a salary as non-Hispanic Whites, with 55% of Hispanic full-time employees making $35,000/year or more, while 68.2% of their non-Hispanic counterparts earn at least this much.

Summary

Hispanic immigrants face a number of challenges, including receiving adequate and appropriate health care. Work environment, availability of care, and educational level all influence the quality of health care that Hispanic immigrants receive, and influence outcomes, such as frequency of illness, and outcomes of illness that differ from that of the general population, and other immigrant populations. Despite this commonality, it is important to remember that specific country of origin often has a greater influence on health problems and outcomes than does belonging to the larger, general Hispanic population.

Related Topics

- ▶ Familismo
- ▶ Healthy immigrant
- ▶ Hispanic health paradox
- ▶ Immunization
- ▶ Language
- ▶ Language barriers
- ▶ Latinos
- ▶ Machismo/Macho
- ▶ Marianismo
- ▶ Mexico
- ▶ Obesity
- ▶ Poverty
- ▶ Puerto Rico
- ▶ Tobacco

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HIV/AIDS

► Acquired immune deficiency syndrome
► Human immunodeficiency virus

Hmong

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Hmong people, numbering in the millions, inhabited remote areas of China, Burma, Thailand, Laos, and Vietnam. The Hmong who immigrated to the USA came from Laos. At the time of their flight beginning in 1975, they made up about 10% of the Laotian population, or about 250,000. About half of them fled after 1965 when communist Pathet Lao and North Vietnamese soldiers occupied Laos.

The Hmong had skills that facilitated relocation. They knew about surviving in the mountains, choosing routes to take, locating safe water, and selecting plants or animals to forage along the way. In the USA, many Hmong students and adults readily took advantage of educational and training opportunities.

However, in several urban ghettos in the USA, the Hmong experienced assault, robbery, and rape by other ethnic groups. Young Hmong men and teenagers joined into gangs to defend themselves. A Hollywood movie, *Gran Turino* (with Clint Eastwood), reflects the often-negative effects of Hmong gangs on Hmong communities.

Nuclear and extended families often pooled their savings to purchase cars, homes or trailers, and appliances. However, a significant minority of Hmong remained on welfare as compared to other immigrant groups. Factors contributing to acculturation failure included illiteracy, unfamiliarity with complex societies, difficulties applying traditional skills (e.g., gardening and animal husbandry), evolution of gangs, numerous widows from the war, and traditional retirement around age 50.

Adjustment and Psychiatric Disorders

During the first decade in the USA, the rates of major depressive disorder, posttraumatic stress disorder, social phobia, and other anxiety conditions were high in Hmong immigrants. Brain damage related to war-affected individuals ranging in age from infancy to old age. Paranoid symptoms and disorders expanded in the early years following resettlement but abated over time. Alcohol, opium, and other drug use disorders were virtually absent before and immediately following relocation but then appeared and increased over time. Many with opium addiction had previously been dependent on opium in Asia, but a large minority became newly addicted in the USA. Some young Hmong began using cannabis and other drugs with US youth.

Folie a Deux, a paranoid disorder found in two or more closely affiliated people, was particularly common among the Hmong as compared to other immigrant groups. Mistrust, projection of harm onto others, and social isolation were prominent features of *Folie*. Depression was a prominent aspect in many cases – especially in the more dependent member(s) with the shared delusional belief (which consisted of the belief that someone had given them a fatal disease, such as tuberculosis or AIDS).

Biomedical Health Problems

The Hmong brought numerous biomedical conditions from Laos, which in turn could affect mental health and social adjustment. Once a biomedical condition was identified and under treatment, some Hmong expressed the belief that doctors were experimenting on them. This mistrust was especially problematic with conditions affecting children, since courts became involved when parents refused treatment for medical conditions (e.g., middle ear disease) or surgical conditions (e.g., congenital heart disease) that could lead to chronic disability or death. Differing Hmong notions about etiology and treatment could also lead to misunderstandings with clinicians.

In general, the infectious diseases that were common in Laos also occurred in the USA, albeit with a dwindling prevalence over time. These diseases included tuberculosis, pulmonary schistosomiasis (a lung disease caused by parasites), leprosy, malaria, genital herpes, hepatitis A, and hepatitis B. Cretinism (a hormonal disorder causing mental retardation) and goiter resulting from low iodine levels in the mountainous soil of northern Laos were seen among some Hmong. Some vitamin deficiencies continued due to lack of a balanced diet. Certain cancers more common among Asian populations, such as craniopharyngioma, nasopharyngeal carcinoma, and choriocarcinoma, were initially overlooked by US clinicians unfamiliar with them. Due to frequent cross-cousin marriage in Asia, certain genetic abnormalities were common (e.g., polydactyly (finger/toe deformities), supernumerary nipples, dental abnormalities, and certain blood disorders). Enteric parasites (e.g., roundworm, hookworm, amebiasis, and tapeworm) had largely received treatment in refugee camps, so their prevalence in the USA was low.

Chronic diseases virtually absent in Laos began to appear within a few years in the USA. Epidemic obesity, hypertension, cardiovascular disease, diabetes, and metabolic syndrome became rife. As their age span increased, the Hmong developed diseases of senescence that were formerly rare and unknown (e.g., dementia, congestive heart failure, and various cancers).

Culture Clashes

Hmong and US cultures clashed in ways that could precipitate or exacerbate psychiatric and medical health conditions. Intergenerational conflict and male–female matters often dominated in these quarrels, as follows:

- Arranged marriage: Elders felt they had primary responsibility to establish successful marriages for their children, although their children and American law did not support this notion.
- Mother-in law and daughter-in-law relationships: Traditionally, daughters-in-law, coming anew to the family, had to obey their husband's mother, who had higher status in the home.
- Clan loyalty: Young people believed that their earnings belonged to them, whereas patriarchs felt the funds belonged to the clan.
- Dating and marriage: Traditional parents would often not permit their adolescent children to date or attend parties. Families did not want their offspring to date or marry non-Hmong partners.
- Marital strife: Clan elders, who typically intervened in marital problems, might be living in another state or back in Laos. American gatekeepers sometimes counseled the use of interventions that worsened family strife (e.g., shelter, restraint orders, and divorce).
- Bride capture: One means to circumvent a family's unwillingness to approve a marriage consisted of "bride capture" in which the potential bride and groom eloped. Some Hmong men in the USA actually kidnapped Hmong girls who did not want to get married.

Some problems involved the replacement of Hmong norms by American norms. Other problems resulted from the loss of traditional Hmong methods for preventing or resolving crises between generations, clans, and men and women. If Hmong families could not work out a resolution, they sometimes sought the services of a mediator. Negotiations between clan elders or through a mediator comprised means of keeping peace and avoiding smoldering hostility. This traditional method still exists to some extent in parts of the USA, with recourse to government courts if the "Hmong method" fails.

Related Topics

- ▶ Asians
- ▶ Culture shock
- ▶ Foreign-born
- ▶ Linguistic minority community
- ▶ Myanmar
- ▶ Posttraumatic stress disorder
- ▶ Refugee
- ▶ South Asians
- ▶ Thailand
- ▶ Vietnam

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Holocaust

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The Holocaust was the systematic murder of six million Jews by the Nazi regime. Between 1933 and 1945, two out of every three European Jews were killed. While Jews where the primary target of the Holocaust, Nazis also killed more than three million Soviet prisoners of war, approximately a half million Roma and Sinti, also known as Gypsies, a quarter million mentally or physically disabled individuals, homosexuals, Jehovah's Witnesses, and political prisoners. The Nazi ideology was based primarily on racism and a belief that Germans and the Aryan race were physically and mentally superior to all others. They felt that other "races" were a threat to the purity of the German "master race." Hitler's plan for the systematic murder of Jews was termed the Final Solution. The Schutzstaffel, or SS, served as Hitler's Praetorian Guard and along with their commander, Heinrich Himmler, were responsible for carrying out the majority of the war crimes of the Holocaust.

In 1933, The Nazis, or National Socialist German Workers Party, comprised primarily of unemployed veterans of World War I, came to power in Germany. Civil liberties in Germany were greatly curtailed under their leadership. The year 1933 also saw the opening of the first concentration camp, Dachau. The first inmates were political prisoners and opponents of the regime. The following year, Adolf Hitler combined the positions of chancellor and president, declaring himself "Fuhrer." Over the next 3 years, the rights of Jews were systematically eliminated. In 1938, Jews were made to carry identification cards, hand over driver's registrations, shut down their businesses, and attend only special Jewish schools. The assassination of a German diplomat in Paris by a German-born Polish Jew prompted the "Night of Broken Glass" (Kristallnacht) on November 9th and 10th, 1938. German and Austrian Jewish homes, businesses, and synagogues were ransacked, and 30,000 Jews were arrested and placed in concentration camps.

Hitler's invasion of Poland in 1939 marked the beginning of World War II in the European theater. At that time, Jews were forced to wear the Star of David on armbands. In 1940, German Jews began to be deported to Poland, and all Jews were forced into Ghettos which were eventually sealed off. Death camps, concentration camps with special equipment for mass murder, began to proliferate in the 1940s. In 1941, the concentration camp, Auschwitz, began experimenting with the use of the insecticide

Zyclon-B for group killings in gas chambers. Auschwitz–Birkenau became the site where the largest number of Jews were killed.

The Nazi's Final Solution is believed to have been ordered sometime between 1941 and 1942. Jews from other Nazi-occupied countries began arriving at death camps. Medical experiments at Auschwitz and sterilization of women at Birkenau began around this time. In April of 1943, Jewish fighters resisted the liquidation of the ghetto in what became known as the Warsaw Ghetto Uprising. This was the first mass revolt in Nazi Germany. Most of its survivors were taken to concentration camps. Throughout the remainder of 1943, most ghettos and many labor camps were liquidated and mass killings increased in the death camps.

On D-Day, June 6, 1944, British and American troops launched the invasion of Nazi-occupied France. This and other operations by the Allies began turning the tide of the war. As Allied forces advanced, Nazis forced evacuations of prisoners in the Auschwitz complex on foot which came to be known as death marches due to the number who died on the journey. On January 27, 1945, Soviet troops liberated the 8,000 prisoners who had been left behind. It is believed that during the time Auschwitz–Birkenau was operating, more than two million people had lost their lives there. In April 1945, US troops liberated more than 50,000 prisoners at Buchenwald and Dachau. On April 23, 1945, Soviet troops reached Berlin. A week later, on April 30, Hitler committed suicide. On May 8, 1945, Germany surrendered, marking the end of the Holocaust.

Holocaust Survivors

There is some disagreement as to who is considered a Holocaust survivor. The term has been used narrowly to refer to those Jews who were living in an area that came under Nazi control as well as broadly to refer to those who were living in these areas at the time Hitler came to power, even if they emigrated prior to the start of the war. It should be noted that under either definition, those who were never in a concentration camp are considered Holocaust survivors.

The emotional consequences for those who experienced the Holocaust are profound. Individuals who were able to avoid concentration camps had to either reinvent themselves as Gentile (non-Jewish), go into hiding, or find a way out of Nazi-occupied countries. No matter what option was taken, the psychological impact was profound. Guilt plagued both those who denied their true identities, as well as those who fled their country often having to leave loved ones behind. Difficulties with grief over lost friends and family became pathological in many people. This leads to increased rates of clinical depression and anxiety disorders. Posttraumatic stress disorder can be seen in this population as a result of their own near-death experiences, witnessing of traumatic events, and learning of horrors experienced by loved ones.

Individuals who were in concentration camps paid and continue to pay a heavy emotional toll. Many developed posttraumatic stress disorder associated with the reexperiencing of the trauma, avoidance of reminders of their experiences, anxiety and hyperarousal, symptoms of numbing, social detachment, and feeling a lack of a future. Depressive and anxiety disorders occur at an increased rate in this population and many developed survivor syndrome. This syndrome is a constellation of symptoms including disturbed cognition, isolation and withdrawal, identity and reality alterations, psychosomatic issues, the physical appearance of a living corpse, in addition to anxiety and depression. Elderly survivors have higher incidence of suicidal ideation and attempts. Kahana et al. compared immigrants to the USA and Israel who had experienced the Holocaust to those who had not and found that those who experienced it scored significantly higher on the Symptom Distress Scale (SCL-90) subscales of somatization, obsessiveness, depression, anxiety, hostility, and psychoticism. Survivors who immigrated to the USA also had significantly higher levels of sensitivity, phobia, and paranoia than immigrants to the USA who did not experience the Holocaust.

The physical consequences of surviving the Holocaust have been closely studied in the past several decades with results demonstrating increased morbidity and mortality. Whether in camps or in hiding, Jews and other survivors were subjected to malnutrition, injuries, and illness. In concentration camps, people were subjected to additional physical deprivations and abuse. Long-term health effects of chronic malnutrition include increased risk of infection, bone weakness and fractures, and heart disease, among others. Studies have found Holocaust survivors are more preoccupied with their psychical health, appraise their health as poor, and use medical resources more frequently. This is particularly true of survivors who lost their original identities such as names and families of origin in the war. Some studies have shown increased amounts of pain in survivors when compared to those who were not directly exposed to the Holocaust. Additionally, there have been reports of increased cardiovascular health problems, skeletal, arthritic, circulatory, gastrointestinal problems, diabetes, and ulcers in those who were directly exposed to the Holocaust. Interestingly, Kahana et al. found different physical sequelae in survivors based on what country they immigrated to.

Some concentration camp prisoners were subjected to unethical medical experimentation under the direction of Doctor Mengele and others. These included removal of organs, sterilization, exposure to extreme temperatures, genetic and twin experiments, and various other invasive procedures. Most were performed without the benefit of anesthesia. Survivors of these experiments have unique medical consequences based on the nature of the procedures they endured as well as a frequent mistrust and avoidance of medical practitioners.

In conclusion, nearly two-thirds of European Jews were killed between 1933 and 1945. The Jews and others who survived the Holocaust were exposed to emotional and physical traumas that have had long lasting effects on their health.

Related Topics

- ► Eugenics
- ► Internment
- ► Posttraumatic stress disorder
- ► Survivor syndrome

Suggested Readings

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Suggested Resources

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The Holocaust History Project. http://www.holocaust-history.org/. Accessed February 12, 2010.

The United States Holocaust Memorial Museum. http://www.ushmm.org/. Accessed February 12, 2010.

Homesickness

- ► Ambiguous loss
- ► Culture shock

Homicide

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The term *homicide* is technically not synonymous with *murder* as *murder* would imply a criminal homicide. For example, some who commit homicide commit the dual act of homicide-suicide, in which they themselves are killed and would never be charged with *murder*. Others may kill in self-defense or in war, and these would not be considered *murder* from a legal perspective.

According to the US Centers for Disease Control and Prevention, while homicide is not in the top ten list of causes of mortality for all American men, when this is separated for race or national origin, it is the fifth leading cause of death for Black men, the sixth leading cause for Hispanic men, the ninth leading cause for Native American men, and the tenth leading cause for Asian/Pacific Islander men.

The leading cause of death in the workplace for immigrants to the USA is homicide. They may take more dangerous jobs than many natural-born Americans, such as clerking at gas stations and convenience shops, and driving taxis. For example, in 2005, 188 of

564 workplace homicides were homicides of immigrants, while they only made up 15% of workers. In the case of workplace homicide, safety measures such as protective shields for taxi drivers could make a difference.

Resettlement may lead to life improvements, but also is rife with challenges, stresses, and conflicts. One's ethnic community may be a source of great support, but there may also be struggles within the community. Persons who have immigrated to the USA are known to disproportionately become victims of homicide. However, increased death rates by homicide do not occur across-the-board for all immigrants. They may differ by ethnicity of immigrants, acculturation, and time period. For example, a study of first generation non-Hispanic White California immigrants found that immigrants had lower proportional mortality ratios. Another recent study in Israel of immigrants primarily from Russia, found that the frequency of unnatural deaths (including accidents, suicides and homicides) were more similar to rates and patterns in Israel (their new homeland) than those in Russia.

An Australian study of homicide victims found a wide range of mortality ratios depending on the immigrant group. Rates of homicide were highest for Korean male immigrants and lowest for those from Africa and America. Among women, those at highest risk of homicide were Indonesian immigrants. More than half of those who died by homicide were killed by immigrants from their homeland, but the range was vast – from none of the New Zealanders, to every Middle Eastern immigrant who was murdered.

A recent significant increase in homicide victimization has been steadily noted among undocumented workers in the American Southwest. Previously deaths occurred from exposure and dehydration, but more recently homicide has become a major factor. Those paid to lead (*smuggle*) the border-crossing undocumented workers across the border from Mexico to the USA (called *coyotes*) may attempt to extort money from families by holding border crossers hostage, and may kill the border crosser if the ransom is not paid. Members of rival gangs or vigilantes may kill border crossers as well.

On a closely related topic, one recent American study examined adult immigrants' experiences with nonfatal violence victimization and found that the prevalence of nonfatal violence was similar to that of American-born adults. Those working in farming or forestry may have higher risk of violence victimization. Another recent study found that those involved in high-risk behaviors, whether immigrant or American-born, were at higher risk for unintentional injury.

While there have been some highly publicized cases of homicide perpetrated by immigrants, such as the Virginia Tech Massacre, one must keep in mind that homicide committed by immigrants is very rare. In the evaluation for potential risk, speaking with family members and others in the cultural group may help the clinician to understand the stresses the client has been under, and to further comprehend any threats the person has made. A thorough violence risk assessment (outside the scope of this entry) should include cultural considerations.

Related Topics

- ► Domestic violence
- ► Gender-based violence
- ► Intimate partner violence
- ► Violence

Suggested Readings

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Suggested Resources

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Homosexuality

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In most countries around the world, homosexuality is denigrated and homosexuals are socially marginalized. Amnesty International reports abuse, torture, and sexual assault against lesbians and gay men in 30 countries, suggesting a global pattern of violence and torture against homosexuals. These acts of violence are often perpetrated with the assent of law enforcement and government officials. In more than 80 countries, homosexual relations are considered a crime. In several countries, such as Saudi Arabia, northern Nigeria, Sudan, and Yemen, the punishments for engaging in homosexual acts range from floggings, fines, and prison time up to the death penalty, whereas Iran and Mauritania mandate the death penalty.

On December 18, 2008, the United Nations General Assembly was presented a statement, signed by representatives of 66 countries, requesting that human rights protections on the basis of sexual orientation and gender identity be included in the Universal Declaration of Human Rights. Opponents of this request countered with their own statement, signed by 57 countries and brought forth by the Organization of the Islamic Conference.

The hostility and discrimination faced by many homosexuals in their native lands have prompted them to migrate to countries with more progressive legislation and greater social acceptance of homosexuality. Many have fled their home countries for fear of their physical safety and the threat of execution. Currently, 14 countries grant homosexuals asylum on the basis of membership in a particular social group, i.e., homosexuals. Countries granting sexual orientation-based asylum include Austria, Australia, Belgium, Canada, Denmark, Finland, Germany, Ireland, the Netherlands, New Zealand, Norway, Sweden, the UK, and since 1994, the USA. Applicants seeking asylum in the USA must submit their application within 1 year after the date of their arrival to the USA. Homosexuals seeking asylum must demonstrate a well-founded fear of persecution due to their sexual orientation or gender identity if forced to return to their home country.

Unfortunately, in many cases, homosexuals are denied asylum because they are unable to provide documented proof of the threat to their life or freedom in their country of origin. They are subsequently deported on grounds of lack of credibility or sole reliance on verbal testimonies to substantiate their claims. Furthermore, homosexuals who are given refugee status, compared to other refugee groups, often face additional challenges due to familial rejection, lack of familial support, lack of other social support networks, and insufficient financial resources, thereby complicating their resettlement process.

For the purposes of immigration sponsorship, a small number of countries recognize homosexual partnerships. These countries include Australia, Belgium, Canada, Denmark, the Netherlands, New Zealand, Norway, South Africa, Sweden, and the UK. All of these countries, with the exception of Canada, require that one of the partners be a citizen or permanent resident of that country before they can sponsor the other partner for immigration. Such sponsorships require proof of the existence of the couple's partnership, such as evidence of prior cohabitation for at least 2–4 years.

Related Topics

- ► Amnesty International
- ► Asylum
- ► Human rights
- ► Immigrant visa status
- ► Psychopathic personality
- ► Refugee status

Suggested Resources

Iranian Railroad for Queer Refugees: provides awareness about and support to, such as legal services and financial assistance, refugees and immigrants leaving Iran due to persecution based on sexual orientation and gender identity. www.irqr.net

Immigration Equality, Inc.: an organization for advancing equal immigration rights for the lesbian, gay, bisexual, transgender, and HIV-positive community. www.immigrationequality.org

Legal resources for asylum seekers and lawyers, and country specific condition information for sexual minorities. www.asylumlaw.org

Hong Kong

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Introduction

Hong Kong is one of two special administrative regions (SARs) of the People's Republic of China (PRC). At present, there are two SARs: Hong Kong, formerly a territory of Great Britain, and Macau, formerly a territory of Portugal. In anticipation of talks with the United Kingdom over the question of Hong Kong's sovereignty, in 1982 the provision to establish SARs was written into the constitution of the PRC. The model was envisioned as a means for reunification with Taiwan and other islands on which the PRC has resided since 1949.

By definition, a SAR is not part of any other administrative division, and each has its own chief executive and basic law. The Hong Kong Basic Law serves as the constitutional document of the Hong Kong Special Administrative Region (HKSAR) of the PRC. The document holds that the territory is *a local administrative region of the People's Republic of China, which shall enjoy a high degree of autonomy and come directly under the Central People's Government.*

History

Hong Kong became a colony of the British Empire after the First Opium War, 1839–1842. The war was fought between the United Kingdom of Great Britain and Ireland and the Qing Dynasty of China; the impetus of the conflict was the goal of securing economic benefits from trade in China. Although its boundaries were limited originally to Hong Kong Island, the colony's borders were widened in stages to include, by 1898, the Kowloon Peninsula and the New Territories, which include presently the mainland north of the Kowloon Ranges and south of the Sham Chun River, as well as the Outlying Islands. The New Territories were leased to the United Kingdom in 1898 for 99 years. Hong Kong was occupied by Japan during the Pacific War, after which the British resumed control until 1997, when, upon expiration of the lease, sovereignty was transferred to China.

Geography

Hong Kong is located on China's south coast, 60 km east of Macau on the opposite side of the Pearl River Delta. It is bordered by the South China Sea on the east, south, and west, and by the city of Shenzhen to the north. The territory's 1,104 km^2 are comprised of Hong Kong Island, the Kowloon Peninsula, the New Territories, and over 200 offshore islands. Of the total area, 1,054 km^2 is land and 50 km^2 is inland water; its land area makes Hong Kong the 179th largest inhabited territory in the world. Hong Kong claims territorial waters to a distance of 5.6 km.

A significant portion of Hong Kong's terrain is characterized as hilly to mountainous with steep slopes; less than 25% of the territory's landmass is developed. Approximately 40% of the remaining utilizable land area is designated for use as parks and nature reserves. Most of the territory's urban development exists on Kowloon peninsula, along the northern edge of Hong Kong Island, and in scattered settlements throughout the New Territories. Hong Kong's long and irregular coast provides it with many bays, rivers, and beaches.

Although Hong Kong has a reputation of being intensely urbanized, the territory has taken measures to promote a green environment. Environmental awareness is growing as Hong Kong suffers from increasing pollution, worsened by its geography and tall buildings. Approximately 80% of the city's smog originates from other parts of the Pearl River Delta.

Though just south of the Tropic of Cancer, Hong Kong has a humid subtropical climate – summer is hot and humid with occasional showers, thunderstorms, and warm air coming from the southwest. Typhoons are most likely during the summer months, sometimes resulting in flooding or landslides. Winters are mild; they usually start sunny and grow cloudier toward February. An occasional cold front brings strong, cooling winds from the north. The most temperate seasons are spring, which brings variable weather, and autumn, which generally is sunny and dry. Hong Kong averages 1,948 h of sunshine per year, while its highest and lowest temperatures on record are 36.1°C and 0.0°C, respectively.

Culture

Frequently, Hong Kong is described as a place where "East meets West," a statement reflective of the culture's fusion of the territory's Chinese roots and influences from its time as a British colony. A modernized lifestyle is balanced with traditional Chinese practices and concepts. For example, beliefs like *feng shui*, an ancient Chinese system of aesthetics believed to help one improve life by receiving positive qi, are taken very seriously. Often, expensive construction projects utilize expert consultants to incorporate feng shui ideas. Ba gua mirrors are still used regularly to deflect evil spirits, and buildings often lack any floor number that has a "4" in it, due to its similarity to the word for "die" in Cantonese.

Hong Kong is a global center of trade, a self-titled "entertainment hub." Its martial arts film genre gained a high degree of popularity in the late 1960s and 1970s, and numerous Hollywood performers, actors, and martial artists have originated from Hong Kong cinema, including Bruce Lee, Jackie Chan, Chow Yun-fat, Michelle Yeoh, Maggie Cheung, and Jet Li. A number of Hong Kong filmmakers have achieved widespread fame in Hollywood, such as John Woo, Wong Kar-wai, and Stephen Chow.

Economy

Hong Kong is one of the leading international financial centers; it has a major capitalist service economy characterized by low taxation and free trade. Its currency, the Hong Kong dollar, is the ninth most traded currency in the world, and the territory was described once by Milton Friedman as the *world's greatest experiment in laissez-faire capitalism*. It maintains a highly developed capitalist economy, ranked the freest in the world by the Index of Economic Freedom for 15 consecutive years. It is an important center for international finance and trade, with one of the greatest concentrations of corporate headquarters in the Asia-Pacific region. Between 1961 and 1997, Hong Kong's GDP grew 180 times while per capita GDP increased 87 times over.

Education

Although international systems exist, Hong Kong's education system has patterned itself after the system in England. The government maintains a policy in which instruction is in the native language, Cantonese, with written Chinese and English. In secondary schools, multilingualism is emphasized, and Mandarin language education has been increasing. The Program for International Student Assessment ranked Hong Kong's education system as the second best in the world. Hong Kong's public schools system features a noncompulsory 3-year kindergarten, followed by a compulsory 6-year primary education, a 3-year junior secondary education, a noncompulsory 2-year senior secondary education leading to the Hong Kong Certificate of Education Examinations, and a 2-year matriculation course leading to the Hong Kong Advanced Level Examinations.

The New Senior Secondary academic structure and curriculum was implemented in September 2009; it provides for all students to receive 3 years of compulsory junior and 3 years of compulsory senior secondary education. Under the new curriculum, there is the public examination only, namely the Hong Kong Diploma of Secondary Education.

Governance

In accordance with the Sino-British Joint Declaration, and the underlying principle of one country, two systems, Hong Kong has a high degree of autonomy in all areas except defense and foreign affairs. The declaration stipulates that the region maintain its capitalist economic system and guarantees the rights and freedoms of its people for at least 50 years beyond the 1997 handover. The guarantees over the territory's autonomy and the individual rights and freedoms are enshrined in a constitution, the Hong Kong Basic Law. The Basic Law outlines the system of governance but is subject to the interpretation of the Standing Committee of the National People's Congress (NPCSC).

Governing bodies include the Executive Council, the civil service, the Legislative Council, and the Judiciary. The Executive Council is headed by the Chief Executive who is elected by the Election Committee, followed by appointment by the Central People's Government. Politically neutral, the civil service implements policies and provides government services. The Legislative Council has 60 members, half of which are elected by universal suffrage, while the other half, known as functional constituencies, are elected by a smaller electorate consisting of corporate bodies and persons from stipulated sectors. The entire council is headed by the President of the Legislative Council who serves as the speaker. Judges are appointed by the Chief Executive on the recommendation of an independent commission.

Migration

Since World War II, there have been several mass waves of emigration from Hong Kong. The Hong Kong Mass Migration Wave was one such wave. The emigration trend was accelerated by the Hong Kong 1967 leftist riots and, extending into the 1980s and 1990s, was fueled further by the Tiananmen Square protests of 1989. By some estimates, the number of emigrants was in tens of thousands during this period. Canada, Australia, and the United States were the primary destinations for migrants.

The precise figure of migration is difficult to estimate. Some people had relocated overseas by studying abroad and staying after graduation, while others simply obtained returning residency visa from the destination country, which was issued by some countries with no conditions attached in the late 1980s, and then returned to Hong Kong. Informed estimates range from 250,000 to 1 million people, with the peak years of outflow between 1988 and 1994 of about 55,000/year.

As a result of failure to succeed overseas and/or the positive outlook of Hong Kong's economy after the handover, a phenomenon called the *Hong-Kong returning tidal flow* occurred approximately 1 year over the transfer.

Related Topics

- ► Asia
- ► Health disparities
- ► Health outcomes

Suggested Resources

For information about Hong Kong from the United Nations. http://www.un.org/en/index.shtml

For information about Hong Kong from the World Health Organization (WHO). http://www.who.int/en/

For information about Hong Kong migration history and policy. http://www.migrationinformation.org/index.cfm

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Honor Killing

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The term is usually applied in order to refer to the (intentional) act of the murdering of women who are suspected to have violated the honor of their families/kin groups by having committed sexual indiscretions and/or being involved in other "amoral" action. In most of the cases, the assaults on the unmarried or married women are undertaken by their own family members, mostly by male consanguinal relatives – father, brother, cousins. The murder is usually approved, supported, and planned by the family as a whole, often including the females (mothers, sisters, mother-in-laws, cousins, etc.), and considered as the only acceptable way to restore the family's honor and social status which was "damaged" by their murdered female relative. Honor killings may thus be expected to appear in societies and migrant communities where the idea of "honor" and the concomitant anxiety of social shame constitutes one of the focal cultural values and is being primarily attributed to the proper behavior of the consanguinal female family members. Many human rights organizations (e.g., UNICEF) argue that cases such as the killing of brides in India because their families were unable to come up for the expected dowry or the various forms of "passion crimes" performed in – or by migrants from – Latin America should also be classified as honor killings, since they are predicated on the same cultural logic according to which such crimes are usually tolerated or even endorsed by the local society. Other commentators suggest that the "acid attacks" on engaged or married women by their husbands/fiancés, known from India, Pakistan, and Bangladesh, be included as honor killings or honor crimes, although the general intention behind such attacks is not so much geared toward the actual killing of these women as to their defacement. The United Nations Population Fund estimates as 5,000 women are killed each year for "dishonoring" their families.

The term honor killing is mostly applied in the context of Middle Eastern societies while some commentators draw an additional connection with Islam. Actually, however, acts of honor killing in the Middle East are not contingent on religious convictions but are based on an overriding regional social code according to which the women are the vessel of the family's/kin groups' outward reputation. Honor killings in the USA, Canada, or Western Europe are thus committed likewise among Christian, Muslim, or heterodox migrants from this region. The reasons behind such honor killings may range from premarital sexual intercourse, sexual relations with persons who do not belong to the same ethnic or religious group, adultery, to rape, and even flirting, depending on the values of the social groups in question and varying among different families.

In most of the cases, however, dishonoring is dealt with by means other than killing. However, young women often suffer from symptoms of enduring stress and anxiety due to the possibility that their conduct may be assessed as being at odds with the family's outward reputation and thus they may eventually be victim of an attack. Apart from the physical injuries and/or the post-trauma problems suffered by those women who luckily survived an assassination attempt, the major health problems resulting from the mere threat of honor killing are situated in the domain of mental health. Frequently, young women are warned repeatedly by their relatives over a period of several years that they eventually will be killed if they dishonor the family by refusing to wear the veil, rebuffing an arranged marriage, or becoming too "Westernized." The ongoing threats and the resulting fear and insecurity may lead to protracted mental health problems, such as anxiety and panic attacks, depression, or paranoia. Moreover, the threat of murder often gives rise to a general mistrust and fear of intimate social relationships due to the menace that has been induced by the women's closest kin.

In some cases, a young woman may desperately search for assistance from a surgeon to reconstruct her hymen after she has secretly engaged in sexual intercourse. This is done to prevent potential dishonor from falling on her family if the woman has been promised in marriage or is there is a forced marriage.

Honor killings can turn out to be the final and most extreme step within a long history of previously applied forms of "honor-based violence" (HBV) such as bashing, torture, mutilation, rape, forced marriage, imprisonment at home, etc. Cases in which female victims have survived an attempted murder and openly dare to talk in public are extremely rare. The somatic and mental problems affecting the victims thus only become evident to outsiders if the women are brought to the hospital, take refuge in a women's shelter, or in cases of asylum seekers (such as Zahida Perveen from Pakistan whose face had been disfigured by her husband). Failed murder attempts may also entail severe health problems resulting from poisoning, cuts, gunshot wounds, and beating. At a later stage, the surviving women frequently fall victim to repetitive assassination attempts by their relatives, eventually leading to death.

Occasionally, health problems surrounding the issue of honor killing are considered to affect not only the victims but also the murderers, who – as some psychiatrists maintain – often are suffering from mental disorders. Indeed, in many cases, migrant families select the "weakest" member to act as the commissioned murderer, preferably a relative who already received medical treatment because of mental health problems or a physically handicapped younger brother of the victim. The intention behind such a selection is based on the expectation that a disabled person arrested for the assault will receive a more lenient sentence at court or even be declared certifiably insane due to mental disorder. Particularly in Germany and other Western European countries, lawyers in trials of honor killing increasingly employ the defensive strategy of pleading for their client's diminished responsibility resulting from mental illness, depression, or other mental health problems.

While some commentators argue that the respective social groups or migrant communities endorsing honor killing have to be informed and educated more broadly in terms of human rights and "moral" values, at present it seems that the only effective way to prevent honor killings from happening is to hide threatened women from their own families by relocating them to other regions or countries and provide them with a new identity. Such a procedure may also entail additional mental health problems for the victims.

Related Topics

- ► Customary marriage
- ► Domestic violence
- ► Gender-based violence

Suggested Readings

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Hospice

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Hospice is a program providing palliative care and supportive services that address the psychosocial, physical, financial, legal, and spiritual needs of terminally ill patients, their families, and other loved ones. The goal of hospice care is to improve the quality of life for the last days of terminally ill patients by offering comfort and dignity. Hospice care does not focus on cure-oriented treatments intended to prolong life.

A multidisciplinary hospice care team consisting of a physician, nurse, social worker, bereavement counselor, or spiritual counselor provides comfort-oriented care including pain management. Hospice is not a facility but a concept of care; thus it is available in various settings such as the patient's home, family member's home, or inpatient facility. Today a majority of hospice care patients receive care at their places of residence such as private houses or nursing homes.

St. Christopher's Hospice, which started in Great Britain in 1967, was the first formal hospice in the world. Seven years later the first hospice in the USA was established in New Haven, Connecticut. Since then the number of hospice programs has increased nationwide. Currently approximately 5,000 hospice programs exist in the United States. In the United States, individuals can choose to enroll in the Medicare Hospice Benefit if they are covered by Medicare (the federal government's insurance program for individuals over the age of 65) and have received a diagnosis of 6 months or less to live. The National Hospice and Palliative Care Organization estimated that approximately 41.6% of the deceased in 2009 received hospice care. The median length of hospice services was about 3 weeks in 2009, which means that one-half of hospice patients received care for less than 3 weeks. Length of service would be influenced by numerous factors such as type of disease, timing of referral, or patient's preference of care.

Racial and ethnic disparities have been reported in hospice use. Ethnic minority immigrants are less likely to enroll in a hospice program. This would be due to their "barriers to hospice use" such as cultural differences in coping with death and dying, limited or no knowledge of hospice, or lack of financial resources if not covered by public or private health insurance. Not-for-profit hospices will enroll uninsured individuals regardless of ability to pay for services; however immigrants may not understand the difference between not-for-profit and for-profit hospices and assume they cannot access these services due to financial restraints. Moreover, limited availability of culturally specific hospice care services also contributes to underutilization of hospice among ethnic minority immigrants.

Related Topics

- ► Barriers to care
- ► End-of-life care
- ► Health insurance
- ► Medicare
- ► Public health insurance

Suggested Resources

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Hospitalization

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Hospitalization refers to a formal admission to a medical facility or hospital for observation, diagnosis, treatment, or surgery with the expectation of an overnight stay. Generally, a formal admission is considered a stay in a hospital for at least 24 h, measured in days, and includes a baby born in a hospital. Such a stay is also known as an in-patient hospitalization and is distinguished from observation, diagnosis, treatment, or surgery done in an outpatient setting.

Hospitalization Data

Throughout the world, hospital records are maintained for all those hospitalized, regardless of their legal immigration status. Hospital discharge records or discharge abstracts contain demographic information about the person, diagnosis and procedure information, and other administrative and billing data for a stay in a hospital of at least 24 h – both in the USA and under the European rules in Europe. However, discharge records generally do not record immigration status or place of birth, making immigrant status very difficult to identify.

Hospitalizations indicate advanced disease, may signal epidemics, and help define trends in immigrant disease profiles, so complete and reliable data is critical. Frenk illustrates the importance of using international methods with country-specific data to develop major health reform affecting bordering countries such as the USA and Mexico, and by extension, other immigrant sending and receiving countries throughout the world.

Inpatient Hospitalization

Hospital utilization varies by sex, race/ethnicity, geography, and age. Throughout the world, women make up the largest number of persons hospitalized and the majority of their hospitalizations are related to pregnancy, childbirth, or post-partum complications. Studies in California and Spain illustrate this fact. For example, in 2005, six of the top ten inpatient procedures in California general acute care hospitals were related to birth, pregnancy, childbirth, or other female condition.

In the USA, Latino immigrant women have higher rates of hospitalizations than non-Hispanic White women, due to pregnancy and childbirth, which contributes to a young immigrant population, particularly among Latinos.

US studies show geographic variation in hospitalization among ethnic groups based on their concentration in certain areas such as El Paso, Texas, and Los Angeles, California, with childbirth-and pregnancy-related hospitalizations higher in these areas. Also, studies of children hospitalization show the significant variation in location of hospitalization that may be driven by source of payment. For example, a California study showed that children with public funding were hospitalized more frequently in pediatric specialty clinics than children with private funding, which suggests that fewer hospital pediatric specialty referrals are being made because they are more costly.

A recent trend has been to use the outpatient setting for care and surgical procedures previously performed in a hospital environment. This change in protocol effectively reduces the number of hospitalizations.

Immigrant Hospitalization

Limited Data in USA

While a significant body of literature has emerged about immigrant health, little exists on immigrant hospitalization, and is only available through targeted research studies that collect place of birth. One example is a study conducted in Illinois over a 10-year period, 1993–2003. In this study, foreign born persons had a lower percentage of hospital admissions and a lower proportion of admissions than did native born Americans.

With the exception for childbirth, Berk reports similar lower rates of hospitalizations among unauthorized immigrants in Los Angeles, California from 1996/1997 survey data. However, hospitalization rates among undocumented Latino immigrants in El Paso and Houston, Texas, and Fresno, California – two states with the largest concentrations of undocumented immigrants – and other Latinos and the US population as a whole were comparable (except for childbirth). In Berk's survey, rates of physician visits were much lower for undocumented immigrants than for Latinos and the US population as a whole.

Because neither hospital discharge data nor workers' compensation claims are reliable sources for hospitalization use by immigrants, Muennig recommends using small area analysis to predict hospitalization rates among immigrants. Yet, the scant data that are available to quantify immigrant hospitalizations provide preliminary insights into immigrant hospitalization, both globally and in the USA.

Challenges

Several fundamental questions emerge when comparing immigrants to other population groups. These questions underscore the complexity, importance, and challenge of understanding hospitalizations among immigrants. Are immigrant hospitalization rates high or low compared to others; and if so, why are they different from others? Do immigrants have equitable access to health care resources? Does immigrant hospitalization impose a burden on the host society; if so, why?

Controversy over immigration health pertains especially to disadvantaged laborers and undocumented populations that do not fully participate in the health care financing system of the host country. For example, in the USA, health insurance coverage rates of African and Asian immigrant populations tend to approximate those of non-Hispanic Whites. Latinos, on the contrary, have low rates of insurance coverage so that questions about both equitable access and burden on the public financial system become more important.

Equitable access to health care services, including hospitalization, centers on two issues: cost and social justice. Immigrants often are employed, but the costs associated with insurance may preclude the employer from providing insurance; or if offered, workers may not be able to pay the premiums and co-pay amounts; or because of generally good health, the immigrant may not believe insurance is needed. Geiger points to overwhelming evidence that minorities and the poor who get medical care receive less comprehensive and lower quality diagnosis and treatment compared with others, even when confounding variables are comparable such as insurance status and severity of illness. A Canadian study noted that immigrant workers were less likely than native born workers to receive a precise diagnosis (64% vs 42%).

Numerous studies have found that the burden on the host country of immigrant hospitalization is significantly lower for immigrants than for the native-born and that immigrants do not contribute disproportionately to high health care costs in public programs such as Medicaid, including emergency department use. However, there are areas where immigrants make up a disproportionate share of the population. One example is the USA–Mexico border region, as illustrated by the University of Texas, El Paso, which incurs huge uncompensated expenses for emergency department visits and inpatient care by the uninsured, underinsured and from patients who receive hospital care because of cross-border agreements. Yet, overall, the Texas Comptroller estimates that undocumented immigrants in Texas generate more taxes and other revenue than is spent by the state on services to them.

Immigrant Flow

Number of Immigrants in USA

Passel and Cohn estimated more than 39 million immigrants (12.8% of the US population) were in the USA in 2009, both legal and unauthorized. About one-third of immigrants are estimated to be *unauthorized,* mostly Latino (nearly 75%), and mostly from Mexico (59%). The fact that nearly one-quarter of all children in the USA are in immigrant families poses a significant dilemma for the US public health system even as it underscores that the immigrant population is a young one, whose health care and hospitalization needs will extend over a considerable length of time. This trajectory of care will span the disease, injury, and illness patterns seen over the life-course from pregnancy, childbirth hospitalizations, childhood immunizations, and work-related injuries, to disability and other older age–related diseases and adverse health conditions that may lead to hospitalization. DuBard's study in North Carolina finds more rapidly increasing spending for elderly and disabled immigrants who may need frequent hospitalizations.

Healthy Immigrant Effect

Is lower hospitalization due to better health, a younger population, or barriers to accessing the health care and hospitalization system? The literature suggests that immigrants to the USA and to other countries in the world are selected because of relatively good health, and advantages in health profiles and mortality rates are attributed to what is known as the "healthy migrant effect." In the USA, this advantage is particularly evident among Latinos, who show lower mortality rates for major causes of death such as cardiovascular disease and cancer as compared to non-Hispanics, which may explain partly why they are hospitalized less frequently.

One reason for the low immigrant hospitalization is the healthy immigrant effect. Another reason is the use of alternative care settings.

Alternative Care Settings

Immigrant health care may be provided outside the medical public health mainstream by religious- and community-based organizations, through self-medication and the use of folk healers. Such alternative healthcare contributes to the challenges in studies on immigrant hospitalizations. Other challenges are that sample sizes are too small to produce reliable results, immigrants are not well identified or described in the records, and the variation in research methodologies makes comparisons between studies difficult.

Social Barriers

Fear

Regardless of legal status, immigrants are reluctant to go to the hospital for care unless absolutely necessary, for fear of deportation or of loss of employment. A Canadian study of differences between immigrant and native-born workers in the injury and illness compensation process found immigrant workers experience greater fear of reporting an injury, face greater challenges to their rights of compensation for their injuries, and by reporting their injuries they encounter greater adverse job re-hire outcomes and social exclusion from the job market than the native-born. Similar experiences by immigrants are reported in the USA and Europe, where fear of hospitalization and seeking health care occur because of numerous potential adverse consequences from such efforts.

Insurance

A principal barrier to health care and hospitalization among immigrants is lack of insurance. In 2007, the majority (59%) of unauthorized immigrants did not have insurance, and 45% of their unauthorized immigrant children were uninsured. This compares with 25% of those children born in the USA and who were US residents that year.

A 2000 study by Currie on the impact of expansion of Medicaid for children of immigrants and nonimmigrants using data from the 1989 and 1992 National Health Interview Survey showed that while children of immigrants are more likely to be eligible for Medicaid than native-born children, actual coverage is higher among native-born children. Increased *eligibility* does not necessarily mean an increase in *utilization.* The study also found that eligible immigrant children, as well as native-born children, are more likely to have at least one doctor's visit with increased Medicaid eligibility, but immigrant children are less likely to be hospitalized. This study suggests that costly hospitalizations are reduced among immigrant children with increased access to primary care doctors and preventive care. The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) significantly changed immigrants' access to Medicaid, excluding many new immigrants from coverage.

Medical Repatriation

Medical repatriation is a process by which hospitals discharge an immigrant patient to their home country, providing a variety of incentives to gain permission from the patient or the patient's family for the voluntary return to their home country for care that often is inferior or without needed medical care resources. Threats of reporting to immigration of those foreign individuals who have not paid their bills fuel unwillingness to seek health care.

Yet, not all medical repatriation situations are motivated by factors related to cost or other burden. For example, patients have been hospitalized in the mental health system for extended periods even though they could have been released to less-restricted environments, and have attempted medical repatriation as less onerous than the mental health facility. But because of language miscommunication and cultural misunderstanding, these medical repatriation efforts have failed.

Immigrant Hospitalization – Global

Anti-immigrant sentiment is evident throughout Europe and the USA, with Phoenix, Arizona serving as ground zero for such discord in the USA. Such sentiments influence availability of and access to primary care resources that can prevent hospitalizations used as a last resort and the attendant costs of such hospitalizations.

Infectious Disease

A study in Valencia during 2001–2002 used hospital discharge records to learn whether the rise in incidence and/or transmission of infectious diseases seen in Valencia could be attributed to the immigrant population. The authors found that the percentage of infectious and infectious–contagious diseases among immigrants did not contribute to the increase in these conditions in Valencia. Such a study reinforces the need for accurate hospitalization data that can be used to identify trends and sources of illness.

Mental Health

A review article on mental health care between 1996 and 2004, among immigrant groups in Germany, Italy, and the UK, countries with the most immigrants during the 1990s, found underutilization of mental health care services in 9 of 13 German studies. Although immigrant groups in the UK had more hospitalizations, poorer outcomes were reported. The article notes the limited research on immigrant hospitalizations to guide the development of mental health services in major countries in Europe.

Workplace Injuries

The International Labour Office estimated that, in 2000, 49% of international migrant workers were active in the labor stream, that is, either seeking work or employed. Immigrants throughout the world take high hazard, precarious jobs that are less desirable, more hazardous, and more stressful, often with few benefits (including health care) and higher risk of injury and death. Lack of regulation in this informal sector economy exacerbates the risks, and women often end up doing this work. These factors increase the hospitalization potential that is not well documented in the USA or throughout the world.

Immigrant Hospitalization – United States

Mental Health

Historically in the USA, mental health hospitalizations have been higher among immigrants during periods of high immigration. Yet, trends during the current immigration wave of Latinos and Asians show lower mental health hospitalization rates. A study in New Jersey illustrates the complexity of immigrant hospitalizations and the difficulty of doing reliable studies on this population. Researchers surveyed four of the state mental health facilities in New Jersey and identified 61 immigrant patients. Of these, 55 could have been discharged to a residential health care facility, but were not because they were ineligible for federal benefits in the community setting. On closer examination, 12 patients did have legal authorization to be in the USA and others had already initiated the process of repatriation, applied for a resident alien card, sought asylum, or had other special circumstances. However, culture and language differences and staff misunderstanding of the immigration processes kept these patients undocumented and hospitalized.

Workplace Injuries

Unauthorized immigrant workers are concentrated in occupations with greater occupational hazards and subject to conditions that cause severe neck, shoulder, and back injury. Workers and employers of immigrants are less likely to report work injuries or go to a hospital than native-born, even if the injuries are life threatening for fear of deportation, retribution, unawareness of their rights to workers' compensation, or fear of drawing unwanted attention from health and safety enforcement agencies.

Conclusion

In summary, hospitalization utilization varies by sex, race/ethnicity, geography, and age with the largest number of hospitalizations due to pregnancy- and childbirth-related conditions. Also, immigrant hospitalization rates are comparable to or lower than for the native-born, except for higher immigrant rates for pregnancy and childbirth and emergency room visits by children; lower rates of insurance among immigrants restrict their access to health care; and immigrants do not disproportionately burden the health care system.

The implications of understanding more about hospitalizations generally, and immigrant hospitalizations specifically can be embodied in these five points:

Education that targets the leading causes of workplace injury, illness, and death, and nuanced to the culture and language of the immigrant's country, even region of origin.

Enforcement of existing regulations and safety inspections throughout the world.

Underreporting of illnesses or injuries is well-known. Fears of job loss, employer retaliation, deportation, or harassment are factors influencing unwillingness to report injury and to seek hospitalization.

Improvement in data collection efforts that are country-specific, with the capacity to collaboratively link records to existing data sets in the USA and internationally.

Research studies that apply similar methodologies with adequate sample sizes to compare across regions, countries, and cultures.

Related Topics

► Healthy immigrant
► Immigration in the global context
► Labor migration
► Methodological issues in immigrant health research
► Occupational injury

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Housing

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Housing is a fundamental human need that provides a critical foundation on which health is heavily determined. Without housing or with substandard housing, people are at risk for numerous health problems. Access to housing and to quality housing that is not overcrowded may be a particular problem for immigrants.

Obtaining accurate estimates of the number of people who are homeless is difficult, but homelessness is usually higher in source than in destination countries for immigrants. Of particular interest though are destination countries since that is where immigrants reside following immigration. A recent estimate suggested that over 12 months from 2006 to 2007, about 1,589,000 persons used an emergency shelter or transitional housing in the USA. In Japan, it was estimated that between 20,000 and 100,000 were homeless. In the UK an estimate was about 100,000.

There are few studies of health of homeless immigrant populations. One recent study surveyed immigrant and non-immigrant homeless people in Toronto, Canada. Chiu et al. concluded in their 2009 article that recent immigrants who are homeless constitute a distinct group and that they are generally healthier than native born homeless people. Thus recent immigrant homeless may need different services compared to other people who are homeless. The authors suggest that a "healthy immigrant," effect, which is common in immigrant populations for many illnesses, might also exist among homeless immigrants. More research is needed on the health condition and needs of homeless immigrants.

Historically, provision of decent housing has been seen as a basic step toward proper sanitation that can prevent the spread of disease. Today in much of the developed world poor housing conditions are of less concern because of the spread of disease, although that is still a concern, but more often because of exposure to toxicants and allergens that are deleterious to health through chronic disease mechanisms. In addition, injuries caused by substandard housing are also a concern. Prime examples of hazardous exposures in the home include water damage and associated mold growth; secondhand tobacco smoke; cockroach, rodent and bed bug infestations; dust mites; lead paint; indoor use of pesticides; and many more.

Because substandard housing is more common at lower socioeconomic strata and immigrants are often concentrated at lower incomes, they may be more likely than native-born populations to experience housing conditions that are unhealthy. Some immigrants may also contribute to housing problems if they have moved from, for example, rural agrarian settings to urban, multifamily housing. These immigrants may bring with them practices that while appropriate in a rural setting, are hazardous in their new housing. An example would be using open combustion for heating in poorly ventilated buildings.

Secondhand Tobacco Smoke

Secondhand tobacco smoke (SHS) is a mixture of thousands of substances, both gases and particulate matter, many of which are known or suspected carcinogens and have other toxicological properties, including effects on the cardiovascular system. Exposure to SHS has been linked to cardiovascular disease, lung cancer, asthma (both occurrence and exacerbation), middle ear infection, pneumonia, low birth weight, and sudden infant death syndrome. Of particular concern for immigrants may be that smoking norms can differ between the country of origin and the new country of residence. Immigrants may move from places with little concern about SHS to places where it is tightly regulated and even banned in some housing.

Further, some immigrant populations, many Asian immigrants in the USA, for example, have vastly different smoking patterns than native born populations. Thus, men in these immigrant populations may have a high smoking prevalence while women rarely smoke. This social pattern means that women are exposed to their husbands' and fathers' SHS more so than the other way around. Coupled with a hesitancy to challenge behavior of others in the family, especially elders, traditional approaches to educating about and discouraging smoking in the home may not be effective.

Water Damage and Mold Growth

Poorly built or maintained housing may be prone to leaks and moisture. Leaks could be from the exterior, for example, a leak through a wall or roof when it rains, or from plumbing. Inadequate ventilation in bathrooms and kitchens can also allow moisture from cooking or showers to build up. Whatever its source, if water is present where it is not supposed to be in a building it can, over time, lead to structural damage and to growth of mold. While there is mold almost everywhere, large growths may be a particular problem to health of people who are exposed. Molds produce spores and hyphae that can elicit allergic responses, including asthma, in some people. Molds also release organic compounds that have toxic properties.

Remediation of mold, once it has taken hold, is not easy. Simple cleaning is often ineffective. In some cases it may be necessary to replace structural elements that are infected with mold. A particular problem for immigrants moving from rural to urban environment might be that uncontrolled indoor moisture may not seem like a problem.

Cockroach Infestation

There are numerous species of cockroaches, but the German cockroach is a particular indoor problem in the Northeastern USA. Populations of these insects will expand to hundreds or thousands in a single apartment and the antigen they leave behind appears to increase risk of developing asthma and exacerbating asthma in some people who already have it. Controlling these infestations is especially challenging in multifamily buildings. Cleaning and eliminating these pests from one apartment is ineffective as they will simply infiltrate from other infested apartments.

Standard pesticide spraying, besides adding highly toxic chemicals to the living space, also appears to be relatively ineffective, sometimes known as, “spray and pray.” Cockroaches usually return after an absence and the space has to be continually sprayed to keep them at bay. Integrated pest management (IPM) across entire buildings seems to hold some promise for eradication of cockroach infestations. IPM uses insect toxins that have lower human toxicity and includes extensive cleaning, sealing cracks and crevices, and altering resident practices to reduce clutter, food and water sources for the insects.

Dust Mites

These arachnids are not insects, but are, instead, related to spiders. They are microscopic in size and live in bedding, carpets, and upholstery. They are highly dependent on humidity and die without enough moisture. Like cockroach antigen, antigen from dust mites is allergenic to people who are sensitive to it. Unlike cockroaches, dust mites tend to be more of a problem in middle class and suburban housing where there are more places for them to grow, including, for example, children's stuffed animals. While some in-home interventions for asthma that included multiple inventions, including dust mite control, claim that reducing dust mite antigen is beneficial for asthmatics, studies that employed these control strategies alone have failed to show consistent or statistically significant benefits.

Lead Paint

While banned for interior residential use in many countries, in the USA lead paint continued to be sold and applied in homes into the latter part of the twentieth century. The legacy of this failure to regulate residential lead paint is that approximately a quarter of a million children in the USA have elevated blood lead levels, even as evidence grows that blood lead levels below the current guideline (10 ug/dl blood) also cause neurological damage.

Residential lead paint is more prevalent in older housing stock, for instance, in the Northeastern USA, and is more likely to be deteriorated, releasing forms that can be ingested, dust primarily, in housing that is overall in poor condition, often low-income housing. A substantial problem is painted window wells. Window wells were not meant to be painted, but many were anyway. Paint in the wells is subject to regular friction when windows are opened and closed, resulting in wearing down the paint into chips and dust.

Young children spend much of their time on the floor and put things into their mouths, including their hands. In a house with lead contamination this is the main route by which lead gets into the body. At high levels lead can lead to acute illness and require immediate medical attention. At levels more common today, lead is associated with more subtle neurological damage, including changes in behavior, loss of IQ and learning difficulties.

Rodent Infestation

Rats and mice are relatively common pests in low-income housing. Like mold, cockroaches, and dust mites, they leave behind antigens that exacerbate or may cause asthma. While poisoning animal pests is an option, anything that is acutely toxic to these mammals is similarly toxic to humans. Because their numbers are usually smaller than insects or arachnids, trapping is a common approach to control. Elements of IPM described above will also help by removing paths of entry and sources of food and water.

Pesticides

Indoor use of pesticides is usually aimed at insect and arachnid infestations. Application of pesticides may be by professionals hired by the home owner or manger or by tenants on their own. Because pests are an easily observed and generally reviled presence while the toxicity of pesticides is subtle and not observable, most people will choose pesticides to address infestations. But the toxicity of pesticides, which, like lead are primarily neurotoxic, is considerable and once introduced into the home, many pesticides are stable and remain for protracted periods of time.

Julien et al. did a study in Boston, Massachusetts, USA, and found that pesticide residues in public housing often included restricted use pesticides that were not supposed to be applied in homes. Hispanic families were buying these pesticides at local bodegas and using them, undiluted and without training on their hazards, to counter cockroach infestations in their apartments.

Injuries

Houses are significant sources of injuries, especially for children and the elderly. In the USA in 2006, unintentional injuries were the leading cause of death for ages 1–44. In almost all age groups, falls were the leading cause of unintentional non-fatal injury. Many of these falls occur in the home and include falls on stairs, a common sort of fall with a high chance of injury. While much of the media attention focuses on violence (intentional injuries in this framework) and motor vehicle–related injuries, in-home injuries are also very common, if not as upsetting to us as a society.

Structural features of the home are important contributing factors to injuries. Taking stairways as an example, elements that reduce hazards of stairs include sturdy handrails, non-slip surfaces, and absence of structural damage and appropriate step lengths.

Other common in-home injuries include burns and poisonings, and cuts and abrasions.

Unlike the lead and allergen exposures described above, injuries are more easily traced to their causes. A fall on a stair is easily attributable to falling on a stair, unlike an asthma attack to which it would be difficult to assign a clear causal link. Because the source of injuries is more easily assessed, they may be easier to prevent. However, to date, attention to injuries, in-home or out of the home, has tended to attract less interest than chemical and biological exposures.

Related Topics

- ► Asthma
- ► Built environment
- ► Environmental health
- ► Environmental tobacco smoke
- ► Injuries
- ► Pesticides

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Human Immunodeficiency Virus

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Human immunodeficiency virus (HIV) is a virus that can lead to acquired immune deficiency syndrome, or AIDS. The World Health Organization (WHO) estimated that 33.4 million people were living with HIV or AIDS at the end of 2008. In the same year, an estimated 2.7 million people became infected with HIV. The US Centers for Disease Control and Prevention (CDC) estimated that 1,106,400 persons in the USA were living with HIV or AIDS at the end of 2006, with an estimated 56,300 new HIV infections that year.

The natural history of HIV infection in adults is well documented in the medical literature. HIV damages a person's body by destroying specific blood cells, called CD4+ T cells, which are crucial to helping the body fight diseases. Within a few weeks of being infected with HIV, some people develop flu-like symptoms that last for a week or two, but others have no symptoms at all. People living with HIV may appear and feel healthy for several years. However, even if they feel healthy, HIV is still affecting their bodies. All people with HIV should be seen on a regular basis by a health care provider experienced in treating HIV infection. Many people with HIV, including those who feel healthy, can benefit greatly from current medications used to treat HIV infection. These medications can limit or slow down the destruction of the immune system, improve the overall health of the person living with HIV, and may reduce the individual's ability to transmit the virus. Untreated early HIV infection is also associated with many diseases including cardiovascular disease, kidney disease, liver disease, and cancer.

AIDS is the late stage of HIV infection, when a person's immune system is severely damaged and has difficulty fighting diseases and certain cancers. Before the development of certain medications, people with HIV could progress to AIDS in just a few years. Currently, people can live much longer – even decades – with HIV before they develop AIDS. This is because of "highly active" combinations of medications that were introduced in the mid-1990s. While current medications can dramatically improve the health of people living with HIV and slow progression from HIV infection to AIDS, existing treatments may need to be taken daily for the rest of a person's life. These treatments need to be carefully monitored, and come with costs and potential side effects. At this time, there is no cure for HIV infection. Additional information on AIDS and the impact of the worldwide HIV/AIDS epidemic can be found in the entry "acquired immune deficiency syndrome" in this encyclopedia.

Many social/psychosocial issues, including homosexuality, drug use, mental illness, racism, homelessness, and poverty, are linked inextricably to the context of HIV/AIDS by association with the communities the disease has heavily impacted, in addition to the clinical challenges of the disease itself and its toll on the health and well-being of those infected.

HIV Transmission

HIV can be transmitted through blood, semen (including pre-seminal fluid, or "pre-cum"), vaginal fluid, or breast milk. The most common modes are: sexual intercourse (anal, vaginal, or oral sex) with an HIV-infected person; sharing needles, syringes, or injection equipment with an injecting drug user (IDU) infected with HIV; and from HIV-infected women to babies before or during birth, or through breast-feeding after birth. HIV also can be transmitted through transfusions of infected blood or blood clotting factors. Some health care workers have become infected after being stuck with needles containing HIV-infected blood. Routine screening of all donated blood since 1985 has made risk by transfusion extremely low in the USA and other developed regions (Canada, Western and Central Europe, and Australia). In contrast, many developing countries have no reliable blood screening due to limited or nonexistent basic laboratory services, irregular testing supplies, poor quality test kits, poor coordination, and/or limited staff; complete, accurate data on testing of donated blood are not available from these areas.

Transmission of HIV can be influenced by several factors, including characteristics of the HIV-infected host, the recipient, and the quantity and infectivity of the virus. Having a sexually transmitted disease (STD) can increase a person's risk of becoming infected with HIV. In addition, if an HIV-infected person also is infected with another STD, that person is three to five times more likely to transmit HIV through sexual contact. HIV cannot be transmitted from casual (i.e., hugging or shaking hands) or surface (i.e., toilet seats) contact or from insect bites. Intact, healthy skin is an excellent barrier against HIV and other viruses and bacteria.

Globally, heterosexual contact between men and women accounts for approximately two-thirds of new infections; around 11% of HIV infections are among children who acquire the virus from their mothers; ten percent result from injection drug use; five to ten percent are from sex between men; and five to ten percent occur in health care settings. According to the United Nations AIDS program (UNAIDS), data on HIV transmission and risks indicate refugees and immigrants newly arriving or resettling in a new country are much more susceptible to and at greater risk for HIV infection than local general populations. The UNAIDS surveillance data attribute this phenomenon to several factors and challenges ranging from financial and environmental conditions to cultural and language barriers, stigma, discrimination, exploitation, and difficulty accessing HIV education or health services.

HIV Testing

Testing for HIV is the only way to determine for certain whether someone is infected with the virus, particularly since many infected individuals do not have symptoms for years. Commonly used tests detect antibodies produced by the body to fight HIV. Most people develop detectable antibodies within 3 months after infection, with the average at 25 days; in rare cases, it can take up to 6 months. HIV testing and counseling offers an opportunity for infected individuals to find out they are infected and gain access to treatment that may help to delay disease progression; for those not infected, counseling offers an opportunity for education on ways to prevent an infection in the future. Unfortunately, many people do not test for HIV until they or their sex or needle-sharing partner develops an AIDS-related illness. Some HIV-positive women may not be tested until they seek prenatal care or give birth.

Preventing HIV Transmission

Abstaining from engagement in any behavior that carries risk of acquiring HIV (e.g., sexual intercourse or using and injecting drugs) is the most effective way to avoid HIV, but not always the most realistic. To minimize risk for those who choose to be sexually active, the CDC recommends the following: engage in sex that does not involve vaginal, anal, or oral sex; have intercourse with only one uninfected partner; and/or use latex condoms every time you have sex. For IDUs who cannot or will not stop injecting drugs, the following steps are recommended to reduce risk: never reuse or "share" syringes, water, or drug preparation equipment; only use syringes obtained from a reliable source (such as pharmacies or needle exchange programs); use a new, sterile syringe every time to prepare and inject drugs; if possible, use sterile water to prepare drugs; otherwise, use clean water from a reliable source (such as fresh tap water); use a new or disinfected container ("cooker") and a new filter ("cotton") to prepare drugs; clean the skin with a new alcohol swab prior to injection; safely dispose of syringes after one use. If new, sterile syringes and other drug preparation and injection equipment are not available, then previously used equipment should be boiled in water or disinfected with bleach before reuse.

Medical therapy with azidothymidine (AZT) effectively reduces the chance of an HIV-infected pregnant woman passing HIV to her infant before, during, or after birth. In 1998, the US Public Health Services released updated recommendations for offering antiretroviral therapy to HIV-positive pregnant women. Unfortunately, outside of high-income countries like the USA, these drugs often do not reach high incidence regions in the developing world where they are most needed.

Care and Treatment

Early medical treatment and a healthy lifestyle can help an individual with HIV stay well, delay the onset of AIDS, and prevent life-threatening conditions. In 1987, AZT became the first approved treatment for HIV disease. Approximately 30 antiretroviral (ARV) drugs are now approved and available in the USA, with more in development. ARV drugs combat HIV disease by interrupting one of the stages of the HIV replication cycle within CD4+ T cells. There are currently five classes of ARV drugs, each of which attacks a different point in the life cycle of the virus. The standard treatment regimen comprises three different ARV drugs from two different classes in order to control the amount of virus in the body, protect the immune system, and prevent resistance. Resistance, which occurs when the virus mutates to a form that doesn't respond to an HIV medication, is less likely to occur with a three-drug combination. Recommendations for treatment continue to evolve rapidly as new medications are developed and additional data from clinical trials is presented. The most current treatment guidelines are available on the US Department of Health and Human Services' HIV/AIDS Information website.

Access to HIV Prevention, Care, and Treatment

Increasing costs of medications and related care, the eroding safety nets of the Medicaid and Ryan White federally funded programs along with reductions in general fund support from state and local governments in the context of a worldwide economic recession, and uncertainties and confusion concerning the roll-out of the Medicare drug benefit and Health Care Reform will continue to challenge many Americans living with HIV/AIDS in future years. Even so, ARV therapies are readily accessible in the USA and other developed, high-income countries (Canada, Western and Central Europe, and Australia), but remain largely unavailable to many infected individuals in the developing world.

Access to HIV prevention, care, and treatment can be particularly challenging for immigrant populations, even within high-income countries. These include asylum seekers, refugees, and undocumented migrants from Latin America, the Caribbean, sub-Saharan Africa, Eastern Europe, and Eastern and Southeastern Asia. Language barriers, marginalization, social exclusion, legal obstacles, cultural attitudes, religion, fear of discrimination, and low HIV knowledge all facilitate vulnerability to acquiring HIV infection and pose barriers to accessing care. Additional obstacles are policies, laws, lack of legal/residence status, limited or no health insurance, inadequate or lack of sustained funding, and fragmented service delivery. Provision of HIV services to immigrants is further challenged by inconsistencies between health and immigration policies regarding rights to health care. Within migrant communities themselves, access is often limited by insular culture, religion, social circumstances, fear of discrimination, and limited knowledge of available services. Within the wider society, stigma and discrimination, fueled by negative social attitudes toward migrants, sometimes exacerbated by unsympathetic media reporting, pose additional barriers. Policies that disperse immigrants within some countries may also limit access to HIV prevention and care. To address these barriers, culturally sensitive and appropriate information and interventions in relevant languages, suitably trained professionals, health and community workers, and services tailored to the specific needs of migrants are required, along with increased efforts to inform migrant communities about available services. On a larger societal scale, joint efforts are required between policymakers, health and social care professionals and civil society, with more migrant community involvement in policy processes. Clear policy and legal frameworks are needed to protect the rights of migrants, in particular undocumented and uninsured migrants, to HIV prevention, care, and treatment.

Another area of particular concern relates to HIV-positive migrants taken into custody and detained pending outcome of an immigration or deportation case. Although international law broadly protects the right to medical care for detainees, including immigration detainees, at least equivalent to that available to the general population, adequate systems are not in place in many countries to ensure HIV/AIDS treatment for detainees pending deportation. In 2007, Human Rights Watch documented substandard policies, procedures, and supervision governing HIV/AIDS care for migrants detained in US custody, leading to treatment that was delayed, interrupted, and inconsistent to an extent that endangered the health and lives of the detainees. Additionally, policies to ensure post-deportation continuity of treatment mechanisms are frequently nonexistent or extremely inadequate to protect the health of deportees, and may lead to illness, premature death, or the development of drug resistance.

HIV Immigration Bans

Since the emergence of the HIV epidemic in the 1980s, immigrants were recognized throughout the world as vulnerable for risk and spread of HIV/AIDS. Some countries sought coercive measures to prevent people living with HIV from entering or residing in their countries, whether for business, family visits, tourism, study, labor migration, or political asylum. In 1988, WHO argued that HIV-motivated travel restrictions and immigration policies were irrational and without public health justification. In 2004, UNAIDS and the International Organization for Migration officially condemned HIV immigration bans, invalidating the myths that the bans protect public health or that non-citizens with HIV place undue economic burdens on countries. In 2008, around 74 countries, including the USA at that time, were still imposing HIV-specific restrictions on entry and residence of HIV-positive people; of these, 29 countries deported people upon discovery of their HIV status.

After 22 years, on November 2, 2009, the Department of Health and Human Services (HHS) finally removed HIV from the list of "communicable diseases of public health significance" that keep non-citizens from entering the USA. The story of the US HIV travel ban illustrates how disease, domestic politics, and perceptions of sexuality and morality, rather than scientific research and public health, dictated foreign policy. In 1987, the US Public Health Service (PHS) under President Ronald Reagan officially added AIDS to the list of dangerous contagious diseases that barred aliens from entering the USA, even while noting that AIDS could not be spread casually and was not a contagious disease. Politics further trumped science when US Senator Jesse Helms proposed the "Helms amendment" to an appropriations bill that added HIV infection, whether or not there were manifestations of AIDS, to the list of excludable diseases maintained by PHS; this was approved with only a cursory discussion and became effective in December 1987. In 1990 and 1992, controversies erupted over the ban related to International AIDS Conferences held in the USA, with over 70 nations boycotting the 1990 San Francisco conference and the ultimate last-minute relocation of the 1992 conference from Boston to Amsterdam. In January 1991, the CDC called for the removal of HIV and all medical conditions other than active tuberculosis from the exclusions list. In response, a mass mailing campaign in opposition was orchestrated and US Representative William Dannemeyer and 66 fellow Republicans signed a public letter in opposition. Ultimately, the Public Health Service argued only Congress could invalidate the HIV exclusion it had adopted. The exclusion was codified in March 1993, by legislation signed by President Bill Clinton, violating a campaign promise. For the next 15 years, the USA had one of the most restrictive policies on immigration and travel of HIV-positive people in the world, compelling all non-citizens to attest they were HIV-negative before being admitted to the USA. At the same time, non-citizens living long-term in the USA were denied permanent resident categorization solely on basis of their HIV-positive status. In July 2008, Congress finally repealed the statutory HIV immigration and travel ban, and restored authority of the Secretary of Health and Human Services to remove HIV from the list of communicable diseases whose carriers are denied entry to the USA.

Related Topics

- ► Acquired immune deficiency syndrome
- ► Addiction and substance abuse
- ► AIDS knowledge
- ► Injection drug use
- ► Sexually transmitted diseases

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Human Rights

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Human rights represent a set of universal rights to which every individual is entitled. These are absolute fundamental and inalienable rights representing the basis of individuals’ treatment by States and non-State actors.

From an historical point of view, human rights are based on three main sources:

1. Nature (natural rights). Every human being belongs to one single family that determines the essence of humanity to respect each member.
2. Divine origin (religion). This refers to the Father of every human being who imposes his indefeasible law.
3. Reason (universality). This refers to the denominator of the human being.

But there is an important distinction between natural rights and positive rights. Natural rights are those that derive from natural or divine origin; they are absolute, inalienable, and immutable. Positive rights are those rights that are recognized in a political/law context and are contained in a normative document such as a law, a treaty, a declaration, etc.

Short History

The idea that rights exist that inure only to human beings has been described in ancient cultures. In the fifth century B.C., Sophocles had illustrated in the tragedy of *Antigone* how a natural moral non-written law had been opposed to a political-based decision. Aristotle wrote about citizens’ rights to hold property and to participate in public affairs. Several philosophers, such as Aristotle, Plato, Socrates, Cicero, St. Thomas of Aquinas, Hugo Grotius, John Locke, and Immanuel Kant wrote about the existence of natural rights or divine rights. Even in medieval history there were documents that embodied and events that reflected concerns for human liberty. Examples include: the Magna Charta, issued in England in 1215; the 1776 revolution in the United States of America; and the 1789 French revolution. These latter two events led to important documents on human rights: The United States Declaration of Independence and the French Declaration of the Rights of Man and of the Citizen.

In 1948, following the Second World War and in response to the atrocities and to the absolute negation of human rights that had occurred, the General Assembly of the United Nations proclaimed The Universal Declaration of Human Rights. Through its adoption by representatives from almost every State, this document became an important instrument that guarantees human rights. Its purpose was to promote human, civil, economic, and social rights as a basis of "freedom, justice, and peace in the world." The document recognizes that "the inherent dignity and the equal and inalienable rights of all members of the human family is the foundation of freedom, justice, and peace in the world."

After The Universal Declaration of Human Rights, there have been several other important documents on human rights. These include the Convention on the Elimination of All Forms of Racial Discrimination adopted in 1966; the document entitled Human Rights and Scientific and Technological Development adopted by the U.N. in 1982; the Convention on the Elimination of All Forms of Discrimination Against Women (1981); the United Nations Convention Against Torture (1984); the Convention on the Rights of the Child (1989); the International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families, adopted in 1990 and entered into force in 2003; the Universal Declaration on Bioethics and Human Rights, UNESCO, 2005; the Universal Declaration on Human Genome and Human Rights – UNESCO; and the Convention for the Protection of Human Rights and Dignity of the Human Being with Regard to the Application of Biology and Medicine of the Council of Europe, 1997.

The Content of Human Rights

The Universal Declaration of Human Rights contains a series of Articles that set forth the various rights. These can be categorized into (1) liberty rights: every person is born free, has the liberty of movement, of expression, of association, of belief; (2) security rights, such as protection of the human being against any cruel punishment or treatment and against torture; (3) social rights, such as the right to create a family, the right to work, the right to education, the right of a living standard adequate for health, the right to participate in the cultural life of the community; (4) political rights, which include the right to participate in political life; (5) judicial rights, encompassing the right to be considered a human being before the law, the right to a fair trial, and the right of presumed innocence; and (6) equity and equality rights, such as protection against discrimination.

Although the content of human rights encompasses a large number of rights, it has been criticized for its vague character and for its lack of provisions concerning the actual involvement and responsibility of States for the protection of the rights, such as the right to education, the right to a living standard adequate for health, and the nondiscrimination rights. Instead, these rights may be considered negative rights, meaning that although they exist, their protection needs no State action; consequently, they are well stipulated but there is no State action specified for their protection. At the same time, because of this absence of concrete action provisions, they are considered vague. And last, but not least, it has been argued that these rights must be prioritized, but there is no consensus on which should be considered a priority.

The Impact of Human Rights upon Immigrants

Several recognized rights may impact on immigrants' lives more immediately than others. These include the right to nondiscrimination, the right to free movement across countries, the right to seek political asylum, and the equal right to social life, cultural life, education, health, and fairness.

Although legal immigrants should enjoy the same rights as native-born citizens, some authors argue that immigrants represent a population that is rejected by both their native country and the country of immigration. For example, although the right of free political expression is a fundamental human right that encompasses the right to vote, during recent history of the 1980s, not all of the European states respected this right. Sweden recognized and respected this right for immigrants, but France and several other European countries did not adequately recognize it for immigrants.

In order to ensure that human rights are respected for all populations, especially those considered to be at a higher risk for discrimination, many countries have created agencies and commissions to address the problems of discrimination against foreign immigrants. Such examples may be seen in Australia. There, the Australian Ethnic Affairs Council functions as an advisory organism for The Minister for Immigration and Ethnic Affairs in issues regarding immigrants' integration in the community. The Multi-Cultural Resource Centre opened by the Australian Government deals with immigrants' needs and provides information related to the availability of benefits at the national and local levels. In Norway, the Norwegian Foreign Workers' Association deals with the protection of immigrants rights. In Belgium, there has been a tradition in this area since 1952.

The Right to Health

The right to health is a fundamental one, having important implications for every person's life. Starting with "the right to life" and continuing with the prohibition against slavery, torture or any cruel, inhuman or degrading punishment and with the right "to a standard of living adequate for the health and well-being," it can be seen that each of these provisions has a health impact. The Universal Declaration of Human Rights does not articulate a specific "right to health" or contain provisions that require States to protect this important right. Article 25 refers to "a standard of living adequate for the health and well-being" that includes "food, clothing, housing and medical care and necessary social services" and also "the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control." The status of this right seems ambiguous; in fact, literally "the right to health" does not exist and any legal forum cannot give "health" to a person. To better understand the meaning of "the right to health," one must place it in the 1948 context. When originally declared, this right referred to the definition of health given by the World Health Organization in the introduction of its constitution on 22 July 1948: "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition."

This perspective has been further articulated in several other documents, such as those promulgated by the International Labor Organization, the U.N. Commission on Human Rights, and UNESCO. The UNESCO Universal Declaration on Bioethics and Human Rights embraces the notion of social responsibility as a factor in the actual involvement of States in promoting and protecting the right to health. The document states in Article 14, paragraph 1, "The promotion of health and social development for their people is a central purpose of governments that all sectors of society share." In addition, it articulates the importance of access to quality health care, because "health is essential to life itself and must be considered to be a social and human good." Like other documents, it underscores the importance of various factors that are determinants of health, such as adequate nutrition and water, living conditions, poverty, and illiteracy. It starts from the premise that these lifelong determinants influence health in a stronger manner than the biological and physical factors. This hypothesis is sustained also by the World Health Organization Commission on Social Determinants of Health that estimated the influence of biological factors on health as 15% and of physical factors at 10%.

All of these social determinants of health must be discussed in relation to the economic status of a person, because a low income often means a lowered quality of living conditions and reduced access to adequate medical care. Although discrimination is said to be prohibited and although every human being should enjoy human rights and, accordingly, should have the right "to a standard of living adequate for the health and well-being," inequities in this area are growing often due to poverty and a lack of access to adequate health care services. It is true that most of the documents on human rights articulate the special protection needed for certain categories of persons, e.g., "the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control," but the reality is that more than one billion people live in extreme poverty, without access to minimum standard of living conditions.

From this perspective, several categories of persons distinguish themselves as vulnerable; in this domain immigrants have a special place. Immigrants, like others, have the right to health, to education, to work, and to not be subject to discrimination. However, immigrants may represent a cheap working force because they often receive less for the same job as a native-born citizen. The Soros Foundation's 2008 study *Immigrant in Romania: Perspectives and Risks* underscores the fact that foreign immigrants in Romania are an easy target for some employers, who are willing to make a good profit with a cheap work force. Factors contributing to this situation include immigrants' cultural and language differences, a lack of labor union representation, and a lack of information regarding immigrants' rights. Immigrants' low income influences their living conditions, and their access to health care (insured/uninsured status). Immigrants' access to adequate medical care may be affected not only by their economic status, but also by language differences, their legal/illegal status, and cultural differences. According to Article 2 of the Human Rights' Universal Declaration, discrimination on the basis of race, color, sex, language, religion, political or other opinion, national or social origin, property, birth or other status is prohibited, but discrimination occurs, nevertheless.

Another important aspect that interferes with immigrants' right to health is the political aspect. The report by the Office of The United Nations High Commissioner for Human Rights in collaboration with World Health Organization, on the right to health underscored the fact that States are unwilling or unable to provide the same level of medical care to immigrants as to their native-born citizens. Most of the States decided that their obligations toward foreign-born citizens in terms of medical care are limited to "essential care," or "emergency health care" domains that may vary from state to state, creating disparities and inequities in medical practices. It is that ambiguous paradox of the "right to health" taken literally as such and undermining its fundamental, inalienable, and absolute character.

The same report draws attention to identified difficulties of immigrants, especially those of the illegal immigrants with respect to their right to health. Their access to health care is limited by two important factors: they are generally inadequately covered by the State health care system and they usually cannot afford insurance. Their illegal status limits their ability to access medical care due to fear of being reported to authorities, they have less access to medical information than do native-born citizens, and their working conditions might be unsafe or unhealthy. Female working immigrants, as well as trafficked persons, may be exposed to sexual abuse and violence, and shelters for undocumented immigrants may have unhealthy conditions that could facilitate disease transmission.

The general recommendation 14/2000 of The Committee on Economic, Social and Cultural Rights, followed by the general recommendation 30/2004 (on non-citizens on the right to the highest attainable standard of health) of The Committee on the Elimination of Racial Discrimination, stipulate the involvement of States in respecting the right of non-citizens to an adequate standard of physical and mental health care. This also means that the State involvement should not be reduced only to "essential care" or "emergency care," but should be extended to provide immigrants with access to preventive, curative, and palliative health services. Additionally, the report stresses that sick asylum seekers or undocumented persons, as some of the most vulnerable persons within a population, should not be denied their human right to medical care.

Another important document regarding immigrants' right to health is The International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families. Article 25 of this document stresses that immigrants should have equal treatment with natural-born citizens, including safety and healthy working conditions. Also, Article 28 of the same document stipulates, "Migrant workers and members of their families shall have the right to receive any medical care that is urgently required for the preservation of their life or the avoidance of irreparable harm to their health on the basis of equality of treatment with nationals of the State concerned. Such emergency medical care shall not be refused them by reason of any irregularity with regard to stay or employment."

Though the framework of the right to health is encouraging for the protection of this right, many States' national provisions interpret and implement differently the terms "emergency medical care" or "essential medical care." These terms are usually defined in a number of ways that create the bases for disparities and inequities.

The goals of the 2005 United Nations' Millennium Project include the eradication of extreme poverty and hunger, the achievement of universal primary education, the promotion of gender equality and empowerment of women, the reduction of child mortality, the combating of HIV and AIDS, malaria and other diseases, the sustainability of the environment, and the establishment of a global partnership for development. Although these seem very promising, there still remains the need for significant action in order to ensure that every human benefits.

Conclusions

Human rights represent a set of norms that every person could claim by virtue of one's status as a human being. These rights are fundamental, absolute, and inalienable. Though they are well articulated and every person should enjoy them, regardless of race, sex, religion, or other factors, some of them may lack application because the documents have only proclaimed them, without requiring that States incorporate them as part of their protection for all citizens. This is why since their first proclamation many other regulations and treaties and conventions at the international level have appeared, in order to articulate more the need for their protection. Though major progress has been made, sustained efforts are needed to assure the protection of human rights for all human beings, especially for vulnerable populations such as immigrants.

Related Topics

- ► Asylum
- ► Convention Against Torture
- ► Ethnic cleansing
- ► European Court of Human Rights
- ► Gender-based violence
- ► Guest worker
- ► Holocaust
- ► Honor killing
- ► Racism
- ► Torture
- ► Trafficking

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Hwa-Byung

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Hwa-Byung translates into English as anger or fire disease. Often termed a Korean folk illness, it is characterized by physical and psychological symptoms that arise as the result of chronically suppressed anger. Reported most frequently by women, *hwa-byung* is believed to develop through an interaction of culturally supported emotional repression, avoidance of conflict and external expressions of anger, and the experience of chronic hardships and oppression.

Traditionally, Korean culture discourages outward displays of conflict and emotion, particularly those labeled as negative, with a cultural emphasis placed on personal temperance and the maintenance of harmonious interpersonal relationships. Consequently, negative emotions, such as anger, disappointment, and sorrow, are internalized. *Hwa-byung* may develop due to the accumulation of internalized emotions and their interaction with the hardships many Korean women report, such as stressful familial and marital relationships, domestic abuse, discrimination, inequity, and abject poverty/deprivation. Accordingly, *hwa-byung* has been suggested by some to be a culturally sanctioned idiom of distress through which Korean women are able to express their suffering. The prevalence of *hwa-byung* has been found to be highest in middle-aged women who have emigrated from Korea. It is believed that the psychological stress and difficulties that often accompany the immigration process are correlated to this increase in cases.

There are multiple symptoms associated with *hwa-byung*. As this is a complex and varied illness, persons with *hwa-byung* present with individually unique clusters of symptomotology and may report experience through a combination of biomedical and lay/cultural terminology. Classic somatic symptoms of *hwa-byung* include the sensation of a traveling epigastric mass that may interfere with respiration and/or digestion; disturbances in the body's ability to regulate temperature, often experienced as an accumulation of heat felt in the neck, face, or head, and/or intolerance to environmental temperature changes; gastrointestinal symptoms including anorexia, stomach upset, constipation, and/or diarrhea; cardiac complaints such as heart palpitations, irregular heartbeat, and/or heart-pounding; and reports of diffuse, chronic muscle pain. Psychological symptoms of *hwa-byung* include anger, insomnia, anxiety, panic, and depression. Individuals experiencing symptoms of *hwa-byung* may seek treatment from a variety of providers including traditional healers, physicians, mental health professionals, and religious leaders.

Hwa-byung is classified as a culture-bound syndrome in the fourth edition, text revision of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (*DSM IV-TR*), and it is referenced, but not independently listed, in the ICD-10 *Classification of Mental and Behavioral Disorders.*

Related Topics

- ► Cultural background
- ► Culture-specific diagnoses

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Hypertension

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Hypertension or high blood pressure is a multifactorial disease. The implications of this disease in cardiovascular diseases is significant (i.e., coronary heart disease, congestive heart failure, ischemic and hemorrhagic stroke, renal failure, peripheral arterial disease, and even cerebral palsy).

Definition

Hypertension is a chronic medical condition in which registered values of blood pressure above 140/90 mmHg is considered to be hypertension.

(The normal value of blood pressure for an adult is considered to be around 120/80 mmHg; the upper number is called systolic and the lower number is called diastolic.) When the cause of hypertension is not medically known, it is called essential. When hypertension is medically proved to be caused by another condition, it is called secondary (i.e., kidney disease, pheochromocytoma, and others).

Epidemiology

This disease is wide spread in all populations except for some isolated populations living in primitive conditions, unexposed to factors such as industrialization, processed food, and others. This condition affects mostly adults, but it can be present in children also. The criteria for diagnosis of hypertension in children is based upon their age, with systolic and diastolic numbers approaching adult measurements when children are near adulthood.

Considered to be an age-related disease, high blood pressure is often associated with growth and maturation; it is usually diagnosed in the second decade of life. Both men and women seem to develop this condition, with preponderance toward men.

Signs and Symptoms

In mild or moderate forms, symptoms of hypertension are difficult to recognize or may be completely illusive. In more serious forms, high blood pressure values are associated with headache, somnolence, confusion, visual disturbances, and nausea and vomiting; in infants and neonates, failure to thrive, seizure, irritability or lethargy, and respiratory distress; in children, hypertension may cause headache, fatigue, blurred vision, epistaxis, and Bell's palsy.

Various individual features and factors have been associated with hypertension. Among risk factors: sedentary lifestyle, obesity (in individuals with a body mass index greater than 25), salt (sodium) sensitivity, alcohol intake, low calcium intake, and vitamin D deficiency. It is also related to aging and to some inherited genetic mutations. Family history of hypertension increases individual risk of developing the disease. Kidney diseases can cause disruption of renin and aldosterone equilibrium, and can predict the development of hypertension in the future. Sympathetic nerve overactivity, insulin resistance, and metabolic X syndrome (a condition which associates obesity, diabetes, dislipidemia, and arterial hypertension present in the same individual) are often associated with hypertension, and it is thought that high blood pressure levels are caused by these conditions. The external factors thought to cause this hypertension are smoking and an unhealthy diet (i.e., a diet with a high content in salt and/or saturated fats).

Secondary hypertension can also mean a disease associated with renal disease, Cushing syndrome (a condition associated with high blood levels of cholesterol), pheochromocytoma (condition in which a tumor releases increased quantities of epinephrine and norepinephrine), and coarctation of the aorta. Some drug treatments are known to induce hypertension (e.g., oral contraceptives, non-steroidal anti-inflammatory drugs such as ibuprofen), and steroids (e.g., prednisone). Some of the antihypertension drugs (beta-blockers and clonidine) are associated with rebound hypertension when they are withdrawn.

The Framingham Study launched by NIH in 1948 found that cardiovascular conditions correlate with high blood pressure, high cholesterol, smoking, diabetes, and obesity. Race and ethnicity seem to also be involved in the development of hypertension. High blood pressure is particularly more common among African American population than non-Hispanic Whites. The number of strokes and heart attacks are increased in the African American population.

Other risk factors for high blood pressure are within a person's control. For instance, lifestyle changes (i.e., an individual can improve his health by reducing the salt and/or fat intake, renouncing to smoke and sedentary habits, managing stress, reducing alcohol consumption, losing weight) may reduce blood pressure levels with 5–10 mmHg. Social stress is another factor that seems to be associated with an increased blood pressure. Since social stress represents a risk factor for developing high blood pressure, it is not uncommon for doctors to find elevated levels of blood pressure in the immigrant population.

Psychosocial stress in this category of the population takes various forms. Family separation, acculturation issues, and lack of health care or lack of access to funds for health care are only some of the psychosocial stress factors. Studies have documented that race and income levels along with limited access to health care system for this category of individuals strongly impacts on their health status. Illegal immigration is often associated with the lack of health insurance and the knowledge of immigrants about their health rights.

According to a study developed by Yechiam Ostchega and others, it was discovered that not only does age strongly correlate with hypertension, but also hypertension has a higher prevalence in the non-Hispanic Black population than the non-Hispanic White and Mexican-American populations. The prevalence was also significantly higher for the non-Hispanic White population compared with the Mexican-American population.

The risk factors mentioned above are not the only ones responsible for high values of blood pressure. Hypertension is frequently found in adult Black populations living in developed countries, and especially located in dry, hot climates and urban areas. Physiologically, this is thought to be due to a certain particularity of this population in transporting sodium from diet through the body.

Similar to social stress, some individuals' physical medical exams mislead doctors in their diagnosis if the patient registers increased blood pressure when periodic assessments are made. "White coat hypertension" represents no real threat to patient's health and does not require treatment.

In conclusion, hypertension is a multifactorial preventable and treatable disease which poses many difficulties in terms of health care due to its cardiovascular complications. Some categories are disadvantaged due to lack of full access to health care services. Between these categories, we can unmistakably name immigrants.

Related Topics

► Cardiovascular disease
► Cardiovascular risk factors

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Hypothermia

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Hypothermia refers to the clinical condition in which the central body temperature drops below 35°C (95°F). The condition may occur in cold climates, during winter in temperate climates, and also in warm climates, especially in elderly or in young children.

Depending on the central body temperature, hypothermia can be mild (35–32°C, or 90–95°F), moderate (32–28°C, or 82–90°F) or severe (below 28°C, or below 82°F). Mild hypothermia is accompanied by shivering, which generates heat, one of the most important protection mechanisms against the decrease of central body temperature; mental confusion; slurred speech; shortness of breath; and increased heart rate. As the central temperature decreases, the individual's ability to combat hypothermia is diminished and the condition may progress to moderate hypothermia. In moderate hypothermia, shaking gradually disappears, breathing decreases, and the victim appears drowsy. Finally, in severe hypothermia the victim shows a marked decrease in brain activity, heart rate and breathing, and ultimately dies due to heart failure.

There are a number of risk factors for hypothermia. Older people can become hypothermic because of their poor economic conditions or mental deterioration, which expose them to inadequate conditions of shelter, heating, clothing, and food. Children are at increased susceptibility due to their big weight/body–surface ratio, which accelerates heat loss. Acute alcohol intoxication, which causes vasodilatation and increases cutaneous heat loss, phenothiazine intoxication, and various underlying conditions and diseases such as malnutrition, diabetes mellitus, and myxedema may also increase risk.

Significant human costs may arise as in conjunction with individuals' attempts to illegally cross international borders. Immigrants are exposed to numerous hazards, including those due to environmental factors such as extreme temperatures. As an example, the transport of

African immigrants from Sub-Saharan Africa (particularly from Senegal, Mali, and Ivory Coast) to Tenerife and Canary islands of Spain, in "Cayucos" (large vessels, of about 30 m length and 3.5 m width, which can fit up to 180 people) requires 7–10 days. During this time, migrants may have to endure extreme cold, extreme heat, dehydration, immobility, and overcrowding. A study conducted during 2005–2006 showed that 649 out of 17,164 illegal immigrants who arrived on the coast of Tenerife Island in 229 "Cayucos" needed emergency medical care (477 on site and 202 at the hospital). Most of those who received medical care were suffering from hypothermia, hypoglycemia, and dehydration. The relatively small number of people who needed medical care was largely due to the fact that they were young and theoretically healthy. To respond adequately to this genuine crisis of "Cayucos" in the Spanish Canary and Tenerife Islands, ERIE services (Immediate Emergency Response Team consisting of: a coordinator, a physician, a nurse, a social-cultural mediator and many volunteers) were created, in order to provide emergency medical care to illegal immigrants at their arrival.

Beginning in 1993, the US government has stepped up measures to prevent and combat illegal immigration from Mexico through the southwestern border, especially in urban areas. In response to increased security measures in urban areas, illegal immigrants are trying to cross the border in rural and remote areas, which are less guarded. The consequence is a marked decrease in illegal border crossing in urban areas but not in illegal border crossing in general. This option, however, involves an arduous journey through the desert and mountains, where the migrants are usually guided by paid smugglers (*coyotes*). During these exhausting trips, immigrants are exposed to a significant risk of death by hypothermia in the mountains or desert, extreme heat and dehydration in the desert, or drowning when crossing the Rio Grande or Rio Bravo. It has been estimated that during the period from 1993 to 1997, nearly 1,600 migrants died, 14% of them due to environmental factors, including extreme cold or heat. Eighty-five percent of the victims were men and the vast majority (62%) was between 20 and 30 years of age.

Sometimes the immigrants are abandoned by the smugglers, and consequently face greater risks. For instance, in May 2001, 14 migrants died in the Mexican desert near Yuma, Arizona, having been abandoned by their guide. However, the increased risk of death does not significantly influence the number of illegal immigrants trying to cross the border between Mexico and the US. Estimates suggest that the number of migrants being smuggled from Mexico into the US increased from 70,000 in 1992 to 237,000 in 2000.

The fate of immigrants trying to cross the border illegally drew attention from human rights activists worldwide. They argue that the manner in which these immigrants are treated is a violation of human rights. Human rights activists have shown that increased border security will not deter illegal immigration but will expose the immigrants to greater risks.

Related Topics

- ► Border
- ► Border health
- ► Emergency services
- ► Environmental exposure
- ► Human rights
- ► Illegal immigration
- ► Refugee
- ► Trafficking
- ► Universal Declaration of Human Rights

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I

Identity

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Identity formation is the process of distinct personality development. The concept of identity encompasses personal, social, cultural, political, and ethnic identities. It also refers to sexual orientation and gender identity.

On a personal level, identity has been conceptualized as a prominent aspect of self, functioning to give meaning to people and their self-images. When referring to social identity, this is often conceptualized as social roles, helping to explain how social position influences one's sense of self; it is gained from memberships in various social groups, including gender, age, profession, vocation, race, and religion. Cultural identity is a person's self-affiliation (or categorization by others) as a member of a cultural group, while national identity relates to belief in membership of a nation. Features of national identity include common myths, culture, and a homeland. Ethnic identity is one's identity or sense of self as a member of an ethnic group as well as one's thinking, perceptions, and feelings that are part of being a member of that group.

From a sociological standpoint, identity has four constructions: personal, relational, enacted, and communal identities. *Personal identity* is an individual's self-concept or self-image. It exists at the individual level of analysis, as a characteristic of individuals. *Enacted identity* is an individual's performed or expressed identity. People enact their identities and exchange the enacted identities in communication. *Relational identity* has four levels. First, an individual develops and shapes his/her identity partially by internalizing how others view him/her. Second, an individual identifies himself/herself through his/her relationships with others, such as someone's spouse and someone's friend. This is another kind of relational identity. Third, identities exist in relationship to other identities. Since people have multiple identities, they exist in relation to each other. As an example, an individual may simultaneously hold identities as a parent, a lover, an adult child, and an attorney. Fourth, a relationship itself can be a unit of identity. A couple, for instance, can establish a relational identity. The communal layer is a characteristic of the group or collectivity. This concept is similar to "collective memory" and ethno-linguistic identity. Although these four frames of identity may be considered independently for analytic purposes, they are not really separate from each other.

Identity has been also described as a key explanatory factor for poorer health. Identity is a multidimensional construct, consisting of three fundamental dimensions. Centrality refers to the extent to which one's ethnic identity is a core part of his or her self-concept. Private regard is one's affective evaluation of his or her ethnic group, while public regard refers to one's perception of how others view one's ethnic group. Individuals with positive identities (higher scores on centrality and private regard) are more likely to engage in health behaviors than are individuals with negative identities.

Two potential variables affect the relationship between identity and health: the individual's coping style and his or her identity expression. Having fewer opportunities to express one's ethnic identity than one would ideally like (expression discrepancy) is likely to lead to feelings of frustration and stress. The acceptance of one's ethnic group leads to positive self-esteem because it anchors one's relatedness to others.

When individuals migrate from one country to another, it is likely that their cultural and ethnic identity will change. When cultural groups come into contact, there is a transfer of schemes and values in both

Sana Loue & Martha Sajatovic (eds.), *Encyclopedia of Immigrant Health*, DOI 10.1007/978-1-4419-5659-0,

directions. This conception of *reciprocal* influences on cultural identities, leading to some degree of *bicultural* identity, is quite recent and it differs from an older position that viewed cultural adaptation as a unidirectional, acculturative process whereby immigrants would adapt their behavior and attitudes toward those of the host society. This unidirectional view derived from the erroneous belief that cultural changes resulted from the modification of a "primitive" culture through contact with a more advanced culture. With the process of globalization, it can be expected that most people around the world will develop a different form of bicultural identity, combining their local identity with an identity linked to the global culture.

These cultural and ethnic identity variations related to migration, either forced or voluntary, may impact upon individuals' mental health and both psychiatric and general medical services utilization. Cultural differences in definitions of normality and abnormality, as well as differences in explanations and presentation of mental illness, exemplify these variations.

A strong sense of ethnic identity may protect against mental health problems. Vulnerability to depression may increase for groups that face social barriers related to language and may be exacerbated by life-changing events such as immigration, which can threaten one's sense of self and mental health status. Previous research suggests that identity issues have significant implications for depression. Depression can be caused by expressing a socially desirable self while silencing an authentic self or when behaviors or ideas, including self-concept, are not reinforced by others.

Korean immigrants, who represent a recent and one of the fastest-growing minority groups in the USA, face various challenges dealing with cultural differences and outgroup immigrant status. Asian Americans, in general, tend to maintain their cultural values longer than other ethnic immigrant groups. Korean immigrants are reported to have relatively higher levels of depression compared to other ethnic groups. For instance, they reported almost twice as many depressive symptoms than did Filipino Americans, Japanese Americans, and Chinese Americans. Depression in Korean Americans may relate to several sociodemographic stress factors, including high unemployment rates, limited English-speaking abilities, and the tendency of Korean Americans to work in low-prestige jobs in comparison with other Asian groups, perhaps due to their limited English skills. Increased depression in men has been found to be significantly associated with decreased family satisfaction, lower job satisfaction, lower individual earnings, and more hours at work. Depression in women has been linked to decreased family satisfaction, less church affiliation, lower job satisfaction, and higher individual earnings. As a result, many Korean immigrants find their identities challenged in their everyday interaction with members of other ethnic groups. Without the requisite coping skills, these identity issues can be particularly problematic among members of this demographic group.

A higher level of acculturation has been associated with less acculturative stress, which, in turn, is associated with lower rates of depression. It has been found that language use and interpersonal associations are mediating influences of stress. For the dimension of acculturation that involved cultural identity and adherence to homeland traditions and values, greater assimilation to US culture resulted in higher depression scores. Maintaining traditional Korean practices and values in the US cultural context carries mental health risks. One way of understanding the mediation process in these data is to consider language-based acculturation as preceding identity-based acculturation. Studies have shown that after an average of 5–6 years in the USA, Asian immigrants showed only a moderate level of acculturation to the host culture, in that their language use, interpersonal relationships, subjective identity, and cultural practices were more likely to reflect their Korean heritage than the US culture.

Immigration is a stressful process for uprooted people adjusting to a new society in Europe as well. Research findings relating to Irish immigrants indicate that at every social level, the health and well-being of both first- and second-generation Irish immigrants are seriously compromised in comparison with both native English and non-emigrating Irish people. A number of specific explanations have been proposed: less healthy people choose to emigrate in the first instance; that first generation Irish engage more in health-compromising behavior such as heavy smoking and drinking than native equivalents; that Irish immigrants hold more fatalistic attitudes toward health and are inclined to attribute health status to external factors and, as a consequence, they are reluctant to acknowledge a developing illness and less inclined to take early counteractive measures. However, one of the most frequent explanations for the decreased well-being among Irish immigrants concerns problems in forming and maintaining a positive ethnic identity. The importance of identity is reinforced by the fact that many Irish immigrants possess inferiority feelings compared with host nationals, due in part to their history of having been colonized until relatively recently.

It has been found that the ethnic identity of immigrants' children forms at an early age, prior to adolescence. Thus, second-generation children of different ethnic groups who are living in the USA showed a high degree of awareness of their ethnic heritage and identified with being both part of their parents' culture of origin and as being American. In a study of children of first generation immigrants from three ethnic groups, all three groups reported similar levels of ethnic identity "centrality," and all reported positive feelings of pride regarding being a member of their ethnic group. Overall, older children demonstrated a greater amount of ethnic identification and exploration, and higher degree of ethnic pride. For all children, older age was associated with greater preferences to play with children of other ethnic groups. "Ingroup" social preference was positively correlated with "outgroup" social preference, demonstrating the positive connection between these two social processes during middle childhood. Thus, having a strong ethnic identity is not associated with prejudices against other groups, as some past scholars have feared.

In conclusion, a positive relationship has been demonstrated between identity and tradition-based acculturation and depression, indicating that the abandonment of the immigrants' identity and traditions may result in increased depression. Language-associated acculturation may increase depression by encouraging the abandonment of homeland identity and traditions.

Related Topics

- ► Acculturation
- ► Acculturative stress
- ► Assimilation
- ► Depression
- ► Discrimination
- ► Ethnicity
- ► Language acculturation
- ► Mental health
- ► Race
- ► Self-concept

Suggested Readings

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IDU

► Injection drug use

IHR

► International Health Regulations

Illegal Immigration

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"Illegal immigrant," "undocumented migrant," or "illegal aliens" are some of the terms used to describe the immigration status of the people who do not have the required documentation that proves they are legally entitled to work, visit, or live in a certain country. "Illegal immigrants" are those who either do not have the proper visas to be in a country legally or have entered in the country legally but did not return to their native countries when their visas expired. For example, former students who do not leave a foreign country when their student visa expires fall into the latter category. Another category of illegal immigrants are those who have violated the terms of entry in a country, for example, by working without authorization, failing to attend school if admitted for that purpose, or by engaging in illegal activities. Rejected asylum seekers may also be thought of as "illegal immigrants."

Therefore, the spectrum of illegal immigration is very wide. Each State has the power to decide where illegal migration begins and ends. The restrictions imposed on entering and leaving a country, as well as the legal conditions governing access to the labor market, coexist in each country, with a lower or higher degree of tolerance on illegal immigration.

Illegal immigration often triggers the fears of governments and citizens of the target countries, as it is sometimes seen as a threat to public order and a burden to education, health care, and welfare systems. Yet, numerous studies show that the most developed nations, where the majority of illegal immigrants are looking for a better life, depend on and even thrive because of the contributions of illegal workers. Agriculture and construction and many services as cleaning and caring for young and elderly persons rely heavily on the cheap and abundant workforce provided by illegal immigrants. However, there are many who argue the opposite: that illegal immigration poses nothing other than trouble to national economies.

The exact dimension of illegal immigration is difficult to establish; according to the International Organization for Migration (IOM) data, there are 20–30 million unauthorized migrants worldwide, comprising around 10–15% of the world's immigrant total number. The majority would leave their homes from "developing" or "Third World" countries to go to developed countries on an "unauthorized," "undocumented," or "illegal" basis. In order to get into such a country, illegal immigrants may use falsified travel documents or permits obtained under false pretences, or use clandestine transportation or other methods to cross the border illegally.

Illegal or unauthorized immigrants are a heterogeneous group. Yet, there is a common factor: wherever they may be, they all have health needs but are excluded, in part or in full, from the systems of health care promotion, protection, and provision that are available for the local citizens. The provision and cost of health care for illegal immigrants is an issue of debate and concern for most of the EU Member States, the USA, and other developed nations. The most common arguments used to justify this exclusion are that national health care systems, whether publicly financed or privately run, are already strained and overburdened, and, because illegal migrants are not part of the social contracts linking States and their constituent citizens, there is no duty toward their health care needs.

Besides that, undocumented migrants, as well as asylum seekers, face practical barriers to access effective health care due to fear, lack of information, poverty, language, cultural constraints, etc. Relatively little is known, though, about the situation of undocumented migrants as the majority of national surveys do not take them into account and there is a lack of global and national statistics about their living conditions, health, and access to care.

Existing research, as fragmented as it is, demonstrates that with some minor exceptions, in most developed countries illegal immigrants are usually not entitled to receive medical care from public services, except in cases of emergencies. In the USA, illegal immigrants are not covered under the new health care plan, and they are not eligible for Medicaid. The situation is slightly different in Europe, where most EU Member States would offer health care services for children and pregnant women. In some countries medical care may be offered to illegal aliens by "alternative health care providers" such as nongovernmental organizations that are supported with public funds. Yet, such organizations, where available, cannot provide a solution to systemic problems.

Related Topics

- ► Immigration status
- ► Undocumented

Suggested Resources

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Illegal Immigration Reform and Immigrant Responsibility Act of 1996 (U.S.)

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The United States has a long history of dealing with immigration issues through legal actions. One of the enumerated powers of the US Congress is to "…establish an uniform rule of naturalization…" (US Constitution Article I, Section 8, Clause 4). The first Congress promulgated the initial statute, "*The Naturalization Act of 1790*, which limited naturalization to free white persons of good moral character." The US Congress has pursued several policies over the following 220 years as it promulgated these "uniform rules of naturalization." The statutes that were followed varied with how persons (aliens) from certain countries and regions were favored or disfavored for eligibility of admission to the United States, and consideration for citizenship.

The 89th US Congress adopted the *Immigration and Nationality Act Amendments of 1965* (Public Law 89–236), codified in Title 8 of the US Code, that defines a lawfully admitted noncitizen or alien as either a permanent immigrant or a temporary nonimmigrant. A lawful permanent resident receives a document (card) noting this status and is eligible to work in the US and may later apply for US citizenship. The nonimmigrant can be in the United States for many different reasons and receives one of several kinds of visas. Nonimmigrants are not eligible for citizenship, but they may later apply for permanent immigrant status. All other aliens in the United States are here illegally.

The 104th US Congress began to attend to the complex matters that were emerging with illegal immigration and other immigrant matters in the *Illegal Immigration Reform and Immigrant Responsibility Act of 1996* (Public Law 104–208). This legislation emerged in response to many concerns about the number of illegal immigrants, their economic contribution or lack thereof to the nation's economy, and a concern about employment of US workers. This legislation has six titles. Title I provides for improvements of border control, facilitation of legal entry, and interior enforcement. Title II provides for enhanced enforcement and penalties against alien smuggling and deterrence of document fraud. Title III revises procedures and grounds for removing inadmissible and deportable aliens. Title IV concerns the enforcement of restrictions against employment. Title V concerns restrictions on benefits for aliens. Title VI includes several miscellaneous provisions of the Act. Highlights of each Title are noted in this suggestive sampling, not a critical analysis, of what is in the law. Examination of the law using standardized browsers offers a comprehensive and detailed review. Also, keep in mind that what the US Congress says it wants done and what it pays to have done may not coincide.

Each Title reveals with greater specificity the authorizations provided in the law. *Title I.* In this Title, the Congress uses its spending power to increase resources at the border by hiring more agents and support persons and direct how they should be deployed. It authorizes the construction of fencing and improvement of roads on the border near San Diego, California. It authorizes the acquisition of equipment that would help with detection and interdiction of illegal immigration into the United States. It asks for improved border crossing identification cards with machine readable biometric identifiers.

Civil penalties are set for illegal entry and criminal penalty for high-speed flights from immigration check points. Funds were to be appropriated to apply to nationwide fingerprinting of apprehended criminal and illegal aliens.

Funds are to be made available to have the personnel needed at border crossings during peak hours to minimize delays. Pre-inspection stations were to be added to those in existence. Additional immigration officers were to be provided to assist foreign air carriers with detecting fraudulent documents.

The Attorney General is authorized to enter into agreements with a State or any political subdivision of a State which the Attorney General determines to be qualified to perform the function of an immigration officer in relation to the investigation, apprehension, or detection of aliens in the USA.

Title II. In this Title, the Congress defines several federal crimes related to alien smuggling and specifies penalties. Wiretapping is authorized, with the expected IV Amendment limitations. An increased number of Assistant United States Attorneys is provided to handle the expected increase *in alien crimes* caseload. Increased criminal penalties are set for fraudulent use of government-issued documents and other prohibited activities under federal law (involuntary servitude, for example).

Title III. In this Title, the revised procedures for removal of an alien are laid out. Aliens who are in the USA without authorization (e.g., a "green card" or visa) are treated as not admitted. The Title lays out provisions dealing with criminal aliens including removal of aliens who have unlawfully voted, incitement of terrorist activity, falsely claiming US citizenship as examples of a longer list with a range of offenses.

Title IV. In Title IV, an employment eligibility information system is established. The statute also considers the treatment of certain documentary practices as unfair immigration-related employment practices.

Title V. In this Title, several restrictions are placed on the eligibility of aliens for public assistance and benefits. An exception is the alien who is a battered wife. Social Security benefits are not available to illegal aliens. This Title describes procedures for requiring proof of citizenship for federal benefits. Using the Attorney General's guidelines, the States can develop programs to determine whether to deny driver's licenses to unlawful aliens.

Title VI. In this Title, several Miscellaneous Provisions are laid out. Asylum granted here does not convey a right to remain permanently and may be terminated by the Attorney General under specified conditions. The section discusses several considerations and definitions on the matter of asylum. There are prohibitions concerning aliens and access to educational institutions. This title criminalizes female genital mutilation. A section of the Title IV authorizes the Attorney General to transfer and convey to the Border Patrol Museum and Memorial Library Foundation, incorporated in the State of Texas, such equipment, artifacts, and memorabilia held by the Immigration and Naturalization Service to further the purposes of the Museum and Foundation.

The events of the 11th September, 2001 led to the enactment of the Homeland Security Act of 2002 (PL-107–296). This Act established the Department of Homeland Security. This Department of a Cabinet level office in the Executive Branch was charged with the mission of securing the United States from the many threats it faces. Among other matters, this Act substantially changed how immigration is handled and by whom. The Immigration and Naturalization Service was abolished, and its functions and others were distributed among three agencies. These include:

1. *Immigration and Customs Enforcement* which enforces the nation's immigration and customs laws (www.ice.gov)
2. *Customs and Border Patrol* has a mission of keeping terrorists and their weapons out of the USA. It also has a responsibility for securing and facilitating trade and travel while enforcing hundreds of US

regulations, including immigration and drug laws (www.cbp.gov)

3. *US Citizenship and Immigration Services* which oversees lawful immigration to the United States (www.uscis.gov/portal/site/uscis)

This legislation defined and specified government responsibilities, enforcement actions, and resources to implement the provisions of the law such as border crossings. Further, it detailed the restrictions of immigrants' benefits and employment, punishments and deportations criteria. In summary, this law increased restrictions on immigrants, enhanced security measures, and reinforced legal measures to control illegal immigration to the United States.

Related Topics

▶ Antiterrorism and Effective Death Penalty Act of 1996 (U.S.)
▶ Bureau of Immigration and Customs Enforcement
▶ Department of Homeland Security
▶ Emigration
▶ Illegal immigration
▶ Immigration Act of 1924 (U.S.)
▶ Immigration Act of 1990 (U.S.)
▶ Immigration and Nationality Act Amendments of 1965 (U.S.)
▶ Immigration and Nationality Act of 1952 (U.S.)
▶ Immigration and Naturalization Service
▶ Immigration processes and health in the U.S.: A brief history
▶ Immigration Reform and Control Act of 1986 (U.S.)
▶ Immigration status
▶ Irregular immigration
▶ National Origins Act of 1924 (U.S.)
▶ Naturalization
▶ Refugee

Suggested Resources

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ILO

▶ International Labour Organization

Immigrant Health Disparities

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Introduction: Health Disparities and Immigrant/Refugee Populations

While the issue of ethnic health disparities in general has been discussed extensively in recent years, less attention has been focused on disparities with respect to immigrant and refugee populations. Yet it is widely acknowledged that the reduction or elimination of ethnic health disparities presents a key and continuing public health challenge. Globally, there is a vast difference in life expectancy and burden of disease between people in wealthier and poorer countries. In the USA, reduction of health disparities was encoded as the second major goal of *Healthy People 2010*, the key national planning document. There were close to 200 million immigrants worldwide in 2006, according to a UN report, where the bulk of immigrants – and refugees – came from countries with relatively high poverty rates or civil/natural crises. In the USA, the population continues to grow increasingly diverse, with much of the growth coming from immigrant populations (primarily Asian and Hispanic). While the interaction between immigration and health disparities is complex, it is clear that progress in this area is an important component of the overall effort to eliminate ethnic health disparities.

The scope of health disparities referred to above includes significant disparities pertaining to immigrant/refugee populations. Such disparities are complex: health status varies by national/ethnic group, and some immigrant groups have better health status than the general population or native-borns when they first arrive, though this often changes over time. Common health issues for immigrants/refugees include: obesity/diabetes, mental health (including depression and, for some refugees, posttraumatic stress), tuberculosis, nutritional deficiencies, intestinal parasites, chronic hepatitis B infection, and lack of immunization, though there are variations in other health and psychosocial issues, as well as cultural beliefs, among different groups. In addition, health status varies within immigrants from the same country depending upon socioeconomic circumstances.

At the same time, in what has been viewed as a "health paradox," immigrant and refugee populations often arrive in a new host country with better health status than the average native-born, yet lose this health status advantage after a number of years. There are many possible reasons – one may be self-selection for healthiness among those who emigrate (explaining better health status at time of immigration), combined with a trajectory in the host country that involves survival challenges as well as multiple barriers to health. At the same time, many immigrant and refugee groups are fleeing traumatic and severe crises, presenting yet another kind of health problem. Understanding such trajectories is a foundation for effectively addressing health problems and disparities that result.

Reasons for Health Disparities

In the USA, there have been a number of efforts to synthesize research related to the causes of health disparities in recent years, as well as an increase in funded programs specifically targeted to reducing such disparities. Some of the factors contributing to health disparities in the USA are: health care bias; racism and discrimination; lower SES as a common factor among ethnic minorities; lack of insurance; differences in knowledge; patterns of mistrust and alienation; cultural differences; language barriers; lack of culturally competent care; exposure to environmental risk; poor neighborhood conditions, including deteriorated housing, pollution, crime/violence; lack of community resources; and inadequate minority health systems, planning, and data. Several agencies in the US Department of Health and Human Services have recently developed frameworks for understanding and addressing health disparities, with a goal of fostering a systematic approach to achieving progress. Globally, the World Health Organization (WHO) Commission on Social Determinants of Health has identified many of the same kinds of issues underlying health disparities, associated with poverty, with the addition of factors such as poor drinking water, unsafe labor environments, lack of transportation, and lack of representation in governance.

For immigrant and refugee populations, a number of the factors cited above as contributing to health disparities in general are particularly salient, depending upon the population. Some of the most important factors are described in the following text.

Poverty and Lack of Resources

Research data show that a higher percentage of children in immigrant families live in poverty, compared to those in native-born families, resulting in hardships in at least three areas: food, housing, and health care. The degree of hardship is also affected by the extent to which public benefits are available to noncitizens. Some research even reports that immigrants are often staying away from public programs and assistance even when they are eligible, out of concern about the effects participation will have on their legal status or potential legal status. In addition, populations that have experienced disproportionate poverty may be less accustomed to some of the lifestyle patterns that have become commonplace among wealthier population segments. For example, *exercise* as a discrete and popular activity, not just as part of life, is a relatively recent and largely middle- or upper-class phenomenon that accompanied the rise in living standards over the past century, and the increasing separation of work from physical activity in a postindustrial, technological society.

While immigrant/refugee populations include members across socioeconomic categories, it is fair to say that these populations are over-represented in lower socioeconomic groups in host countries. Low socioeconomic status is widely associated with health risks and problems, such as nutrition, smoking, injuries, environmental pollution, lack of clean water access, unemployment, low income, family dysfunction, psychosocial stress, presence of community violence, poor neighborhood conditions, and limited recreational space. Moreover, risks such as housing segregation and lack of access to services may also be the product of discrimination against minority populations. These risks in turn have an impact on such health conditions such as obesity, violence, and substance use.

Immigrants and refugees who experience higher rates of poverty and social marginalization have little access to the interrelated systems of health, economic, and social resources. This general access-poor status generates patterns of living that tend to focus more on survival and achieving social goals (e.g., family needs, access to resources) within a very limited sphere, as opposed to maximizing health. This view is often expressed in the literature on *vulnerable populations* and on *syndemic* conditions associated with poor health. At the same time, there is also research showing that strong ethnic group identification, even in the face of discrimination and marginalization, may have some protective effect.

Lack of Health Insurance/Health Coverage and Economic Support

Access to health and social services for immigrants and refugees varies by country, and by legal status. In general, most immigrants are in working families. This does not guarantee that they will have health insurance or coverage, or enough income to afford adequate care. Immigrants who are not citizens typically face a significant lack of access to care compared to native-borns and citizens. This has serious implications for children, who may also not be covered. And of course, lack of access to care is correlated with poor health status.

Difficulties in Accessing Health Care and Treatment Bias

Financial, cultural, and language differences all make it hard for immigrants to afford care, understand medical advice, or embrace recommendations from host country providers. Even when there is access to health care, studies in the USA (by the Institute of Medicine, Kaiser Family Foundation, Commonwealth Fund, and others) have documented differential treatment for ethnic minorities in the *health care* system. Physicians and other practitioners are not always trained in competent cross-cultural care, including the provision of care to individuals with non-biomedical health beliefs or to new immigrants.

Differences in Health Knowledge and Practice

Immigrant populations may come to a host country with different understandings about health and health care. Such knowledge differences may be related to indigenous ethnomedical systems – that is, cultural systems of knowledge and practice that define the spectrum of illnesses and diseases, their causes, appropriate treatments, and appropriate treatment providers. Where these culturally specific definitions vary from Western biomedical knowledge and practice, and where immigrant and refugee populations maintain strong adherence to these definitions, a significant gap in understanding and utilization of standard medical care may result (see, e.g., Fadiman for a classic case of this kind of gap among Hmong refugees in the USA). Or, some immigrant populations may not have adequate information about available preventive and treatment procedures.

Migration and Immigration Experiences Including Acculturative Stress

Three additional and related sets of factors must be considered as unique to immigrants/refugees: home country trauma, migration trauma, and the impact of social, cultural, and economic change after arriving in the USA. Many immigrant groups – for example, Sudanese and Somalis today, Central Americans and Southeast Asians in previous years – are coming from home country situations in which there are brutal civil wars, genocide, and starvation. Moreover, the migration experience is itself dangerous and difficult for many, including persecution, pirate attacks, rape, robbery, years in refugee camps, family separation, and other experiences. Once they are in a new host country, immigrant and refugee families may then experience social role changes, generational family disruption, economic hardship, language and other difficulties. There is a high likelihood that these factors have an impact on health.

Related to these factors is the role-shifting that occurs within immigrant families. This has significant impacts on health and health care. It is often necessary for children to serve as interlocutors because they become more fluent in the host country language and familiar with public transportation and logistics. The role-shifting may in turn strain family decision making and lines of authority.

Mistrust and Other Attitudes

Mistrust of the host country health system may also exist in different forms among immigrant/refugee communities. Migrant worker populations from Central America who come to the USA, for example, are sometimes reluctant to trust government agencies and institutions (including public health clinics) due, among other things, to bad experiences during the years of civil conflict in Central America. If one adds to this a long history of dealing with health problems outside of the mainstream health care system, because of a lack of insurance or other resources to cover the cost, because of language barriers, or simply because of exclusion, it is not surprising that immigrants/refugees are often less likely than native-borns to see a doctor, even when they are in poor health.

Perceived Discrimination

Although discrimination is a complex issue with respect to immigrant/refugee communities, the negative association between perceived discrimination and health has been demonstrated across numerous studies. With respect to immigrants/refugees, the negative effects of discrimination are intermingled with political and economic contributing factors, though some research has shown that discrimination experience may be counterbalanced by the strength of ethnic identity.

Lack of Community Efficacy

One additional factor that has emerged as important is the lack of community efficacy (this can be thought of as "collective confidence") as a factor contributing to reduced access to services and to the continuation of substandard housing as well as other community conditions affecting health. Due to language barriers, unfamiliarity with supportive resources, fear, and mistrust, many immigrant community members are reluctant to take action or make complaints regarding such conditions, and may feel they cannot do anything to change the community.

Lack of Data and Systems to Address Health Needs of Immigrant and Refugee Populations

Finally, there are often few systems in a host country set up to address ethnic minority health disparities in general, and even more so for immigrant/refugee populations. Before such disparities can be addressed, they have to be identified; data need to be collected and maintained on health status and disparities among ethnic minority populations, and the data used to inform policies and programs. Currently, this is often not the case, and data that are collected may be lumped together in broad demographic categories that obscure actual conditions. In the USA, for example, peoples from Vietnam and India are both included in the "Asian" category.

Immigrant/Refugee Health Disparities as a Trajectory

The panoply of factors contributing to ethnic and immigrant/refugee health disparities most likely operates in a co-occurring and interactive fashion, as a *pathway* or *trajectory* of health for a specific population and subgroups within it. The trajectory, over time, may also shape a "way of life" with respect to health that encompasses real limitations on access to and quality of care, and higher exposure to community and environmental health risk, as well as behavior patterns and community norms that follow from expectations of high risk and limited care options, and a particular "relationship" to the health care system. For immigrant and refugee populations, such trajectories are also shaped by cultural patterns related to health, the immigration experience itself, and the dislocations and traumas that may be associated with it, as well as the socioeconomic status. The combination of *vulnerability*, *circumstance*, and *response* forms the larger set of forces that, together, create the differences in health status referred to as health disparities.

A Model for Assessing and Understanding Health Disparities Among Immigrant/Refugee Populations

Building on the general discussion of contributing factors for health disparities, below are a set of domains that can represent an *ongoing relationship between an immigrant/refugee population and the health-related system*. The term "health-related system," in this approach, refers to the combination of health services and the economic, community, social, and cultural supports necessary for their effective delivery. Health disparities experienced by immigrant/refugee populations can be seen as an outcome of these domains. [Note: This model and set of domains is adapted from Edberg et al. listed below under "Suggested Readings".] The domains are as follows:

- *Domain One – Migration Experience.* Includes the home country situation at time of emigration (crises, civil war, famine, disasters, etc.), the migration experience, including difficult or lengthy migration periods (e.g., exposure to violence, robbery, rape; extended exposure to severe conditions; and extended time in refugee camps before migration).
- *Domain Two – Social Adjustment.* Length of time in the host country, acculturation, home country social status and gender relationships, stressors created by the acculturation/adjustment process itself, regardless of migration experience. These may include: changes in social status, challenges to traditional gender roles and parental authority, change in SES (from home country), change in available social supports, and intergenerational conflict.
- *Domain Three – SES.* Economic, employment, and housing status to include economic supports for health care, such as insurance, employment with benefits, types and availability of employment, etc. (and change over time in any of these factors).
- *Domain Four – Social Supports.* Degree of cultural identity, extended family, neighborhood, cultural, employment and other important social network systems, and the degree to which any of these networks facilitate access to health care (social capital).
- *Domain Five – Neighborhood Characteristics.* Other community and neighborhood supports or barriers for health, including community organizations, social networks, recreation sites, parks, sources of healthy food (restaurants, grocery stores), etc. Presence/absence of environmental risks such as water/sanitation problems, sources of pollution, and crime and violence. The level of community efficacy fits in this category.
- *Domain Six – Health Status.* Health status (self-report), focusing on a general measure of health status (such measures could focus on health issue "clusters" that current research suggests are impacted by migration and transition – e.g., CVD/diabetes/obesity, and mental health).
- *Domain Seven – Health Knowledge and Practices.* Knowledge, attitudes, and practices with respect to health, disease, and health care treatments and utilization, including knowledge connected to indigenous ethnomedical systems and approaches to treatment and care, etc. This category should include any differences between home country health care practices and current/US practices.
- *Domain Eight – Access to Care.* Actual and perceived physical availability of and access to health care services, location of services. Actual and perceived availability of culturally competent care at service delivery settings – including language interpretation services, health care practices that recognize client cultural patterns, diverse health care staff, etc.
- *Domain Nine – Perceived Discrimination.* This is often measured as perceived level of discrimination and racism in daily experience, frequency of these experiences or events, as well as perceived acceptance, integration, and involvement in various community settings (e.g., neighborhood, school, work, health care, etc.).

These domains also set out the kinds of data that could be collected to assess a health-related *trajectory* for one or more immigrant/refugee populations, and therefore the syndemic set of circumstances, over time, that are integrated in a particular experience of health disparities. The health trajectory described through these domains incorporates a migration process beginning with a home country situation and health-related patterns, then impacted by the nature of the emigration/immigration experience itself, then impacted by an often complex and extended adjustment to life in a host country.

As a trajectory, what occurs within each of these domains may, over time, increase or decrease the "distance" between a population and the mainstream health-related system – where increased distance can be understood as *marginalization.* However, it is acknowledged that factors existing within a context of marginality may also be protective (e.g., social cohesion). Thus marginalization in itself may include positive and negative aspects. In general, however, we can hypothesize that an increase in *negative marginality*, represented by the presence or degree of negative factors in the above domains, will be associated with a decrease in health status in general and with disparities between immigrant/refugee populations and majority host country populations.

Related Topics

- ► Access to care
- ► Acculturative stress
- ► Birth weight paradox
- ► Cross-cultural health
- ► Discrimination
- ► Environmental health
- ► Epidemiological paradox
- ► Immigration in the global context
- ► Poverty
- ► Sanitation
- ► Vulnerable populations

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Immigrant Visa Status

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In major immigrant-receiving countries, such as the United States, Canada, and Australia, immigrants who are admitted to legal permanent residence can generally be classified into three broad categories based on their types of visas at entry: (1) economic immigrants, those who migrate to seek better economic opportunities, including employer-sponsored workers, skilled professionals, entrepreneurs, and investors; (2) family reunification immigrants, those who move to reunite with one or more family members; and (3) humanitarian immigrants, such as refugees and asylees.

The selection criteria vary considerably across different visa types. While immigrants on work-/employment-related visas are selected primarily based on the skills or human capital they possess, immigrants on family reunification visas are selected because their spouse, children, siblings, or parents are permanent residents or citizens of the host country. Migrants on humanitarian visas are admitted mainly due to geopolitical, religious, and humanitarian reasons.

Because of the differences in selection criteria, immigrants differ systematically based on their visa types. As a result, the type of visa at entry has implications for immigrant health status at arrival and their long-term health adjustment in host countries. Table 1 presents immigrant self-assessed health status separated by types of visas at entry in the United States and Australia. In both countries, economic migrants reported the best health status among all three immigrant groups, while humanitarian immigrants reported

Immigrant Visa Status. Table 1 Immigrant self-assessed health status at arrival and types of visas, USA[a] (Age 18 and above) and Australia[b] (Age 15–64)

Country	Health status	Visa categories (%)		
		Economic immigrants (Independent, business skills)	Family immigrants (Concessional, preferential family)	Humanitarian immigrants
Australia	Very good	62.5	52.7	42.4
	Good	33.1	39.1	46.2
	Fair/poor/very poor	4.4	8.2	11.4
		Economic immigrants (Employment principal)	Family immigrants (Spouse of US citizen)	Humanitarian immigrants (Refugee/Asylee)
USA	Excellent/very good	85.2	75.6	73.0
	Good	13.7	20.8	20.6
	Fair/poor	1.1	3.6	6.4

[a] USA: Table 5 derived from Jasso et al. (2005)

[b] Australia: Table 2 derived from Chiswick et al. (2008)

the worst health status. In Australia, for example, the percent of immigrants who rated their health status as "Fair/Poor/Very Poor" among family migrants (8.2%) almost doubles that of economic migrants (4.4%), and among humanitarian migrants, 11.4% rated their health status as "Fair/Poor/Very Poor." A similar pattern is observed in the US data.

The selection based on health status is most intense for immigrants on work/employment visas. A few factors contribute to the better health among economic migrants. First, employers in the host country have strong incentives to sponsor healthy immigrant workers, everything else being equal, because it translates to higher productivity, less health care costs, and higher profits for employers. As a result, immigrants on work-/employment-related visas are prescreened by employers based on health status even before they obtain their visas. Second, those who are less healthy are less likely to apply for a work/employment visa to begin with. Migration is an investment in human capital whose rate of return depends on, among other things, the earnings' differentials between the country of origin and country of destination, and migration costs. Healthy persons are therefore more likely to migrate than the less healthy because the former command higher wages, and hence higher earning differentials due to the ability to work longer, more vigorously, and a longer working life. Consequently, economic migrants are favorably self-selected on the basis of health. Finally, compared with family reunification immigrants and humanitarian immigrants, economic immigrants usually migrate in their prime ages, have a higher level of education, are more prepared for moving and more proficient in the host country's language, and receive higher income. Age, education, income, and access to health care, which is facilitated by immigrant language proficiency, have been shown to be the most important determinants of health status. As a result, economic migrants tend to have better health status than other immigrant groups.

For family reunification immigrants, their primary goal is to reunite with family members, as a result, health plays a less significant role in their migration decision than it does for economic migrants. However, because of the positive assortative mating in the marriage market, and the inter-generational transfer of human capital and wealth, the spouse, children, siblings, and parents of previous migrants also tend to possess certain favorable traits, including better health. Consequently, their health profiles, though not as good as those of economic migrants, are better than those of humanitarian immigrants who are subject to the least selection on the basis of good health.

In recent years, immigrants on humanitarian visas compose about one-tenth of the total annual immigration to the United States. The majority of humanitarian immigrants are those who faced security concerns or were in need of legal protection in their countries of origin, and those who have experienced recent persecution because of their political, religious, or human rights activities. Many humanitarian immigrants are women- and children-at-risk, victims of torture or violence, physically or mentally abused persons, and persons in urgent need of medical treatment not available in their countries of origin. Moreover, administrative health requirements for obtaining a visa are relaxed for refugees. Consequently the health status of humanitarian migrants tends to be the worst among the three major immigrant groups.

In sum, there is a strong link between visa types and immigrant health. The differences in selection criteria for different types of visas result in great variations in health selection and in various human capital dimensions among immigrants, such as age, education, income, and language skills, which are the key determinants of health. The correlation between visa types and immigrant health has important public policy implications. It implies a skill-based immigration system that emphasizes migrants' educational attainment, occupational achievement, and language skills, among other productivity-related characteristics, would result in healthier immigrants and less health care costs for destination countries.

Related Topics

- ▶ Illegal immigration
- ▶ Immigration status
- ▶ Inadmissibility on health grounds
- ▶ Undocumented

Suggested Readings

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Immigration Act of 1924 (U.S.)

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The US government signed into law the Immigration Act of 1924, also known as The Johnson–Reed Immigration Act. This legislation was developed as a measure to control the number of immigrants entering into the USA as well as to exclude people migrating from specific countries and regions.

The Immigration Act of 1924 limited immigration visas to 2% of the total number of people from each nationality already living in the USA based on the 1890 census, inspiring the Act's more popular name, the National Origins Act. The 2% quota was actually lowered from a previously established quota of 3% based on the 1910 census. The idea of quotas was controversial. On the one hand, nativists and many politicians at the time argued that it was critical to maintain homogeneity in the USA. Those who opposed such a quota pointed out that it unfairly reduced the number of people from certain areas, such as Southern and Eastern Europe because there were fewer people from these parts of the world already living in the USA than those from Northern Europe and Britain. In addition, by going back to the 1890 census figures, it favored immigrants from Western Europe even more prominently. The other important provision of the Act was that it excluded immigrants from Asia. This did not specifically include the Japanese or immigrants from the Philippines, however. The Japanese government had voluntarily limited Japanese immigration to the USA prior to 1924 and the US Congress expected the government of Japan to honor its own promise. The Philippines were excluded because it was an American colony.

In addition to excluding entry of individuals based on national origin, certain health conditions were also considered as a basis for exclusion such as "feeble-minded, insane, narcotic drug addicts, or chronic alcoholics, those with epilepsy, psychopathic personality, a mental defect, tuberculosis, leprosy, or a dangerous contagious disease, and those whose physical defects affect their ability to earn a living." Each immigrant entering the USA had to undergo a medical examination and if determined by a US physician upon observation to be symptomatic of the health conditions on the exclusion list, he/she was separated for further examination to determine a prognosis, which may or may not have been grounds for exclusion and return to his/her country of origin.

In 1917, setting the stage for the 1924 Act, the US Congress had enacted more restrictive immigration laws driven in part by national security concerns that arose during World War I. This is also when the idea of literacy examinations for anyone over the age of 16 became mandatory. President Woodrow Wilson had vetoed a similar bill in 1922, but in 1924, the newly inaugurated President Warren Harding called a special session of Congress to pass the 1924 law. The US Department of State itself admits that the most basic purpose of the Immigration Act of 1924 was to preserve the ideal of American homogeneity. There were no revisions to the 1924 Act until 1952.

Related Topics

► Immigration processes and health in the U.S.: A brief history

► Medical examination (for immigration)

Suggested Resources

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Immigration Act of 1990 (U.S.)

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The United States Immigration Act of 1990, signed by President George H.W. Bush, made significant changes to previous immigration legislation. The 1990 Act increased the limits on legal immigration, even compared to the significant increases allotted for by prior legislation in 1965 following the Civil Rights Era. The 1990 legislation maintained family-based criteria, that is, immediate relatives of US citizens with unrestricted numbers and placed significantly more emphasis on employment considerations for immigration, especially for highly skilled labor.

Although immigrants were considered for entry to the USA based on needed labor skills prior to 1990, this new immigration reform focused much more on making accommodations for more skill-based immigrants. Before 1990, 54,000 visas were available for occupation-based immigrants. After 1990, this number changed to 140,000. In addition, what is referred to as "diversity" immigration was introduced and designed to facilitate the entry of potential migrants that had been adversely affected by the 1965 immigration law. The diversity immigration included 55,000 visas allocated to natives of countries that had sent fewer than 50,000 immigrants to the USA over the previous 5 years. To be eligible for this particular visa, however, a prospective immigrant was required to have at least a high-school education or its equivalent, and at least 2 years of work experience or training in a particular occupation. Critics argued that this requirement would result in more overall emphasis on immigrants as skilled labor and not any other criteria which, in the end, was the major goal of the1990 law.

As intended, the 1990 immigration law amendments resulted in a significant increase in the number of employment-based immigrants. Immigrant professionals with an advanced degree increased significantly. Between 1992 and 1996, a total of 121,646 people entered into the USA from countries like China, India, and Canada via employment visas. Professionals in health care-related fields had the largest increases between 1995 and 1996, followed by other professionals like managers, executives, and those with special technical skills.

With regards to family-based immigration, or people who immigrated because they already had a close family member residing in the USA, the most notable increases were for migrants from Africa – although the total number of Africans was still small in comparison to other regions and countries. Mexico, however, was and remains the major source of immigrants to the USA with the largest immigration increases occurring between 1995 and 1996, with family-based migration accounting for almost 11.9% of those admissions.

A significant component of the 1990 Act was that it eliminated the entry ban under specified circumstances against individuals with HIV. Prior to this, those seeking entry to the USA via immigration and tested positive for HIV were excluded. The explicit HIV ban was added in 1987 in which it joined a list of other communicable diseases such as syphilis, gonorrhea and tuberculosis, originally introduced by immigration policy established in 1952. However, the lifting of the HIV ban on immigration created intense controversy, and eventually, in 1993, the US Congress conceded to pressures by those opposing the removal of the HIV exclusion and reinstated the ban. A provision was nonetheless included for immigrants to obtain discretionary wavers from the Immigration and Naturalization Service (INS). In order for an HIV positive individual to qualify for a waiver, he/she had to be "the spouse or unmarried son or daughter or the minor, unmarried adopted child of a US citizen or Lawful Permanent Resident (LPR) or have a son or daughter or lawfully adopted child who is a US Citizen or LPR; or the applicant must be eligible for classification as a self-petitioning spouse or child (including derivative children) because of abuse." Once an applicant had met these requirements, he/she was required to show that he/she would not pose more than a minimal "danger" to the public health of the USA and minimal risk for the spread of the disease. Individuals were also required to demonstrate that there would be no federal, state, or local public costs incurred by the admission of an HIV positive person. The INS issued guidelines in 1995 on how applicants could meet these caveats. The first two could be met by issuing a personal statement or a statement from a medical professional emphasizing the individual's knowledge of the disease and how it is transmitted. The third could be achieved by providing proof of private medical insurance – this one being challenging as it was unlikely that a private health insurance company would not consider HIV infection a preexisting condition, therefore excluding the individual from qualifying for insurance or, at best, excluding any treatment from the disease from an HIV positive person's insurance plan.

The HIV entry ban, even with the waivers, remained controversial with immigration and civil rights groups, along with public health professionals pushing for it to be removed from the legislation. One of the strongest points in the argument to remove the ban was that it did not prevent the spread of HIV across international boundaries. Beginning in July 2008, a series of events led to the HIV ban once again being lifted when President George W. Bush signed legislation for the President's Emergency Plan for AIDS Relief, which eliminated the provision that made individuals with HIV inadmissible to the USA. Then, in October 2009, President Barack Obama announced the final rule eliminating the ban of HIV positive individuals to the USA, effective January 4, 2010.

Related Topics

- ► Acquired immune deficiency syndrome
- ► Communicable disease of public health significance
- ► Medical examination (for immigration)

Suggested Readings

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Immigration and Nationality Act Amendments of 1965 (U.S.)

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The Immigration and Nationality Act Amendments of 1965 was signed into law by President Lyndon Johnson. It phased out the use of the national origins quota which had been the basis of previous immigration legislation. Prior to 1965, immigrants were admitted to the USA based on their country of origin and race, with the vast majority of the immigrant slots allotted to people who were from Northern Europe, primarily the UK, Ireland, and Germany. The quota allowed only 2% of immigrants from each country based on the numbers of people from those countries already living in the USA. Asians, with the exception of the Japanese (whose government voluntarily prohibited it citizens from migrating to the USA) and the Philippines (a US territory), were only admitted to as immigrants beginning in 1952. In place of using nationality and racial criteria, this new legislation implemented a system based on family reunification and needed labor skills. In fact, the Immigration and Nationality Act Amendments of 1965, also known as the Hart-Celler Act, made family reunification the cornerstone for America's immigration policy.

Elected officials who were opposed to the 1965 immigration amendments feared a sudden flood of immigrants and argued that a drastic change in immigration statistics would have negative effects on the country by creating overpopulation, increasing unemployment, increasing welfare spending, and overcrowding schools, ultimately resulting in lower living standards for Americans. However, the US Civil Rights Act of 1964 was signed into law just 1 year prior and was at the heart of the changes reflected in US immigration policies in 1965. For many, the immigration amendments were seen as an extension of the civil rights movement. There were also foreign policy concerns that motivated elected officials to make some of the changes reflected in the new law. The immigration quota system based on nationality and race was now considered contrary to the civil rights movement and the image of equality and respect for all people that the USA wished to demonstrate and convey to the world.

Immigration to the USA did increase significantly during the first few years after the bill's passage, especially from Asian countries. Those escaping from war-torn Vietnam and Cambodia were particularly numerous. The Cold War also pushed millions of people fleeing from communist governments such as those in Cuba and Eastern Europe to seek refuge in the USA. More than 18 million people migrated to the USA during the three decades following the 1965 immigration amendments.

The impact of such high numbers of immigrants on the US health care system has two interesting facets. First, studies have shown that immigrants tend to have better health outcomes that their native-born counterparts. They tend to have lower morbidity rates, fewer restricted-activity days and bed disability days, fewer physician visits and lower hospitalization rates. Immigrants show a significantly lower risk of mortality not only from all causes combined, but also from several major causes of death, such as cardiovascular diseases, lung cancer, prostate cancer, COPD (chronic obstructive pulmonary disease), liver cirrhosis, pneumonia and influenza, unintentional injuries, and suicide. This suggests that immigrants place less of a burden on the US health system because they tend to be healthier than their native-born counterparts. Yet, large numbers of immigrants have less access to private health insurance for reasons of non-affordability and employment in sectors that do not traditionally offer health insurance as a benefit to employees, such as low-wage construction jobs and farming. In 1986, another obstacle to obtaining health insurance to the US immigration experience was added: except under specified conditions applicable to relatively few individuals, immigrants were prohibited from obtaining federal assistance during the first 5 years after obtaining permanent residence ("green card"). For most immigrants, this foreclosed for 5 years the possibility of receiving health care through the government-sponsored programs of Medicaid and Medicare.

Related Topics

► Immigrant visa status
► Immigration status
► Medicaid
► Medicare

Suggested Resources

Braziel, J. E. (2000). *History of migration and immigration laws in the United States*. Department of English and Comparative Literature, University of Cincinnati. Retrieved February 23, 2010, from http://www.umass.edu/complit/aclanet/USMigrat.html

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Immigration and Nationality Act of 1952 (U.S.)

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The United States Immigration and Nationality Act of 1952, also known as The McCarran-Walter Act, upheld the national quota system put in place by the Immigration Act of 1924. The quota called for no more than a 2% increase in the number of immigrants from countries that already had established citizens in the USA. It did, however, end the exclusion of Asians as was mandated in 1924. It also introduced an immigration preference system based on both needed labor skills and family reunification.

The Immigration and Nationality Act of 1952 was influenced greatly by the US Cold War philosophy that dominated much of US foreign relations at the time. There were great concerns among elected officials that America could be infiltrated by communists and their allies from their Cold War enemies, such as the former Soviet Union. Therefore, the national origins quota of 2% established in 1924, which was a reduction from the previous quota of 3%, was maintained in 1952. The Cold War had such a great influence in the 1952 legislation that neither economic nor labor factors were considered when crafting the bill.

Although the 1952 Act now allowed Asians to migrate to the USA, using the 2% national quota system meant that immigration laws remained restrictive toward Asians because until 1952, they were completely excluded (with the exception of the Japanese and Filipino). The number of Asians already living in the USA was very low, in fact, the lowest of all ethnic and racial groups. Furthermore, language in the 1952 Act was changed from "national origin" to specific racial and ethnic terms such as "Chinese." Since there were many Chinese living in other parts of Asia, legislators argued that the quota system continued to be unfair with regards to the Chinese and considered it unnecessarily restrictive toward people of Chinese ethnicity. President Harry Truman was concerned enough about the decisions to maintain the national origins quota, especially in how it affected the Chinese, that he vetoed the bill. Congress, however, overturned his veto and the bill was passed.

Other exclusions for those wishing to immigrate to the USA during this period include those based on health. The exclusions that were implemented in the Immigration Act of 1924 were largely maintained in 1952 legislation. Exclusions included such health conditions described as "feeble-minded, insane, narcotic drug addicts, or chronic alcoholics, those with epilepsy, psychopathic personality, a mental defect, tuberculosis, leprosy, or a dangerous contagious disease, and those whose physical defects affect their ability to earn a living." Some of these conditions were subjective or broadly described, largely based on political and social ideas and opinions. Included in conditions such as "mental defect" were such traits as homosexuality. (In fact, it was not until 1973 that the American Psychiatric Association finally removed "homosexuality" from the *Diagnostic and Statistical Manual of Mental Disorders*.) As was put in practice in earlier immigration legislation, each immigrant entering the USA was required to have a medical examination by a US physician who could determine an individual to be symptomatic of the health conditions on the exclusion list and therefore considered for rejection from immigration to the USA.

Related Topics

▶ Exclusion

▶ Immigration processes and health in the U.S.: A brief history

▶ Medical examination (for immigration)

▶ Psychopathic personality

Suggested Resources

Braziel, J. E. (2000). *History of migration and immigration laws in the United States*. Department of English and Comparative Literature, University of Cincinnati. Retrieved February 1, 2010, from http://www.umass.edu/complit/aclanet/USMigrat.html

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Immigration and Naturalization Service

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The US Immigration and Naturalization Service (INS) was established in 1933 as part of the movement of immigration policies in the USA designed to regulate immigration. The first immigration act of the USA was in 1882 in which a tax was levied on each immigrant and certain persons were, for the first time, excluded from entry. Prior to this, there were no policies regulating immigration and people entered the USA freely. Subsequent immigration legislation continued to impose more restrictions on immigration especially restricting the number of immigrants based on nationality. These laws led to the federal government's creation of immigration enforcement agencies, and as early as 1891, the Immigration Service was established with the main responsibility of monitoring the entrance of immigrants and guarding against illegal entry.

In 1906, the US Congress passed the Naturalization Act with the goal of creating a uniform naturalization process. Prior to this time, each state followed its own policies. The rules established by this particular law remain in effect today. Legislation contained within the Naturalization Act of 1906 expanded the Bureau of Immigration into the Bureau of Immigration and Naturalization, which then became the Immigration and Naturalization Service in 1933.

The functions of the INS have changed over time and have included the operation of internment camps and detention centers during World War II. The INS also expanded its role by managing and operating border patrols and crackdowns on illegal immigration.

In 2003, the INS was divided into three new agencies, managed under the newly created US Department of Homeland Security. The three new agencies responsible for immigration services and enforcement are: the US Citizenship and Immigration Services (USCIS) which manages permanent residency and naturalization (granting citizenship); the US Immigration and Customs Enforcement (ICE) responsible for the investigative and enforcement functions of immigration; and the border control and enforcement roles were combined with US Customs Inspections to become the US Customs and Border Protection (CBP).

Between April 2000 and July 2009, the US Census Bureau estimates that there were 8.9 million immigrants. The three states with the highest number of immigrants during this period were California with over 1.8 million; Texas with at least 933,000; and Florida had over 851,000. The USCIS, responsible for granting legal residency and citizenship, makes information available to new immigrants in 14 different languages regarding essential services ranging from how to access health care, education, employment, housing, childcare, food stamps and other financial assistance, emergencies and safety, the role of government, and individuals' basic rights as US residents and citizens.

The healthcare section of the Department of Homeland Security, USCIS' publication "Welcome to the United States: A Guide for New Immigrants" describes how residents and citizens in the USA pay for their own health care, unless they can purchase private health insurance. It gives a general description of how private health insurance works (i.e., doctors bill insurance companies for the services rendered) and provides general information about how to obtain federal and/or state assistance obtaining health insurance if purchasing private insurance is not affordable. It also states that most hospitals with emergency rooms are obligated by law to care for people with an urgent medical need even if they do not have the ability to pay for services.

New immigrants who have been granted legal residency, often referred to as a "green card," have access to Medicaid, the US federal health insurance program, if they are permanent residents who entered the USA prior to August 22, 1996; or if they entered on or before that date and have lived in the USA for 5 years or longer. Medicare, another federal health insurance program, is available to those 65 years or older and for individuals younger if they have a qualifying disability. New immigrants also have access to State Children's Health Insurance Program (SCHIP), which is available in all 50 US states for children and youth age 18 years or younger.

Related Topics

- ► Medicaid
- ► Medicare

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Immigration Reform and Control Act of 1986 (U.S.)

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The US Immigration Reform and Control Act of 1986, signed by President Ronald Reagan, had the main goal of controlling unauthorized immigration to the USA. It primarily focused on the hiring of unauthorized immigrants by creating controls and restrictions for employers and financial penalties for hiring undocumented workers with the threat of imprisonment for repeat offenses.

Prior to the 1986 immigration reforms, the last major piece of legislation regarding immigration in the USA was the Immigration and Nationality Act of 1965. This was preceded by the US Civil Rights Act in 1964, and the 1965 immigration legislation established the most liberal immigration policies of the twentieth century. Immigration to the USA in the three decades following the 1965 law was more than 18 million persons. It had ended the previous policy of nationality and race quotas, and introduced a preference system based on both family reunification and needed labor skills. By the end of the twentieth century, the ethnic and racial makeup of the American population was vastly diverse. In the 1950s, more than half of all immigrants were of European origin, and only 6% were Asians as they had been excluded from immigration to the USA for at least 50 years prior. In 1965, however, new US immigration policies allowed Asians the option to immigrate to the USA which created significant increases in the number of Asians along with a large increase in the number of people from Latin America.

The Immigration Reform and Control Act of 1986 introduced the requirement on the part of US employers to verify the eligibility of each person hired after November 1986. The completion of a specific form called an I-9 was required by all employers for each employee hired with specific instructions as to which identity documents were to be verified to prove an individual's legal right to work in the USA. The law is still in effect today. Employers who hire immigrants not authorized to work in the USA face fines with the possibility of serving time in prison for repeat offenders. The 1986 changes to immigration laws also included an amnesty provision which provided legal US residency to anyone who had been living in the USA illegally but continuously since January 1, 1982, if they applied for residency by May 4, 1988. As a result, almost three million people received amnesty.

In 1987, this immigration legislation was amended to add HIV to the list of "dangerous contagious diseases," a list that was originally developed as far back as 1891. Enforcement required that all persons wishing to immigrate to the USA be subjected to HIV testing and could be denied entry if tests results were positive. However, individuals arriving in the USA as nonimmigrants, such as tourists or businesspersons, were not required to be tested for HIV. The HIV ban was controversial and spurred complaints and protests from civil rights and gay rights groups, but the USA joined 14 other countries in introducing the ban. Critics said the law failed to effectively "protect" the USA from a "dangerous contagious disease" because HIV was not spread through casual contact and the law did not deter tourists who were HIV positive from coming to the USA and spreading the disease. Furthermore, if someone tested positive and was denied entry, there were no services offered to the individual who may have just learned of the HIV status; they were simply turned away from entry. Subsequent immigration legislation included the introduction of HIV waivers so that individuals wishing to immigrate who tested positive for HIV could apply for a waiver and, if granted, were allowed entry. In 2010, the federal government eliminated the HIV immigration ban entirely.

Related Topics

- ► Illegal immigration
- ► Immigrant visa status
- ► Immigration processes and health in the U.S.: A brief history
- ► Medical examination (for immigration)

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Immigration Status

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Immigration status can have a powerful impact upon immigrants' health and ability to access health care. This applies especially to unauthorized immigration status, or "illegality," which interacts synergistically with factors like poverty, political marginalization, and social exclusion to put unauthorized immigrants' health at risk. The forms of health-related vulnerability that result raise complex questions and challenges for scholars and practitioners in fields as diverse as medicine, nursing, health administration, public health, public policy, bioethics/public health ethics, anthropology, sociology, and law.

Some social scientists avoid terms like “illegal” status and “illegality,” which tend to carry strong pejorative connotations, whereas others argue that “illegality” constitutes a juridical, sociopolitical, and experiential condition that requires critical and comparative analysis. There are multiple pathways to “illegality,” including entry into a country without legal permission, entry with one form of legal permission and then taking on an unauthorized role (i.e., entering as a student or tourist and then seeking work), or entry with a time-bound legal permit and “overstaying.” Unauthorized immigrants tend to occupy the most “dirty, dangerous, and demeaning” roles within local labor markets, especially in gray- and black-market labor sectors.

Although unauthorized immigrants often play pivotal roles in local economies, they frequently are portrayed in public and political discourse as unwanted, undesirable, and undeserving of health-related attention, investment, or care. Moreover, they are more likely than other groups to encounter occupational hazards such as dangerous work conditions, toxic chemical exposures, lack of protective knowledge and safety equipment, and pressure to avoid reporting injury or seeking health care treatment. Structural constraints like these – along with fears of job loss and fears of arrest and deportation – prevent many from pursuing needed health care, arguing for greater worker protections, or finding safer jobs.

Beyond the workplace, immigrants’ homes may also be places of health vulnerability and risk. Many unauthorized immigrants live in workers’ camps or private dwellings that house more than the intended number of inhabitants. If a single occupant is exposed to a communicable or infectious disease, a high degree of residential density can quickly pose a health hazard for other occupants. In addition, unauthorized immigrants tend to live in low-rent neighborhoods that are more likely than affluent areas to contain toxic exposures like traffic pollution, landfills, or toxic dumping sites. They are also more likely to encounter physical and mental health risks associated with street drugs, sex work, and vulnerability to theft and other forms of crime. Although unauthorized immigrants often are held to blame for social problems like these, they are more commonly forced to seek housing in areas where such risks are already present because of their own social marginalization, political exclusion, and poverty.

Violence is also a source of health risk for many immigrants, particularly those who are undocumented. Some become targets of racially or nationalistically motivated violence, and others become embroiled in gang-related violence. Domestic violence is also a health risk of concern, especially for women. Unauthorized immigrants’ risk of serious injury or even death due to a violent encounter is exacerbated by their lack of access to health care and to other protective institutions and services like the local police and women’s shelters.

Although some unauthorized immigrants are safe from the health risks identified above, nearly all face exclusion, in part or in full, from the systems of health care promotion, protection, and provision available to local citizens and authorized residents. In many countries, health insurance is tied to authorized employment, and workers in the gray or black market are automatically excluded, as are their children. Other countries, most notably Spain and Italy, have implemented inclusive laws and policies, but their inclusionary steps are hindered by implementation challenges and exclusionary institutional and clinical practices.

When mainstream pathways to health care are blocked, unauthorized immigrants’ health-seeking pathways are limited. Available alternatives include reliance on self-diagnosis and treatment with over-the-counter or traditional remedies, consultation with folk healers or alternative medical practitioners, postponement of care seeking until a condition becomes acute, and stopgap measures like emergency rooms or clinics run by nongovernment organizations (NGOs). Since the right to emergency care is legally protected throughout North America and Western Europe, last-resort health centers like emergency rooms are vital resources for uninsured immigrants. Yet emergency rooms and NGO clinics often are not free, they cannot provide preventive or comprehensive curative care, and they are vulnerable to political, administrative, and financial constraints that may lead to reductions in available care or even to sudden closure.

Finally, linguistic and cultural obstacles to health care have received considerable attention in recent years. Although efforts to make health care for immigrants, including unauthorized immigrants, more "culturally competent" and "culturally appropriate" have yielded some positive effect, the "cultural competence" movement sometimes assumes that culture – as opposed to such structural factors as "illegality" combined with poverty, exclusion, and social inequality – is the prime cause of delayed care-seeking or "noncompliance" with medical advice. As physician-anthropologist Paul Farmer notes, it is a grave error to confuse structural obstacles – in this case, formal mechanisms of exclusion in conjunction with prohibitive cost, inability to take time away from work, lack of transportation, fear of losing one's livelihood, and the physical and mental health risks and dangers of "illegality" itself – with cultural difference.

Related Topics

- ► Access to care
- ► Cultural competence
- ► Cultural humility
- ► Illegal immigration
- ► Immigrant visa status
- ► Undocumented

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Immunization

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Immunization (in common language means protection against something) is a way to control and eliminate life-threatening infectious diseases. It is considered to be one of the most cost-effective investments in health care system. It is a part of national health care programs and in some countries it is mandatory by law.

Edward Jenner demonstrated the value of immunization against smallpox in 1792. Approximately, 200 years later, in 1977, smallpox was eradicated from the world through the widespread and targeted use of the vaccine. In 1974, based on the emerging success of smallpox, the World Health Organization (WHO) established the Expanded Programme on Immunization (EPI). Through the 1980s, UNICEF worked with WHO to achieve Universal Childhood Immunization of the six EPI vaccines (BCG – bacille Calmette-Guerin for tuberculosis, OPV – oral polio vaccine, diphtheria, tetanus and measles).

Mechanism of Action

When a competent immune system is exposed to molecules that are foreign to the body, so-called antigens, it will develop an immune response that can be humoral (producing antibodies against the antigen) or cellular based on activity of cytotoxic and helper lymphocytes.

In order to achieve protection against a certain disease (to be immunized), vaccines are used. Vaccines have the characteristics to induce the immune response (forming of antibodies) but not the diseases.

In order to improve the effectiveness of immunization it is recommended to have periodic injection vaccines. A vaccine is an artificial substance that improves immunity to a particular disease when is administrated in an appropriate way. It contains the microorganism or parts of microorganism that stimulate the immune system to recognize the agent as foreign, to destroy it, and "remember" it, so that the immune system can more easily recognize and destroy any of these microorganisms to which the body will be exposed in the future.

Vaccines contributed to the eradication of smallpox, one of the most contagious and deadly diseases known to man. As long as the vast majority of people are vaccinated, it is much more difficult for an outbreak of disease to occur. This effect is called herd immunity.

Poliomyelitis, which is transmitted only between humans, is targeted by an extensive eradication campaign that has seen endemic polio restricted to only parts of four countries (Afghanistan, India, Nigeria, and Pakistan).

Types of Vaccines

Prophylactic (to prevent or ameliorate future disease)
Therapeutic (vaccines against cancer)

There are several types of vaccines currently in use (The methods used in order to obtain it have as a goal the reduction of illness and an increase in the capacity of vaccine to induce immune response.):

1. Vaccines that contain killed microorganism using chemicals or heat. Examples are the influenza vaccine, cholera vaccine, polio vaccine, and rabies vaccine.
2. Vaccines that contain live, attenuated microorganisms. Examples are the viral diseases yellow fever, measles, rubella, and mumps and the bacterial disease typhoid.
3. Toxoids are inactivated toxic compounds (toxins) in cases where these cause illness. Examples of toxoid-based vaccines include tetanus and diphtheria.
4. Vaccines that include protein subunits; examples are HBS antigen for hepatitis B virus, VLP-virus like particle for human papilloma virus, hemagglutinin and neuraminidase for Influenza virus.

Types of Immunization

1. Active immunization involves introduction into the body of a foreign substance. It happens when a person came into contact with a virus or a bacterium for the first time without having preformed antibodies against it. This stimulates an immune response and is called active natural immunization.

   Active artificial immunization refers to the situation when the microbe or parts of it are injected to human body, generating also an immune response.
2. Passive immunization involves inoculation of presynthesized elements of the immune system (usually antibodies) to a person so that the body does not need to produce these elements itself.

   There is a passive natural immunization which is physiologic when antibodies are transferred from mother to fetus during pregnancy in order to protect the child after birth against some infection. Artificial passive immunization is achieved by administration of a vaccine that contains antibodies against certain viruses or bacteria.

Vaccines can immunize against one single bacterium or virus (monovalent, univalent) or against two or more strains (multivalent polyvalent).

Effectiveness of vaccines depends on:

1. Host immune system capacity. Sometimes it cannot respond in an appropriate way probably due to special conditions such as diabetes, use of steroids, alcoholism, renal failure, live failure, and blood diseases.
2. The strain contained in the vaccine. For example, people can be vaccinated with other strains than those that are circulating in a certain period of time.
3. Time table of vaccinations has to be adhered to. (See American Academy of Pediatrics Redbook)
4. Some persons do not respond to vaccinations. There are few explanations for that. Most of the time, people do not respond to vaccinations either due to a suppressed immune system resulting from chronic diseases, different treatments, for example, for cancer, in order to retain a transplanted organ), or because the immune system is not completely developed, as is the case with young children.

Legislation Regarding Immigrants' Immunization

As of 1997, all persons who want to enter and live in USA have to be immunized. Moreover, in order to immigrate in USA, documentation is required to establish past immunization against a few diseases considered to be high risk for the general population such as hepatitis, mumps, measles, polio, whooping cough, and varicella.

Related Topics

- ► Adolescent health
- ► Education
- ► Health promotion
- ► Infectious diseases
- ► Pediatrics

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INA

► Immigration and Nationality Act of 1952 (U.S.)

Inadmissibility on Health Grounds

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Inadmissibility on health grounds refers to the disqualification of a visa applicant or immigrant to a country based on health-related grounds that are of public health significance. The US *Immigration and Nationality Act*, 1965 (INA) requires certain classes of visa applicants, refugees and immigrants to undergo a medical examination to identify ineligible applicants with health-related conditions for the Department of State (DOS) and US Citizenship and Immigration Services (USCIS).

Medical examination is also mandatory for foreign residents in the United States who apply for an adjustment of their immigration status to that of a permanent resident. Applicants for temporary or non-immigrant visa to the USA may be directed to undergo a medical examination at the discretion of the immigration officer at the US consular office overseas. This discretion may be exercised where there are circumstances that suggest that the applicant has an inadmissible health-related condition. Other classes of aliens, including fiancés and migrants who entered the USA without inspection and with or without proper documentation, are required to have a medical examination done before they are admitted to the USA.

Section 212(a)(1)(A) of the INA stipulates the classes of foreigners that are ineligible for visas or inadmissible to the USA based on health-related grounds. The classes of foreigners include persons with a communicable disease of public health significance, who have no documentation evidencing receipt of vaccination against vaccine-preventable diseases, who have been diagnosed with a physical or mental disorder that results in harmful behavior, and who are drug abusers or addicts. Some examples of the communicable diseases of public health significance that would cause an applicant to be ineligible to enter the USA include tuberculosis, Hansen's disease (Leprosy), syphilis, gonorrhea, and diseases that may require quarantine, such as cholera, small pox, yellow fever, and pandemic flu. Under section 212(g) of the INA, a visa applicant, refugee or status adjuster who has an inadmissible health-related condition requires a waiver to come to the USA. A waiver authorizes the applicant who is otherwise ineligible based on one or more health conditions to enter into, or remain in the USA. A waiver is granted on a case by case basis. An applicant is eligible for a waiver if the applicant is the spouse, unmarried son or daughter, or the minor adopted child of a US citizen or permanent resident; has a son, daughter, or lawfully adopted child who is a citizen of the USA or a permanent resident; or if the applicant can be classified as a self-petitioning spouse or child based on abuse.

Similarly, Canadian immigration policy establishes standards to be met by people seeking entry into Canada. These standards constitute grounds for inadmissibility under the Canadian Immigration and Refugee

Protection Act, 2001 (IRPA). Among the criteria set out under the IRPA is section 38, which outlines three health grounds under which a foreign national may be denied admission to Canada: a health condition that is likely to be a danger to public health, a condition that is likely to be a danger to public safety, and a health condition that might reasonably be expected to cause excessive demand on health or social services. The IRPA denies admission on health grounds based on two distinct rationales: the protection of public health and the public economy. A foreign national is inadmissible if his or her health condition is likely to be a danger to public health or public safety. The public health and safety policy aims to protect Canadians from a broad range of pathologies, particularly contagious or highly infectious diseases such as tuberculosis in its active state, which might pose a threat to public health.

The second rationale involves the protection of Canadian healthcare resources from unusually excessive demands on Canada's health or social services that a visa applicant might require if he or she were to be admitted to Canada. These excessive demands could take either or both of two forms. First, they could result in excessive public expenditures for the cost of the health care. Alternatively, the need to provide visa applicants with health care could result in lengthened waiting lists and increase the rate of mortality and morbidity among Canadian citizens and permanent residents as a result of the denial or delay in the provision of those services to them.

Medical and visa officers are charged with determining the inadmissibility of an applicant on health grounds. The Supreme Court of Canada in two notable cases has disapproved of speculation by medical and visa officers in determining inadmissibility. Reasons such as the likelihood of bankruptcy, mobility, school closure or parental death could be raised in relation to any applicant and are inadequate grounds for a finding of inadmissibility. Rather, medical officers must assess the applicant's likely demands on social services, not his or her eligibility for them. In making this required individualized assessment, they must consider both medical and non-medical factors, such as the availability of publicly funded services and the applicant's ability and willingness to pay for the required services.

Visa officers are now required to evaluate the intention and ability of the applicants to alleviate the burden they allegedly place on publicly funded social services before finding business class applicants or their dependants medically inadmissible for excessive demand on social services. The individualized assessment is usually made based on the likelihood of the business-class applicant accessing specific state-funded services. According to Citizenship and Immigration Canada, this approach is supported by the fact that there is a private market for some social services, and that some social services are means tested. The term "means tested" is used to determine eligibility of individuals and families for government subsidies. It involves making an assessment of a person or family's financial capacity and determining (usually according to a formula) how much of the cost of a good or service should be borne by that individual or family, and how much publicly funded subsidy the individual/family should receive.

Related Topics

- ► Border health
- ► Communicable disease of public health significance
- ► Immigration processes and health in the U.S.: A brief history
- ► Medical examination (for immigration)
- ► Panel physician
- ► Tuberculosis

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India

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Introduction

India is a subcontinent whose history can be traced to one of the world's oldest civilizations, the Indus Valley civilization, that flourished during the third and second millennia BC. Today's classical Indian culture began to develop approximately in 1500 BC, as Aryan tribes from the northwest gained access to the subcontinent and merged with earlier Dravidian inhabitants. Uniting much of South Asia, the Mauryan dynasty ruled from 321 to 185 BC, followed by the reign of the Gupta dynasty from AD 400 to 600. The Gupta dynasty ushered in India's Golden Age, during which science, art, and culture flourished. Turks and Afghans invaded India throughout the tenth and eleventh centuries and established the Delhi Sultanate. The Emperor Babur established the Mughal dynasty in the early sixteenth century; the Mughals reigned for more than three centuries.

European explorers began establishing a presence in India during the sixteenth century, and, by the nineteenth century, Great Britain had become the dominant political power. Nonviolent resistance to British rule, led by Mohandas Gandhi and Jawaharlal Nehru, brought about India's independence in 1947. Violence and segregation resulted in India's divisions into two separate states: India and Pakistan. The two countries have fought three wars since independence, the last of which in 1971 resulted in East Pakistan becoming the separate nation of Bangladesh. Today, despite serious challenges such as overpopulation, environmental degradation, poverty, and corruption, rapid economic development has set India as a key player on the global stage.

Geography

India is located on the southern portion of the continent of Asia; it borders the Arabian Sea and the Bay of Bengal, between Burma and Pakistan. While India is the seventh largest country by geographical area – with a land mass slightly greater than one third the size of the United Sates – with more than 1.2 billion residents, it is the second most populous country and the most populous democracy worldwide. Mainland India is bounded by the Indian Ocean on the south; the Arabian Sea and Pakistan on the west; Bangladesh, Burma, and the Bay of Bengal on the east; and Bhutan, the People's Republic of China, and Nepal to the north. Geographically, India dominates the South Asian subcontinent; it is positioned near key Indian Ocean trade routes.

India's climate varies, from tropical monsoon in the south to temperate in the north. The terrain is varied also, characterized as upland plains (Deccan Plateau) in the south; flat to rolling plains along the Ganges; desert in the west; and mountainous (Himalayas) in the north. India's climate is influenced strongly by the Himalayas and the Thar Desert, both of which drive the monsoons of the area. The Himalayas prevent cold Central Asian katabatic wind from blowing in, keeping the bulk of the Indian subcontinent warmer than locations at similar latitudes. The Thar Desert plays a crucial role in attracting the moisture-laden southwest summer monsoon winds that provide the majority of India's rainfall. Natural resources include iron ore, manganese, mica, bauxite, titanium ore, chromite, natural gas, diamonds, petroleum, limestone, and arable land, as well as the fourth largest coal reserves in the world. In 1993, it was estimated that India's land usage included 56% arable land, 1% permanent crops, 4% permanent pastures, 23% forests and woodland, and 16% other.

India lies within the Indomalaya ecozone, contains significant biodiversity, and is 1 of the 17 megadiverse countries. Many of the country's ecoregions exhibit high rates of endemism; overall, 33% of Indian plant species are endemic. Potential natural disasters for the subcontinent are droughts, earthquakes, volcanic eruptions, severe thunderstorms, flash floods, as well as widespread and destructive flooding from monsoonal rains. In recent years, a volcano has been active on the Barren Island in the Andaman Sea. Currently, there are numerous environmental issues facing India, such as deforestation, soil erosion, overgrazing, desertification, air pollution from industrial and vehicle emissions, water pollution from raw sewage and runoff of agricultural pesticides, variability in tap water potability, and overstraining natural resources.

Culture

India has been home to the ancient Indus Valley Civilization, a region of historic trade routes, and many large empires. For much of its history, the Indian subcontinent was noted for its commercial and cultural wealth. Four of the world's major religions – Hinduism, Buddhism, Jainism, and Sikhism – originated here, while Zoroastrianism, Judaism, Christianity, and Islam arrived in the first millennium and shaped the region's diverse culture. Gradually annexed by the British East India Company from the early eighteenth century and colonized by the United Kingdom from the mid-nineteenth century, India became an independent nation in 1947 after a struggle for independence which was marked by a nonviolent resistance led by Mahatma Gandhi.

Characterized by a high degree of syncretism and cultural pluralism, a record of India's culture can be traced to 8000 BC. With roots based in the Indus Valley tradition, the Indian culture took a distinctive shape during the eleventh century BC Vedic Age, which laid the foundation of Hindu philosophy, mythology, literary tradition, and such beliefs and practices as dharma, karma, and yoga. It has managed to preserve established traditions while absorbing new customs, traditions, and ideas.

A chief aspect of Indian culture is formed by the various schools of thought and religious teachings developed in the region. Major dharmic religions that were founded in India include Hinduism, Buddhism, and Jainism. Hinduism has been shaped by the various schools of thought based on the *Upanishads*, the *Yoga Sutras*, and the *Bhakti* movement. Buddhism originated in India in fifth century BC, gained dominance during the Maurya empire, and played an influential role in shaping Indian philosophy and thought.

The diversity of Indian culture is reflected in its architecture, with notable references to Mughal, Dravidian, and Indian vernacular architecture. Mughal architecture, the distinctive style developed by the Mughals in the sixteenth and seventeenth centuries, is symmetrical and decorative in style. Dravidian architecture emerged thousands of years ago and consists primarily of a pyramid shaped step design consisting of many statues of deities, warriors, kings, and dancers. Indian vernacular architecture is the informal, functional architecture often found in rural areas of India. The builders of these structures are unschooled in formal architectural design and their work reflects the rich diversity of India's climate, locally available building materials, and the intricate variations in local social customs and craftsmanship.

Indian culture is reflected also in its rich literary traditions. Considered to be from the earliest and foremost era of Indian literature, the Vedic or Sanskrit literature was developed from 1400 BC to AD 1200. Prominent Indian literary works of the classical era include epics, dramas, and poetry. Sangam literature, developed between 600 BC and AD 300, consists of more than 2,000 poems and is regarded as a predecessor of Tamil literature. From the seventh century AD to the eighteenth century AD, India's literary traditions went through a period of drastic change characterized by varied thought and expression. During the nineteenth century, Indian writers took new interest in social questions and psychological descriptions and during the twentieth century, Indian literature was heavily influenced by the works of universally acclaimed Bengali poet and novelist Rabindranath Tagore.

One cannot examine current Indian culture devoid of the framework of the traditional Indian caste system, first postulated by the Brahminical texts found in Hinduism. It has been proposed by some that the initial purpose of the fourfold caste system was to categorize society in ways that furthered the well being of all of society by developing in each innate inclination toward social good. However, the practice has come to be viewed largely as a method of social stratification and social restriction. The original Indian caste system proposed in Hindu texts consists of four castes, or *varnas*: the *Brahmins* (poets, priests, teachers, scholars); the *Kshatriyas* (kings, agriculturists, and nobility); the

Vaishyas (merchants); and the *Shudras* (artisans, service providers. and laborers).

India's caste system has evolved over time to include numerous castes and subcastes, classifications that persist particularly in more rural areas and small towns. Despite recent attempts to do away with caste distinctions, to varying degrees, the practice still factors in Indian culture – in politics, for example. The Indian Government lists consist of Scheduled Castes (SC), Scheduled Tribes (ST), and Other Backward Classes (OBC).

The SC consist generally of *Dalit*, referred to also as *Outcaste*. Outcaste is a self-designation for a group traditionally regarded as untouchable and unsuitable for making personal relationships. Currently, the SC comprise 16% of the total population of India (around 160 million). Numerous castes come under the larger category of SC; for example, the Delhi state lists 49 castes as SC. The ST consist generally of tribal groups. The current ST population is 7% of the total population of India, approximately 70 million. More than 3,000 castes fall under the category of OBC. It has been estimated that this group forms between 32% and 52% of the total Indian population.

Economy

From 1947 to 1991, India was under social democratic policies and had an economy characterized by extensive regulation, protectionism, and slow growth. Continuing economic liberalization that began in 1991 has been the impetus for India's shift toward a market-based economy. The country experienced a revival of economic reforms and better economic policy in the first decade of the twenty-first century, which served to accelerate India's economic growth rate. In recent years, Indian cities have continued to liberalize business regulations. By 2008, India had established itself as the world's second fastest growing major economy.

India's large service industry generates 57% of the country's GDP, while the industrial and agricultural sectors contribute 28% and 14.6% respectively. More than half of the nation's 500 million workers are employed in agriculture; 34% are employed in the service sector; and approximately 14% are employed in the industry sector. Major agricultural products include rice, wheat, oilseed, cotton, jute, tea, sugarcane, potatoes, cattle, water buffalo, sheep, goats, poultry, and fish. Major industries include telecommunications, textiles, chemicals, food processing, steel, transportation equipment, cement, mining, petroleum, machinery, information technology-enabled services, and pharmaceuticals. During the years 2008 and 2009, India's top five trading partners were the United Arab Emirates, China, the United States, Saudi Arabia, and Germany.

Politics

India is a federation with a parliamentary government; it is a constitutional republic and a representative democracy. The Constitution of India, adopted in 1950, defines India as a sovereign, socialist, secular, democratic republic; it features a bicameral parliament that operates under a Westminster-style parliamentary system. Its form of government was traditionally described as being "quasi-federal"; however, as a result of political, economic, and social changes, it has grown increasingly federal since the late 1990s.

India's head of state, its president, is elected indirectly for a 5-year term by an electoral college. The Prime Minister is appointed by the President and is the head of the government, exercises the most executive power, and is supported by the party holding the majority of seats in the lower house of Parliament. The executive branch consists of the President, Vice-President, and the Council of Ministers. In the Indian parliamentary system, the executive is subordinate to the legislature, with the Prime Minister directly responsible to the lower house of the Parliament. The Legislature of India is the bicameral parliament, which consists of the upper house called the Council of States and the lower house called the House of People.

Education

In 2009, India passed a landmark act, the Right of Children to Free and Compulsory Education (RTE) Act. The legislation guarantees all children the right to quality elementary education by the state with the help of families and communities. India's education system has made significant progress over the past several decades. According to Education for All Mid-Decade Assessment, between 2000 and 2005, India increased primary school enrolment overall by 13.7% and by 19.8% for girls. Notably, the country has reached nearly universal enrolment in grade 1.

However, even with these commendable efforts, in 2005, one in four children left school before reaching grade 5, and almost half exited the system before reaching grade 8. Learning assessments indicate that the children who do remain in school are not learning the key skills necessary for their overall development. Although there have been significant improvements in the proportion of children from socially disadvantaged groups in school, gaps remain. Girls are still less likely to enroll in school than boys; in 2005, for grades 6–8, girls' enrolment was still 8.8% less for ST and 3.4% for SC.

Previously referred to by the British as the *depressed classes*, ST and SC are Indian population groupings that are explicitly recognized by the Constitution of India. The proportion of SCs and STs in India's population has risen steadily since independence in 1947; together, the groupings comprise over 24% of India's population. Per the 2001 Census, SCs formed 16% of India's total population, while STs made up 7.5%. Recognized as depressed or underserved, India's Constitution puts forth general principles for the policy of affirmative action for the SCs and STs.

Health Care

Health care in India is comprised of a universal health care system run by the constituent states and territories. Treatment at government hospitals is provided without charge or with a minimal charge, and most essential drugs are offered free of charge. In-hospital treatment costs are dependent on the financial condition of the patient and facility, but they are much less costly usually than the private sector.

India's health care system has improved over the last several decades, although it continues to lag behind those of its neighboring countries. The poor state of health care may be attributable to the lack of government funding on health care initiatives; estimates suggest that health care spending per capita by the Indian Government is well below international recommendations. In spite of a steady increase in medical establishments, severe shortage remains still in number of medical facilities and health care personnel. India scores poorly on most generally accepted health indicators.

Of late, as India's health care needs have increased, so has the role of the private sector. Public–private partnerships have emerged also as a potential means of growing the health care sector while keeping public goals in mind. It is expected that the private sector will continue to take on an increasing significant role in India's health care system. This growth is expected to be driven by factors that include rising life expectancy, rising income, increasing health insurance, government action, and rising incidence of lifestyle-related diseases.

Primary care is focused on immunization, prevention of malnutrition, pregnancy, child birth, postnatal care, and treatment of common illnesses. Patients who receive specialized care or have complicated illnesses are referred to secondary and tertiary care hospitals. The country suffers still from high rates of malnutrition and disease and a lack of safe drinking water and proper sanitation facilities, especially in rural areas. India suffers high incidence rates of malaria, polio, tuberculosis, and AIDS. Furthermore, according to the World Health Organization, contaminated water or air attribute to more than 900,000 deaths each year in India. As India grapples with basic health needs, new challenges are emerging with rising rates of chronic adult diseases associated with changing lifestyles. India faces significant manpower shortages. It is estimated, for example, that 700 million persons have no access to specialist care. Notably, 80% of specialists reside in urban areas. Furthermore, in terms of availability of hospital beds per 1,000 persons, with a worldwide average of 3.96 hospital beds per 1,000, India stands just a little over 0.7 hospital beds. Better policy regulations and the establishment of public–private partnerships are possible solutions to the problem of manpower shortage.

Concurrent with the gaps in health care delivery are entities that meet or exceed international quality standards, and the medical tourism business in India has been growing in recent years. The country is a popular destination for medical tourists who receive effective medical treatment at costs lower than in developed countries. Many Indian hospitals are attracting foreign patients by promoting their international quality of health care delivery and by turning to international accreditation agencies to standardize their protocols and obtain the required approvals on safety and quality of care.

Brain Drain

While India struggles with meeting the basic health needs of its population, eliminating disparities in the quality of care, and combating emerging diseases concomitant with a changing lifestyle, a disquieting potential is looming, threatening to exacerbate that country's challenge to improve the overall quality health staffing, for example, between the United Kingdom and India. India has fewer than 3,000 psychiatrists for its one billion residents compared with one psychiatrist for every 9,000 persons in the United Kingdom. This represents a 27-fold difference between the countries. Despite this inequality, however, the National Health Service (NHS) has launched a scheme to recruit senior psychiatrists and other specialists from India and other developing countries.

Although the recipient nations and the immigrating physicians benefit, the proposed recruitment plan threatens to worsen inequities in global health. Furthermore, as physicians migrate, less developed countries lose important health capabilities as a result of the increased physician shortage. One method of mitigating the brain drain phenomenon is to attach explicitly linked measures to enable the flow of doctors back to developing countries. Many familiar with the struggle of developing nations to meet health challenges have suggested that institutions in developed countries have an ethical obligation to facilitate the return of health professionals to their countries of origin. The following measures have been proposed as a means of facilitation: flexible training schemes that permit doctors from developed countries to work in developing countries; long-term partnerships to strengthen the research, clinical, and teaching infrastructure of institutions in developing countries; grants to enable returning doctors to establish personal and professional lives; and ongoing auditing of overseas doctor training schemes in terms of proportion of doctors who return home.

Migration

India has a diverse and complex migration history. In fact, since the nineteenth century, ethnic Indians have established communities on every continent of the globe. The flows have been comprised of such groups as indentured labor in far-flung colonies, postwar labor for British industry, high-skilled professionals in North America, and low-skilled workers in the Middle East. In addition, ethnic Indians in countries like Kenya and Suriname have migrated to other countries, a movement called secondary migration.

There have been several large waves of emigration from India. Upon independence from British rule in 1947, British India was divided into predominantly Hindu India and predominantly Muslim Pakistan. This division was the impetus for an enormous migration that occurred between 1947 and 1950, estimated at 12–18 million people. About half of the migrants, predominantly Muslims, moved to Pakistan and half, predominantly Hindus and Sikhs, moved in the opposite direction. This migration was accompanied by severe violence between caravans of migrants and those in the source regions; death toll estimates stand between 200,000 and 1 million people. Also, in 1971 during the war in East Pakistan that led to the formation of Bangladesh, around ten million refugees, approximately 80% of them being Hindus, crossed the border into India. It is estimated that 35,000 remained in India, mostly in West Bengal.

Internal Migration

India's Constitution guarantees its citizens the right to move freely within the country; as such, internal migration occurs within and between states. India's population, in 2009, was estimated at 1.17 billion, with an estimated 20 million internal migrants. The majority of internal migrants work as temporary migrants in construction, agriculture, and manufacturing. As for interstate migration, frequently persons from the states of Bihar, Uttar Pradesh, and Rajasthan in northern India move to New Delhi, Gujarat, or Maharashtra, while in South India, persons from Tamil Nadu move to Kerala, Karnataka, and Maharashtra. While these are the primary internal migration corridors, there are numerous secondary corridors. Although internal mobility is critical especially to the livelihoods of people from economically marginalized areas, the country's high degree of ethnic, linguistic, and religious diversity means that internal migration can have the same challenges for internal migrants, including xenophobia, as faced by internal migrants in other countries.

Refugees and Asylum Seekers in India

Although not a party to the 1951 Refugee Convention and its 1967 Protocol, traditionally India has treated refugees well. Notably, the Dalai Lama found refuge in India when he fled Tibet in 1959, as the country permitted him to set up a government-in-exile in Dharamsala. For example, while not officially recognizing it as a government, the Indian government allows the Central Tibetan Administration autonomy in public education. It is estimated that there are 110,000 Tibetans currently living in India. Approximately 80,000 Tibetans arrived in the first wave of migration. The Indian government offered permits and low-paying public works jobs; however, more recent Tibetan refugees have not been as welcome, as many have been denied resident permits.

Another wave of migrants sought refuge in India when an estimated 60,000 Afghans fled to India after the Soviet Union invaded Afghanistan in 1979, and thousands more came when the Taliban took power in 1992. Since 2001, the United Nations High Commissioner for Refugees (UNHCR) has helped some 500 return and 650 to resettle to third countries, mostly to the United States, Canada, and Australia. Recently, the Indian government has agreed to naturalize many of these Afghans who have lived in India since 1979.

Indian Student Migration

According to the United Nations Education, Scientific, and Cultural Organization (UNESCO) Institute for Statistics, the number of Indian students abroad tripled from approximately 51,000 in 1999 to over 153,000 in 2007. Thus, India ranks second among the world's largest countries sending students abroad. Five receiving countries accounted for 90% of all Indian students abroad. The United States is by far the most important destination country, receiving more than half of the worldwide expatriate Indian student force in 2006–2007, followed by Australia (16%) and the United Kingdom (15%).

Migration Outlook

Although ethnic Indian communities in receiving countries such as the United States and the United Kingdom have realized a measure of economic success and have achieved mostly peaceful integration, in many other receiving countries, millions of ethnic Indians have limited rights and less secure futures. The Indian government has demonstrated a commitment to differing groups abroad, and investment and return to India have become easier for the more well-off members of the diaspora. Those on temporary contracts have benefited from more government preparation before their departure and from more efficient remittance systems.

Although India has long served as a destination for economic migrants and refugees from neighboring countries, its policymakers have yet to address clearly the challenges related to illegal immigration. In an effort to address illegal immigration, in 2009, the government initiated a process to provide forgery-proof identity cards to all nationals. With regard to refugee-related policies, both UNHCR and India's National Human Rights Commission have urged the Indian government to ratify the refugee convention and its protocols and to enact special legislation related to refugees and child refugees. After all, India is a country people also immigrate to, rather than merely a country people leave.

Related Topics

- ► Brain drain
- ► Emigration
- ► Health care
- ► Health disparities
- ► Refugee

Suggested Readings

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Suggested Resources

For information about India from the World Health Organization (WHO). http://www.who.int/en/

For information about India from the United Nations. http://www.un.org/en/index.shtml

For information about Indian migration. http://www.migrationinformation.org/index.cfm

Individualism

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Individualism has typically been defined in terms of autonomy, individual responsibility, rights, and self-sufficiency and advocates that humans are rational beings, able to use reason to make rational decisions and personal choices. Within individualism, at the interpersonal level, social relationship ties are seen as impermanent as individuals continuously weigh the costs and benefits of social relations and transition out of them when costs are too burdensome suggesting individual initiative and choice. Individualism not only refers to the self, but also describes values, norms, attitudes, and behaviors.

Health care policies informed by the ideology of individualism are problematic particularly in the area of immigrant health. Immigrants often lack full participation in the political and economic systems that create and sustain health care. Thus, their health care choices, or rather options, are not always autonomous, voluntary, or based on equal status in the same way as native-born individuals. Individualism's focus on individual motivation, assertiveness, lifestyle, and choice obscures the role of society and its social structures in shaping health services and therefore personal health outcomes. Structural factors such as socioeconomic status, residential location, racial and ethnic discrimination, and marginalization constrain immigrant health care options. In addition, immigration status, language barriers, and issues related to acculturation further limit immigrant health care access and practices. Due to these and many other factors, immigrants utilize health services less often and have worse health outcomes than native-born individuals. Utilization and responsibility for health care framed within an individualistic model masks these structural limitations.

A changing global economy also strains opportunities of immigrants to shape their personal health. Global economic and financial pressures have resulted in more health care costs being forced onto individuals even in universal health insurance programs as a means of reducing national health care debt, as is occurring in Canada. In the US where undocumented and legal immigrants are ineligible for public health care programs such as Medicaid, individual responsibility for health care grows while government accountability declines. Such health policies are aimed at discouraging foreign-born individuals who may be interested in public health benefits from initially immigrating. Yet, restrictive health philosophies such as this miss the point. As numerous studies show, a desire for jobs and not health care fuels immigration. Limiting immigrant access to health care providers and regular care through public health care programs overwhelms secondary health care systems including emergency rooms. These health rules, as well as new immigration policies that place restrictions on immigrants' opportunities to adjust their illegal status, increase the number of undocumented immigrants and negatively influence their health care utilization and outcomes.

In the US, policies surrounding immigrant health care have paralleled general immigration policies over the past century. Individualism, informed by the ideology of traditional liberalism with its focus on individual liberty, self-definition, and moral worth, coupled with a need for populating the country at the time, was the backdrop of the early immigration policy of open borders and easy access to citizenship prior to the 1880s. But these immigration policies were eventually challenged by exclusionary impulses and practices that changed the outlook for immigrant groups. The new ideology and legal structures that emerged favored immigration less so that an individual's natural right to pursue their own self-interest were circumscribed and regulated by a new individualistic ideology focused on consent, national sovereignty, and national community. The result is that immigrants' supposed natural rights to pursue their own self-interest in the US were curbed as a result of these policy changes. Health policies in the US that favor restrictive immigrant health policies inevitably increase immigrants' vulnerabilities. Although health care in the US, and in many other nations, is embedded in individualistic values, the status of immigrant health care demonstrates that the principles of individualism such as personal independence and decisions, and rights and responsibility for health care choices are more often absent and ineffectual with regard to immigrant health experiences. Ultimately, national health and immigration policies such as those in the US, as well as structural constraints inhibiting immigrant access to adequate health services, may have greater influence in shaping health outcomes than individual expressions of free will and choice.

Related Topics

► Assimilation
► Community

- ► Cultural background
- ► Immigrant health disparities
- ► Nativism

Suggested Readings

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Suggested Resources

Resources on immigrants and health care coverage. http://www.kff.org/uninsured/immigranthealth.cfm.

Infant Health

- ► Childhood injuries
- ► Immunization
- ► Infant mortality
- ► Pediatrics

Infant Mortality

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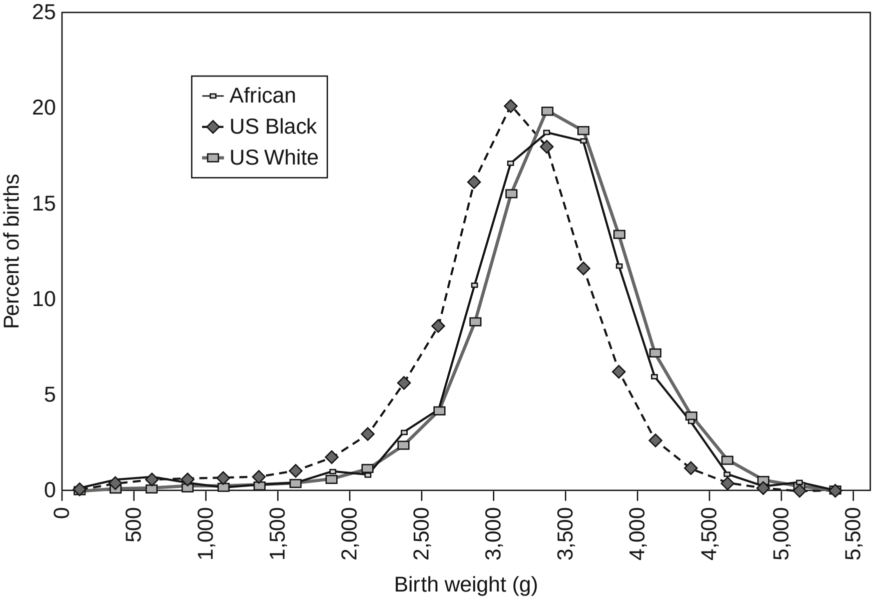
Infant mortality, that is, the number of deaths in the first year of life per 1,000 live births, more than any other population health indicator, reflects the well-being of a society. It is intimately connected to the rate of preterm birth (and its proxy, low birth weight) since the organism's maturity at the moment of biological separation from its mother to a great extent determines the success of the transition to independent existence. The relation between the rate of first year deaths and social conditions in which the birth occurs has been written about at least since the publication of Engels's classic *The Condition of the Working Class in England* in 1845. Unlike the situation prevailing in the nineteenth century, however, a full picture of population health today requires a study of social conditions in more than one country. This reflects the large and growing number of people who emigrate from their country of birth to a new land. Immigrant women give birth to about one quarter of infants born in the United States and some European countries each year, increased from under 10% just 30 years ago.

The range of infant mortality rates in different countries is quite wide, reflecting the wide gulf between social and economic conditions in different parts of the world. According to the World Health Organization, the risk of death for a newborn baby ranges more than 20-fold between countries. International comparisons are complicated because of different levels of accuracy and completeness in recording of vital events, but clearly huge differences exist between different parts of the world and societies of different levels of wealth. Interestingly, among countries of a moderate to high economic level income inequality in the population, as opposed to average income, becomes an equal or stronger predictor of first year death. Of course, within-country rates also vary strikingly by social class and by "race" or ethnic group. Finally, within a given ethnic group giving birth in a given country, there are differences between outcomes of women born in that country and those who have immigrated there from their country of birth. The specific issues surrounding infant mortality among immigrants, compared to the population of their host country and to their population of origin, are the focus of this article.

Racialist theories to explain health problems in immigrants were popular in the receiving countries in the late nineteenth and early twentieth century. For example, the high rate of rheumatic heart disease in Irish immigrants to the USA, now understood to be mediated by higher prevalence of rheumatic fever caused by crowded living conditions, was at one point hypothesized to be a constitutional predisposition linked to the gene for red hair. Similar theories to explain health disparities between people of European and those of African ancestry continue to be advanced, although they have been repeatedly shown to be at odds with most empirical research from population genetics and epidemiology. The genetic theory of "racial" differences in birth weight has been seriously challenged by observations that women immigrating to the USA from Africa have infants with a birth weight pattern closer to that of US-born White women than that of US-born Black women (Fig. 1).

In many respects, immigrants in various countries fare better than expected for their level of income and education. In many cases they are healthier than native-born individuals of a comparable socioeconomic stratum. This is true for a variety of health measures but clearly the case for birth outcomes. A number of theories have been advanced to explain this so-called "epidemiologic paradox." It is likely that more than one hypothesized process is at work in various national contexts. For example, women immigrating to Taiwan were less likely than Taiwan-born women to have an infant of low birth weight. In that case, selective immigration of healthier individuals, the "healthy migrant" theory, appears to fit the data best. In the United States, birth weight advantage in the immigrant generation is related to the country of origin. Women whose race is listed as "White" on the birth certificate (the US still records "race" on its vital records) and who immigrated from Europe enjoy a negligible advantage compared to US-born White women, approximately 15 g. In contrast, Mexican immigrants have about a 60 g advantage over US-born women of Mexican descent. Black women immigrating from African or Caribbean countries have about a 180 g birth weight advantage over US-born Black women. All of these differences disappear in the next generation. The correlation of the protective birth weight effect in the immigrant generation with the socioeconomic hierarchy of ethnic groups that obtains in US society has led investigators to interpret these observations as reflecting the physiologic effects of perceived racial discrimination and institutional racism, leading to chronic stress.

Support for the discrimination-stress hypothesis also comes from studies of birth outcomes in women with different lengths of time between immigration and giving birth. In a study of approximately 75,000 women immigrating to Canada, compared to about 400,000 Canada-born women, there was a measurable birth weight advantage from 0 to 5 years after



Infant Mortality. Fig. 1 Distribution of birth weights among infants of U.S.-born White and Black women and African-born Black women in Illinois, 1980–1995 (David & Collins, 1997, © 1997 Massachusetts Medical Society. All rights reserved.)

immigrating, decreasing in the 5–10 year post-immigration group and becoming a disadvantage in those with Canadian residence more than 10 years. This was true for women coming from a variety of home countries, although the protective effect in the early years was strongest for women from sub-Saharan Africa or the Caribbean.

A meta-analysis of 133 reports of birth outcomes among immigrants does show an overall trend toward higher infant and fetal death rates among some immigrants to the USA and Europe, especially those from sub-Saharan Africa and the Caribbean. This is interesting since no birthweight disadvantage (or often an advantage) was noted when compared to the population of the receiving country. One possible explanation for this apparent contradiction would be the combined effects of two epidemiologic phenomena related to immigration. The mass of immigration into many host countries is driven by economics, with immigrants seeking improved opportunities for their families. However, superimposed on this migration are special situations such as refugees and asylum seekers, many of whom may have health and nutrition problems related to internment prior to arrival in their new country. There is also anecdotal evidence for "medical migration" in which individuals at risk for adverse health outcomes arrange to give birth in a country with more sophisticated healthcare services. Support for this notion was reported in a large study of African immigrants to the USA. These investigators showed overall similarity of birth weight distribution between Africa-born Black women and US-born White women as noted above, but also a high rate of very low birth weight premature infants, a group with 15-times higher mortality than the general birth population. African immigrant women giving birth to these very small infants were more likely to have had prior pregnancy losses. Selective "medical immigration" is speculated to have played a role in some of those cases.

With almost 200 million people migrating between countries every year by some estimates, the impact of immigration on the health of the migrants and the populations they merge into will be of increasing importance. Infant mortality and related birth outcomes are increasingly viewed from a life-course perspective. The physiological, nutritional, and psychosocial influences on females from fetal life through infancy, childhood, and adolescence impact childbearing health. That these factors will be significantly different for women born, and perhaps raised, in a very different national context is clear. However, much work remains to sort out the most important factors and their mechanisms of action. Implications for clinical management as well as targeted public health interventions are only beginning to become clear as research in this important area begins to accumulate.

Related Topics

- ► Birth weight paradox
- ► Racial disparities

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Infectious Diseases

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Introduction

Infectious diseases are a significant cause of morbidity and mortality worldwide, with the major burden occurring in developing countries. human immunodeficiency virus (HIV), tuberculosis (TB), malaria, and respiratory and diarrheal illnesses have led to over five million deaths each year. Developing countries are both the source and host to most of the global population of refugees, who are at risk of these and other infections.

Refugees have multiple risk factors for infectious diseases in their countries of origin, transit, and settlement. Source countries are typically characterized by conflict, with the disruption of basic infrastructure such as sanitation, health services, and vaccination programs. Living conditions in transit countries, both in refugee camps, or other situations, are frequently crowded and unsafe. People may also lack basic requirements, such as access to clean water, a regular food supply and health care. Other risk factors for infectious diseases in refugees include inadequate immunization, lack of access to barrier contraception and exposure to sexual violence. Stress associated with trauma and migration may affect the manifestation of infectious diseases; for example, the risk of developing tuberculosis disease is highest in the initial years after migration.

Refugees settling in more economically developed countries may have undiagnosed and/or untreated infections, which can cause long-term complications and chronic ill health. Some of these infections are latent, meaning the person feels well and may not seek assessment. Health screening and disease prevention may be a low priority for refugees arriving in a new country, especially in the early stages of settlement and diagnosis, and treatment of infectious diseases is often poor. Health providers in the country of settlement may be variably familiar with infectious diseases in refugee populations, and may not consider relevant differential diagnoses, or perform appropriate screening. Refugees may face barriers to accessing health care in their country of settlement. In general, the risk of transmission of infectious diseases to others in the host country is very low.

Health Screening in Refugee Populations

There is general consensus that refugees settling in developed countries need health screening. Screening protocols vary depending on the countries of origin/transit and the country of settlement. Health screening may be completed offshore (prior to leaving for the country of settlement) or after arrival in the new country (onshore or domestic screening) and may include presumptive treatment for infectious diseases. Many countries use a combination of both offshore and domestic health screens. Examples of current protocols are shown in Table 1.

Health screening also varies according to how refugees arrive in a new country. The majority of the world's refugees are hosted by neighboring developing countries and do not have specific health screening based on their refugee status. A small number of refugees applying for resettlement through the United Nations High Commissioner for Refugees (UNHCR) are offered permanent resettlement in a developed country and may undergo offshore screening. Alternatively, refugees may arrive in a developed country by boat, or on a short-term visa or permit, and then seek asylum (onshore processing). In this situation, access to health screening depends on their asylum status and access to local health services.

Infectious Diseases in Refugees

Infectious diseases in refugees can be considered in six main groups: Tuberculosis, blood-borne viruses, parasitic infections, other gastrointestinal infections, vaccine-preventable diseases, and sexually transmitted infections. There may be multiple concurrent infectious diseases to consider in a refugee patient, in addition to their other health issues.

Tuberculosis

Tuberculosis (TB) is caused by organisms from the *Mycobacterium Tuberculosis* complex and is the second most common cause of death from infectious diseases worldwide. In 2008, there were an estimated 9.4 million incident cases of TB, 11.1 million prevalent cases of TB and 1.3 million deaths from TB in HIV negative people, and an additional 0.52 million deaths from TB in people with HIV.

One third of the world's population has been exposed to TB, however only 5–10% of those exposed will develop active disease. People can develop TB disease after their initial exposure (primary disease) or after a period of latent infection (reactivation disease). Latent TB infection (LTBI) refers to the situation where a person is infected with small numbers of TB organisms, but does not have symptoms or features of TB disease. TB disease occurs most commonly in the lungs (pulmonary TB), but may occur at any site in the

Infectious Diseases. Table 1 Health screening for infectious diseases in refugee populations: examples of protocols

Country and approximate annual intake	Offshore screening	Presumptive treatment	Onshore	Specific details
USA 60,000	Medical examination: all ages	Directly observed treatment for malaria with artemether-lumefantrine completed within 3 days of departure, directed treatment used for pregnant women or babies <5 kg weight	TB – follow-up for treated active disease, LTBI and contacts	HIV testing no longer required in offshore screening (from January 2010)
	TB screening:			
	Age < 2 years: where clinical assessment suggests TB, or HIV positive: TST or IGRA, CXR and 3 sputum samples		HIV testing aged 13–64 years, and aged $\leq$ 13 years unless maternal status negative and no risk factors	
	Age 2–14 years: TST or IGRA, CXR if +	Treatment for intestinal parasites varies with area of origin (CDC 2010):	Presumptive treatment for malaria for refugees from sub-Saharan Africa if not given offshore	Culture of sputum specimens, drug susceptibility testing, and use of DOTS introduced since 2007
	Age $\geq$15 years: CXR, TST, or IGRA based on prevalence area origin, if assessment suggestive three sputum samples with culture, drug susceptibility testing if +	Middle East, South/Southeast Asia: Albendazole/Ivermectin	Screening for intestinal parasites varies with offshore screening completed and presence of eosinophilia	
	TB disease treated using DOTS predeparture, no travel until treatment completed	Africa (areas without Loa loa): Albendazole, ivermectin, praziquantal	Serologic testing for syphilis aged $\geq$ 15 years (regardless offshore results) and age $<$15 years with risk factors	
	Malaria screening for pregnant/lactating women and children $<$5 kg (otherwise presumptive treatment)	Africa (areas with Loa loa) Albendazole, praziquantal	Chlamydia NA amplification tests females $\leq$25 years, or older females/children with risk factors	
	Serologic testing for syphilis		Gonorrhea NA amplification tests in people with symptoms or urine dipstick suggestive and children with risk factors	
	Clinical examination for other STIs		Vaccination requirements must be met to obtain legal permanent resident status (12 months after arrival)	
	Vaccination proof not required for refugees (required for other permanent immigrants)			

Australia 13,500	Medical examination: all ages	Additional predeparture medical screen (not universal) includes albendazole and MMR vaccination, also RDT malaria and	Recommended (ASID 2009):	A diagnosis of tuberculosis disease in off shore screening delays travel
	FWTU aged $\geq$5 years		Hepatitis B serology	
	CXR aged $\geq$11 years		Hepatitis C serology	
	HIV aged $\geq$15 years		HIV testing	
	Hepatitis B pregnant women, UHM		TB screening	
	Hepatitis C applicants deemed "high risk" by examining doctor		Schistosoma serology	
	Syphilis serology aged $\geq$15 years from refugee camps		Strongyloides serology	
			Syphilis serology	
			Malaria films/RDT	
			Fecal specimen	
			Urine chlamydia	
			Urine gonorrhea	
			Other tests frequently performed include:	
			Full blood count, glucose, ferritin, folate, B12, vitamin A, vitamin D, Measles, rubella, tetanus serology, chest X-ray	
Canada 11,000	Medical examination: all ages	No	No standardized post arrival health screening recommendations	Positive HIV status does not preclude migration
	CXR aged $\geq$ 11 years			
	FWTU aged $\geq$ 5 years			
	Syphilis serology aged $\geq$ 15 years			
	HIV testing			
	TB disease treated prior to travel			

Infectious Diseases. Table 1 (continued)

Country and approximate annual intake	Offshore screening	Presumptive treatment	Onshore	Specific details
UK	No	No	TB screening (CXR) at ports of entry on arrival for people staying in the UK for longer than 6 months	
Few UNHCR refugees, large numbers onshore asylum seekers			Routine health care generally provided through the National Health Service for asylum seekers (free of charge) Voluntary HIV screening for asylum seekers coming into the UK Comprehensive screening for infectious diseases encouraged as part of an integrated primary care resource. Health screening offered to those asylum seekers in designated reception centers	
European Union 330,000 asylum claims	Generally not used	No	Varies. A 2004 survey reported:	
			TB screening in 22 countries (compulsory in 12)	
			HIV screening in 19 countries (compulsory in 5)	
			Emergency care at time of arrival only – 12 countries	

Based on 2008 UNHCR figures

Note: only screening directly related to infectious diseases included in this table, other health checks recommended

Albendazole used for presumptive treatment of helminths

Ivermectin used for presumptive treatment of strongyloides

Praziquantal used for presumptive treatment of schistosomiasis

UHM unaccompanied humanitarian minors

NA nucleic acid

body. The classic presentation of pulmonary TB is a productive cough associated with fevers, malaise, and weight loss. Children aged less than 5 years are at higher risk of developing TB after exposure and have a higher risk of disseminated TB disease.

Screening for tuberculosis is a cornerstone of health assessments for all new migrants in many countries (not just refugee entrants). Protocols vary, but most include a chest X-Ray (CXR) for adolescents and adults, with further investigations based on the results of a medical assessment and the CXR findings. Mantoux testing (a skin test) and/or interferon gamma release (IGRA) assays may also be used in predeparture screening for people from areas with a high prevalence of TB. The assessment of children is usually limited. People diagnosed with active TB disease may be offered treatment. Successful completion of treatment is a mandatory condition of immigration for countries such as the USA and Australia.

LTBI can be identified by scarring on a chest X-ray, a positive Mantoux test or a positive IGRA test in a person without features of active TB disease. People with LTBI have a lifetime risk of developing TB disease of up to 10%, although the risk is higher in children, adolescents, and people with HIV. This risk can be reduced by preventive treatment with an anti-TB medication over 6–9 months. Treatment of LTBI is generally recommended in developed countries.

Refugees are at high risk of developing TB disease. They have often lived in countries with high rates of TB infection, crowded living conditions facilitate transmission, access to adequate treatment is variable for cases, and the risk of developing TB disease is increased in the first years after migration. Recent research has shown that low vitamin D is associated with both active tuberculosis and latent TB infection in refugees from sub-Saharan Africa settling in Australia. Low vitamin D is increasingly recognized as a health issue in dark-skinned refugees settled in areas of high or low latitude, and in women who wear covering clothing for religious or cultural reasons.

The prevalence of positive TB screening results in refugee groups settling in developed countries is high, and foreign-born people account for over half the cases of TB disease in the USA, Canada, and Australia. Refugees have a higher prevalence of TB disease than other migrants. A large study of US-bound migrants over 1999–2005 found the prevalence of smear negative TB disease in refugees was 1,036 cases per 100,000 people and the prevalence of inactive TB (CXR suggestive of old TB changes) was 2,838 per 100,000 people, which was threefold higher than other immigrants. Other studies have examined TB screening tests and found the prevalence of positive results (suggesting LTBI) was 35–60%.

Blood-Borne Viruses

HIV/AIDS

The human immunodeficiency virus (HIV) invades specific cells of the immune system, leading to the acquired immune deficiency syndrome (AIDS). The World Health Organization (WHO) estimates that in 2008 there were 33.4 million people living with HIV, 2.7 million new infections with HIV, and 2 million AIDS-related deaths worldwide; the majority of HIV is acquired by heterosexual sexual contact, although a significant number of children acquire HIV "vertically" (at birth or by breast feeding from an HIV-infected mother). In many parts of the world, injecting drug use and unsafe medical practices are additional routes of acquisition.

Many refugees come from countries with high rates of HIV infection. Although refugees are often screened prior to arrival, and a positive test may preclude immigration, cases of HIV are still identified in refugees after settlement. This can be due to poor test quality, delay between the time of testing and the time of arrival, or infection with HIV during return trips or while living in the new host country.

Very effective treatment is available for HIV; however this is expensive, and can have significant side effects. There is no cure or vaccine, despite ongoing research.

Hepatitis B

Hepatitis B is a viral infection that primarily affects the liver, causing inflammation. Worldwide, two billion people have been infected with the virus and 350 million have chronic infection. Up to 1.2 million people die each year from the complications of hepatitis B, including liver failure, cirrhosis, and liver cancer.

Hepatitis B can be acquired sexually, by contact with infected blood, or transmitted vertically (from mother to child) or horizontally (between children or household contacts). In developing countries, the majority of infection occurs at birth or in early childhood. People who acquire hepatitis B at birth or in early childhood are less likely to have symptoms when they acquire the infection, but are much more likely to develop chronic infection that persists for life. Hepatitis B infection can be prevented by vaccination; however, most refugee source countries in recent years do not include hepatitis B vaccination in their national immunization schedules.

Refugees have high rates of chronic hepatitis B infection and should be offered screening. The prevalence of hepatitis B infection in refugee cohorts settling in developed countries is generally reported at 5–9% although a prevalence of over 10% is noted in some groups. Many refugees originate from countries with a high prevalence of hepatitis B, especially those from Asia, the Middle East, and Africa. If refugees do not have evidence of infection or immunity to the virus, they should be offered vaccination.

People with chronic hepatitis B infection require long-term follow-up, monitoring, and surveillance for complications. Chronic hepatitis B can be treated with antiviral medications or interferon; however, these treatments are expensive and have side effects.

Parasite Infections

Malaria

Malaria is a potentially fatal parasitic infection spread by mosquitoes. Some forms of the parasite can lay dormant in the liver for extended periods. Over half of the world's population lives in malaria-endemic areas, and in 2008 it was estimated there were 247 million cases worldwide, leading to nearly 1 million deaths. Refugees who arrive from malaria-endemic areas should be screened for malaria. Symptoms of malaria can be nonspecific; people may present with cough, abdominal pain, headache, or vomiting. Young children (below 5 years) have a higher risk of rapid deterioration and severe disease. It is crucial for clinicians to consider the possibility of malaria in any new immigrant who has a fever, even after more than a year in the new country. Treatment is readily available and very effective.

Schistosomiasis

Schistosomiasis (also called bilharzia) is a trematode (fluke) infection transmitted by skin contact with contaminated fresh water. Schistosomiasis affects over 200 million people worldwide, with the greatest burden of disease in Africa. Five main species cause disease in humans. The parasite lives in the blood vessels around the gut or urinary system (depending on species) and can survive for many years after the initial infection. The manifestation of disease is determined by the species and the immune response to the parasite. Schistosoma infection may be asymptomatic, or it may cause gastrointestinal symptoms (such as abdominal pain, diarrhea, or blood in the feces) or urinary symptoms (blood in the urine). Chronic *schistosoma* infection is associated with liver disease, portal hypertension, and bladder cancer.

Schistosomiasis is common in refugees who have arrived in developed countries, even years after resettlement. Around 20% of African refugees have schistosomiasis in studies from Australia, New Zealand, and the USA, although a higher prevalence (up to 44%) is reported in Sudanese refugees arriving in the USA. Schistosomiasis is also occasionally seen in refugees from the Middle East and South Asia. Predeparture empiric treatment with the medication praziquantel may be used; however, many refugees remain untreated. Screening recently arrived refugees and treating people with positive results with a short course of cheap and effective medication is an appropriate strategy to prevent long-term disease complications.

Strongyloidiasis

Strongyloides stercoralis is a helminth (worm) that is transmitted by skin contact with soil containing infective larvae. Humans are the definitive host. Strongyloides infection is endemic in tropical regions; worldwide, 100 million people are thought to be infected. The parasite can reproduce within the human host and infection can persist for more than 40 years if left untreated. People with Strongyloides infection can develop a hyperinfection syndrome (with overwhelming fatal infection) if they become immunosuppressed for any reason.

Predeparture presumptive treatment with single-dose albendazole therapy is used by several countries. This reduces infections with other soil-transmitted helminths; however, it is inadequate treatment for Strongyloides infection. Newer predeparture protocols include ivermectin, which is a more effective treatment for Strongyloides. Refugees should be screened for Strongyloides infection after arrival, unless they have clear documentation of predeparture treatment. Infected individuals should be offered a course of treatment and followed up, to document cure.

Other Gastrointestinal Parasites

People in the developing world frequently have infestation with other intestinal helminths (worms) or protozoan parasites such as *Giardia intestinalis* or *Entamoeba histolytica*. Other helminths include roundworms (*Ascaris lumbricoides*), whipworms (*Trichuris trichiura*), and hookworms (*Necator americanus* and *Ancylostoma duodenale*). These infections are spread in conditions of poor sanitation. They may be asymptomatic, or they may cause diarrhea, abdominal pain, malaise, weakness, and poor nutrition, depending on the type of infection(s). Anemia is a significant problem with hookworm infestation.

Treatment is generally straightforward, and in immigrants who have moved to conditions of good sanitation, reinfection is unlikely. Many refugees who have a health check overseas are given empiric treatment for gut parasites. This treatment is generally more effective for helminths than protozoal infections. Refugees with gastrointestinal symptoms after settlement require further screening and treatment.

Other Gastrointestinal Infections

Helicobacter pylori

Helicobacter pylori is a bacterium that colonizes the stomach. Half of the world's population is thought to be infected with *H. pylori* and most *H. pylori* are acquired in childhood. The bacteria are found in all populations worldwide and colonization can be lifelong. Rates are much higher in the developing world. Infection with *H. pylori* causes gastritis (inflammation of the lining of the stomach), peptic ulcer disease, and gastrointestinal malignancy. Currently, most guidelines do not recommend screening for *H. pylori* in adults without symptoms; however, we would recommend a low threshold for testing in refugees with gastrointestinal symptoms, and treatment for people found to have *H. pylori* infection. The significance of *H. pylori* infection in children and the relationship between infection and symptoms is not clear.

Vaccine-Preventable Diseases

Many refugees who arrive in the developed world have not had complete vaccination, and very few have written records of immunization. Refugees are at high risk for inadequate immunization for many reasons, including disruption of health services in their countries of origin, poor-quality vaccines, reduced access to vaccines, and difficulties completing catch-up vaccination after settlement. Studies have shown that catch-up vaccination is often not considered and that rates of vaccine coverage in immigrants are low.

All refugees should have an assessment of their vaccination status. Catch-up immunization is recommended if there is no written record of immunization, although a BCG scar is considered adequate evidence of BCG vaccination (for tuberculosis). Catch-up immunization will vary depending on national protocols; however, it usually includes coverage against tetanus, diphtheria, pertussis (whooping cough), measles, mumps, rubella, and polio, and can also include other vaccines such as *Haemophilus influenzae* type B, meningococcal, pneumococcal, and hepatitis A and B vaccines. Clinicians need to be alert to the development of vaccine-preventable diseases in the immigrant population due to the low vaccination rates.

Sexually Transmitted Infections

Many refugees have been exposed to sexually transmitted infections (STI) before arrival in a developed country. There are many reasons for this, including lack of education, poor availability of barrier contraception, and high rates of exposure to sexual violence, although this history may not be disclosed. Screening for sexually transmitted infections should be part of routine refugee health assessment for people who have been sexually active. This includes a clinical assessment and urine testing for gonorrhea and chlamydia, as well as blood testing for syphilis, HIV, and hepatitis B. Most of these infections are easily treated. If they are not treated they can have significant long-term consequences, including adverse effects on fertility. When assessing refugee patients for STI, providers should be particularly aware of protecting patient confidentiality, and using an appropriate interpreter.

Conclusions

Infectious diseases are common in refugees and may have long-term effects on health. Detection and treatment of infectious diseases is an important part of the post arrival health screen, and many of these conditions may not be associated with symptoms.

A refugee patient is unique in that he or she has often been exposed to a large range of infections in the course of his or her lifetime and may present with diseases that are rarely, if ever, seen in people who have always lived in a developed setting. Clinicians need to be alert to the possibility of unusual infections, and know how to assess refugee clients for these conditions, and when to refer to an infectious disease specialist. A number of excellent guidelines are available to assist the clinician and these should be used whenever possible.

Significant improvements are occurring in health care provision for refugees who arrive in developed countries. Fortunately, the infectious diseases described in this entry can be effectively cured or managed, allowing better health and well-being for people of a refugee background after settlement.

Related Topics

- ▶ Acquired immune deficiency syndrome
- ▶ Asylum
- ▶ Hepatitis
- ▶ Immunization
- ▶ Malaria
- ▶ Medical examination (for immigration)
- ▶ Refugee
- ▶ Refugee camp
- ▶ Tuberculosis

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Influenza

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Influenza is generated by influenza viruses A and B that are members of *Orthomyxiviridae* family. These viruses are enveloped, single-stranded RNA. The envelope is derived from host cell membrane, and hemagglutinin (HA) and neuraminidase (NA) form rod-like spikes and spikes with globular heads. The matrix-1 (M1) protein is present between nucleocapsid and the envelope, and the matrix 2(M2) protein forms an ion channel across the envelope in influenza A virus.

Epidemiology and Transmission

Influenza viruses are known for their ability to cause epidemics and pandemics during which acute respiratory diseases occur in all age groups. Immigrants may be more vulnerable than other groups to influenza because of preexisting diseases, inadequate access to medical care, inadequate living conditions (many people living in a small area favor the spread of influenza), and poor hygiene. Although there are no reliable estimates of influenza prevalence among immigrants, the prevalence among immigrants is likely higher than among host high-income country populations for two reasons. First, most migrants are from low-income countries characterized by poor vaccination programs. Second, many of the countries from which migrants originate are known to have a high prevalence of influenza (e.g., Thailand, Philippines).

Influenza viruses are usually transmitted via air droplets generated by sneezing, coughing, and speaking, from person to person. Direct contact with contaminated secretion may be another route of transmission. There are several recorded pandemics of influenza starting with Spanish flu (1918–1919), then Asian flu (1956–1958), Hong Kong flu (1968–1968), and most recently the H1N1 strain epidemic (2009–2010).

Viral Aggression and Host's Response

The pathogenicity of the influenza viruses depends on host factors such as presence of target receptors on host cells, immunocompetence of the individual, ability of the immune system to control the viral replication effectively without causing serious collateral damage for the host by its inflammatory response along with viral factors, such as ability to bind to host cells escape from immunosurveillance by evolution of antigenic variation driven by selective pressure of the immune response or by recombination with different virus strains from zoonotic disease.

The Humoral Immune Response

Influenza is associated with systemic production of antibody to both influenza glycoproteins HA and NA, as well as M and NP proteins. HA-specific immunoglobulins appear within 2 weeks inoculation. The peak in antibody titers is seen between 4 and 7 weeks after infection, and are followed by a decline. Antibodies remain detectable for years after infection even without re-exposure. The anti-HA antibody protects against both disease and infection with homologous virus. Serum HA-inhibiting titers of 1:40 or greater, or serum neutralizing titers of 1:8 or greater, protect against infection. Higher levels of antibody are required for complete protection in older individuals.

Anti-NA antibody does not neutralize virus infectivity, but instead reduces the efficient release of virus from infected cells because neuraminidase cleaves the cellular-receptor sialic acid residues to which the newly formed particles are attached.

Anti-NA antibody can protect against the disease and results in decreased virus shedding and severity of symptoms. Similar effects have antibodies against M2 protein of influenza A, although in general, antibodies against internal antigens are non-neutralizing, disappear more rapidly, and do not appear to play a role in protective immunity.

The Cellular Immune Response

Dendritic cells play a central role in initiating and driving T lymphocyte responses. Lung-resident dendritic cells acquire antigen from the invading pathogen, become activated, and subsequently travel to the local draining lymph nodes. The antigenic sample is processed and fixed on the dendritic cell surface as peptides that are presented to CD8 T and CD4 T lymphocytes that are activated. Their activation correlates with a reduction in the duration and level of virus replication. Moreover, CD4 T lymphocytes help B lymphocytes to generate anti-HA and anti-NA antibodies.

Clinical Aspects

Influenza is characterized by fever, dry cough, sore throat, rhinorrhea, nasal congestion, and nasal discharge. Elderly people may present with lassitude and confusion instead, as well as myalgia, headache, malaise. Illness typically begins suddenly after 1–5 days of incubation. Fever lasts for 3–5 days but symptoms such as malaise and dry cough may persist for several weeks. Adults are infectious from as early as 24 h before the onset of symptoms until about 7 days thereafter. Children are even more contagious: young children can shed virus for several days before the onset of their illness and can be infectious for >10 days. Severely immunocompromised persons can shed influenza virus for weeks or months.

Complications

There are several potential complications of influenza including otitis media in children, secondary bacterial pneumonia (*Staphylococcus aureus*, *Hemophilus influenzae* and *Streptococcus pneumoniae*), seizures, acute encephalopathy, Reye's syndrome (associated with aspirin use), and myopericarditis.

Diagnosis

This can be done in two different ways: direct using techniques such as immunofluorescence, Enzyme immunoassay or Polymerase chain reaction or serologic diagnosis based on detection of antibodies.

Treatment

There are four licensed antiviral drugs available for the treatment of influenza A infection (two neuraminidase inhibitors-Zanamavir, Osetamavir and two M2 ion channel inhibitors Amantadine and Rimantadine), and the neuraminidase inhibitors oseltamivir and zanamivir are also active against influenza B. All are administered within a few hours of the onset of symptoms. These drugs can modify the severity of illness, as well as reduce the intensity of influenza symptoms and decrease the duration of illness by about 1–3 days.

Prophylaxis

Prophylaxis is possible using a trivalent vaccine that includes circulating stains of influenza viruses The strains to be included in the vaccine are selected in January and February to make a vaccine for use in September. There are two types of vaccines: one uses an inactivated virus and the other one includes a live attenuated virus.

Related Topics

► Immunization

Suggested Readings

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Informed Consent

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History has shaped how patients discuss various treatment options with their medical providers.

Traditionally, there has been an asymmetry of knowledge between provider and patient about various forms of treatment. This had led to patients placing faith in their doctors to act in the patient's best interest and to do no harm. However, as patients have become more educated about their treatment options and their rights, the asymmetry of knowledge has decreased. Patients have become more active participants and have taken increasing responsibility for their care. The concept of informed consent has evolved to protect the rights of patients and to ensure that the minimum adequate information is communicated and understood by the patients both before and during treatment.

Informed consent is a process that occurs between patients and providers. The process may involve family members or other significant persons in the patient's life and may be influenced by culture and religion. The process leads to the patient accepting a form of medical treatment such as a medication or a surgical procedure. The process can occur after one meeting between the patient and provider or after a series of meetings. The process can also occur over the course of treatment. As more information about a treatment or alternative treatments becomes available, patients will continue to work with their providers on understanding their current and available treatment choices. This is especially true of modern-day medicine where the asymmetry of knowledge between providers and patients has decreased because of the Internet.

A patient must have the capacity to provide informed consent. This means patients must have the ability to make health care decisions, and the decisions made must be both rational and reasonable. For example, a psychotic patient with no intracranial pathology who only chooses to have surgery to remove most of their brain as a treatment of their psychosis does not have the capacity to consent to treatment as their choice of treatment is neither rational nor reasonable. Having the capacity to make a health care decision is relative to both the decision being made and the individual making the decision. For example, patients, with intellectual disabilities may have less capacity to make treatment decisions when treatment decisions are complicated and potentially life-threatening but may have the capacity to choose among simple and relatively harmless forms of treatment. Children who are not at the age of majority may require a parent or guardian to make treatment decisions for them. One example of a patient not having any present capacity to make a choice regarding treatment is an unconscious person who presents to an emergency room. Absent other information, providers will act in the best interest of the patient, make treatment choices, and work toward saving that individual's life.

If a patient does not have the capacity to provide informed consent, there are other options in which consent can be obtained. In certain areas, family members or other substitute decision makers may be able to consent to treatment on behalf of the patient. In other areas, a judge may be legally authorized to make medical decisions on behalf of a patient. It is therefore important to understand the patient's social and family background as well as legal and other factors influencing or determining who can make treatment decisions on behalf of patients with less or no ability to choose between or among treatment options. Sometimes patients will have specified their wishes for treatment in the event that they lose the capacity to participate in the informed consent process. A living will is an example of a document in which patients can express these wishes.

Informed consent requires that the patients have information or knowledge about the proposed treatment. This includes adequately understanding the benefits, risks, and alternatives to treatment. The patient must first understand their diagnosis so they have a basis upon which to accept or refuse treatment. Understanding the benefits includes understanding the extent to which a particular treatment will cure or relieve a given ailment. Discussing risks with a patient raises the question as to how much information should be disclose to a patient. A provider may opt to provide volumes of information including listing every known potential side effect and complication of a particular treatment. However, the patient may not read and/or understand information presented in this manner. One concept regarding the disclosure of information is that providers disclose to patients' material information about a proposed treatment. Material information is information that is relevant to the patient in that patient's particular circumstance. For example, although there may be a small chance that a particular treatment can cause a heart attack, this information may be material to someone who has a history or coronary artery disease. Choosing among alternative treatments may include choosing among different medications or choosing among alternative modalities of treatment. For example, a patient with back problems may be offered the choices of physical therapy and/or medications.

Patients should also understand the option of not having treatment at all. This includes understanding their prognosis with and without treatment. One reason it is important to understand the option of not accepting a proposed treatment is that although a treatment may have benefits, there may be risks or other factors associated with the treatment that are not acceptable to a patient. For example, a patient with a terminal illness may opt to not accept potentially life-lengthening interventions if the intervention will lead to prolonged suffering. A Jehovah's Witness may not accept a blood transfusion because of his or her religious beliefs.

A patient's decision to choose a treatment must be voluntary. This means that a patient must be able to exercise his or her free power of choice when providing informed consent. This does not mean that others such as providers and family cannot have a due influence on a patient's decision for treatment, such as providing a good faith recommendation and reasons to accept a particular treatment modality. A patient's decision to accept treatment is not voluntary if he or she was forced or tortured into accepting treatment. There exist situations in which the voluntary exercise of power of choice may not be possible. For example, in a psychiatric hospital, a patient may be violent to the extent that there is no option but to provide involuntary medications to the patient in order to help protect the lives and safety of the patient and others.

In conclusion, informed consent is a process. It can be obtained after one or multiple visits between patient and provider but can continue during the course of treatment. The process empowers patients to make an informed decision regarding their treatment options. Potential positive outcomes of engaging in an adequate informed consent process include but are not limited to increased dialog between the provider and patient, an increased likelihood that a patient will be compliant and an active participant in treatment, and a strengthening of the provider–patient relationship.

Related Topics

- ► Cultural background
- ► Ethical issues in research with immigrants and refugees
- ► Ethical issues in the clinical context
- ► Health education
- ► Human rights
- ► Nuremberg Code

Suggested Resources

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Inheritance

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Immigration is a complex issue in healthcare as it places people of different ethnicities in alien environments, with differing susceptibility to diseases, different healthcare needs, and different health-seeking behaviors. These differences present a challenge to adopted healthcare systems in meeting population needs, especially with the disproportionate increase in the prevalence of vascular risk factors and diseases in immigrant populations, which far exceed the prevalence rates in native people. Recent years have seen considerable effort being devoted to understanding inherited and non-inherited factors that may underlie predisposition to excess vascular disease.

A dramatic increase in the risk of vascular diseases such as myocardial infarction, stroke, and sudden death with migration was first identified in Japanese immigrants to Hawaii, in whom the status from a low-risk group to a high-risk group changed in one generation. A similar increase in risk with migration has been identified in African origin populations in the West Indies, Americas, and European and Asian origin populations in the United States and the United Kingdom. Initially this was attributed to acquisition of behavioral risk factors prevalent in local cultures, but it does not fully explain why the vascular risk in migrants should exceed that of the local population. The increased predisposition of immigrant populations to vascular diseases is probably attributable to a clustering of genetic and environmental factors within these populations, represented as:

$$\text{Phenotype} = \text{genotype} + \text{environment} + \text{gene} \times \text{environment}$$

This assumes that differences in disease prevalence may not be due to genetic differences alone but may also reflect differences in environmental influences (some of which may also be inherited as food habits, cultural beliefs, and traditions) or interactions between genetic heterogeneity and environmental pressures.

The determination of the role that inheritance may play in disease patterns amongst immigrant populations is complex. Migration is not a homogenous phenomenon that occurs at one point in time; it has occurred at different periods, quite often separated by decades or even centuries. Despite a common ethnicity, immigrants come from a range of different source populations, especially if they are of African or Asian origin. Most of the migrations from West Africa to the Americas or later from the Indian subcontinent in the eighteenth and nineteenth centuries were forced migrations because of slavery, bonded labor, or wars. The source population for these migrations is very different from that of the economic migration seen in the latter half of the twentieth century and may represent different frequencies of variations in the genes within populations, food habits, and cultural practices despite a common ethnicity or geographical region of origin. Hence, heterogeneity is the rule rather than the exception, which is further complicated by different environments to which people have migrated over time and the evolution of societies to which they have migrated.

Do differences in genetics between migrant ethnic groups and native populations explain increased susceptibility to disease in immigrant people? Various studies have shown that the frequencies of different forms of the same gene differ between ethnic groups and there is a higher prevalence of disease-associated gene variations (such as those regulating control of blood pressure, health of blood vessels, salt handling by the kidneys, and control of atherosclerosis) in African and Asian origin populations. In addition, there are minor differences in the structure of blood vessels and how they react under stress between different ethnic groups, which predispose some groups to earlier or faster degenerative changes associated with high blood pressure and furring of arteries. However, only a low percentage of differences between ethnic groups are explained by differences in gene composition; many studies have shown that differences within individuals of the same ethnic group and much greater than those seen between different ethnic groups. Furthermore, there are variations in disease susceptibility within the same ethnic group (and hence, sharing the same genetic inheritance) with geography, with risk increasing proportionally to the degree of urbanization or westernization. Clearly, inherited genetic traits alone are not enough to explain the higher incidence of disease in immigrant ethnic groups.

If inherited factors do not explain increased disease incidence, can this be attributed to a change from the native "low-risk" environment to an alien "high-risk" setting? There is considerable literature to support this view. A move to more urbanized settings has been associated with changes in diet (e.g., increased calorie, fat salt intake, and decreased fruit, vegetable, and fiber consumption), reduced physical activity, relatively lower socioeconomic status in adopted settings, increased psychosocial stress, and inequities in health care access. However, it would be expected that this increase of risk in immigrants due to change of environment will eventually match that of the native populations. However, studies show that risk factor acquisition and its impact in immigrant populations exceed that of the native population, suggesting that there is an interaction between the changed environment and inherited traits (whether genetic or nongenetic) that may be responsible for the higher risk. Researchers have identified various physiological mechanisms to support this concept, such as exaggerated insulin responsiveness to energy/metabolic challenges in Africans or Asians living in highly urbanized settings, increased salt sensitivity in Africans leading to increased sodium reabsorption, hypertension, and vascular disease in Western societies and dysregulation of the hypothalamic-pituitary-adrenal axis leading to changes in diurnal variations of stress hormones.

Several models have been developed to explain the interactions between genetic inheritance and the environment. The "thrifty genotype" hypothesis is based on an assumption that evolution has selected genes that promote insulin resistance (the main hormone involved in energy handling) and confer a survival advantage in nutritionally deplete environments. However, the same genes polymorphisms (potentially more frequent in less urbanized immigrant populations) lead to a greater disease risk in nutritionally rich environment, affecting handling of energy or metabolic challenges and leading to early atherosclerosis. The "thrifty phenotype" model focuses on preprograming of metabolic responses and vascular modelling during the fetal phases, which has consequences for health in later life. It has been suggested that the fetus, regardless of genetic inheritance, makes adaptive changes to intrauterine nutrient limitation by inducing insulin resistance. Although this would continue to remain beneficial in nutritionally deplete environments, the phenotype would confer predisposition to developing the metabolic syndrome and early atherosclerosis in nutritionally enriched environments. Gluckman and Hanson have proposed a model that combines elements of both the "thrifty genotype" and the "thrifty phenotype" models. They suggest that the fetus constantly interprets the environment created by the maternal milieu and placental function and responds to this by a process of silencing or expression of genes in the cells of specific tissues, organs, and systems.

Changes in how genes are expressed in a particular individual or ethnic group are largely regulated by genes themselves. However, recent evidence suggests that early environmental exposures can modify these processes during growth and development, thus having a durable effect on adult biology and disease risk. Some fetal responses to environment act to help the fetus cope better with the existing milieu, some reflect developmental disruption and have echoes in later life, and some confer advantage by establishing metabolic physiology appropriate for the predicted postnatal environment. Such responses are appropriate if the predicted and actual postnatal environments match, but inappropriate if they do not, as would happen with migration to a different ecological niche.

The relationship between inherited traits, environmental pressure, and cardiovascular disease is complex, and noninherited influences within the environment may play a significant, but potentially modifiable, role in ethnic predisposition to vascular disease. Literature supports a focus on the investigation of multiple environmental factors and gene–environment interactions, specific to ethnic groups in different environments, as an approach to eliminating the excess of vascular disease in immigrant populations.

Related Topics

► Environmental exposure
► Health disparities

Suggested Readings

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Injection Drug Use

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Injection drug use (IDU) in immigrant populations has been a substantial concern primarily due to HIV transmission. Many different small studies have examined the prevalence of injection drug use relative to the immigrant community's country of origin or country of residence.

One of the greatest concerns is the ability of immigrant IDUs to access medical care, and/or the paraphernalia they need to protect themselves against HIV and other blood-borne illnesses (like hepatitis C), as well as illnesses that tend to be prevalent in injection drug using communities (like TB). Additionally, IDUs are at risk of overdose from their drug(s) of choice, and so may need to access medical care or drug treatment as a result of overdose.

Immigrant IDUs are at additional risks from adulterants in street drugs, or from fillers in prescription pills that are crushed and then injected, leading to a wide variety of heart, lung, kidney, and blood problems like endocarditis (inflammation of the lining of the heart), interstitial lung disease (causing fibrosis and difficulty breathing), and kidney failure (the inability of the kidney to rid the body of waste). Immigrant IDUs, like other IDUs, are often in need of both urgent medical care and medical care for chronic conditions that may result directly from injection drug use, or from the stress and difficulty of acquiring sufficient income to maintain a chronic drug habit.

Injection drug use tends to be a part of progressive increasing addictive drug use, as injection is the least expensive manner of ingesting drugs. Individuals often begin injecting after a period of snorting, swallowing, or smoking the drug of choice. Of course, some injection drug users also begin with injection. Immigrant populations are no different in this regard.

Harm reduction is a drug treatment modality that aims to address the needs of drug users who may or may not want to stop using drugs. A harm reduction approach offers them services and skills to take care of their health and prevent disease, such as syringe exchange, hepatitis B vaccination, overdose prevention, and information about how to use drugs more safely.

Immigrant IDUs face several barriers to care in accessing these services. First, they face the access to care issues that confront immigrants in general: language, ability to navigate the health system in the new country, lack of income, and lack of culturally competent health care providers and services. Beyond these already significant issues, immigrant IDUs also must face the discriminatory attitudes many communities (and traditional service providers) have against drug use in general, and injection drug use in particular. This means that immigrant IDUs may not be able to use traditional community channels (like talking to immigrants with longer experience in the country of residence about navigating medical systems) and may face barriers accessing competent drug treatment services that respond to their particular social needs. If immigrant IDUs face the additional barrier of undocumented status, these problems are only increased, as they may feel that any and all services aren't available to them (even if the services in question do not require documentation of immigration status from their patients/participants).

In all, the experience of injection drug use among immigrant populations varies widely by culture and country of origin, country of residence, access to services (particularly drug treatment and harm reduction services), and values, attitudes, and beliefs in immigrants and their country of residence about injection drug use.

Related Topics

- ► Drug use
- ► Human immunodeficiency virus
- ► Sex work and sex workers
- ► Tuberculosis

Suggested Readings

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Injuries

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Injuries are a significant public health challenge that can be studied just like disease. Using a public health approach, they are often predictable, preventable, and responsive to intervention. Injury results from unintentional and intentional damage to the body due to acute exposure to thermal, mechanical, electrical, or chemical energy or from the absence of essentials like oxygen or heat. Injuries encompass both intentional violence that is purposely inflicted (e.g., homicide and assaults, suicide and attempts, child abuse, domestic violence) and unintentional injuries or so-called "accidents." The unintentional category includes injuries from drowning, fires and burns, motor vehicles, poisonings, falls, choking, and suffocation among others.

Injuries and their adverse health outcomes are a major public health concern for countries across the world. As public health improvements in the twentieth century reduced the prevalence of infectious diseases, the negative toll of injury on the public's health has become more significant. For example, in the United States, injury and violence kill 170,000 people annually. Injuries are the leading cause of death for those 39 years of age and younger, a leading cause of disability, and a major contributor to health costs. And injury ranks fourth as the leading cause of death overall. Injuries disproportionately affect a younger population – children, teens, and young adults. Half of all deaths to 5–14 year olds and nearly three quarters of all deaths to 15–24 year olds are due to injuries.

Despite the magnitude of the problem, injury is not near the top of society's list of preventable health problems and has been called a neglected epidemic:

- People seem resigned and accepting of injury as an "accident" and inevitable part of life – a mistaken belief.
- The media sensationalizes the reporting of separate and unique injury events rather than focusing on patterns of injury and long-term trends as is done with the study of disease.
- There is a tendency to blame the victim and portray injury largely as a matter of individual fault (carelessness, aberrant behavior), much more so than with cancer, heart disease, and infectious disease.
- The medical community and advocacy coalitions concerned with injury issues tend to focus on post-injury treatment rather than prevention.
- Because the contributors to injury are largely man-made (consumer products, motor vehicles, firearms), business considerations often overshadow the adoption of technology for safety of the public.

Immigrant populations experiencing rates of injuries are of specific concern for countries hosting these populations. Immigrant populations often face health disparities, including health disparities resulting from injuries.

Injury Data and Immigrants

Injury and violence-related data specific to immigrants are limited, both in the United States and other countries. Immigrants may be less likely to report injuries and violence if they are in a country illegally or if there is cultural stigma associated with the injury (e.g., suicide, intimate partner violence). In the USA, data are largely collected by race and ethnicity, not by nativity. And death data available through the National Center for Health Statistics have not recently been analyzed to separate out injury for the foreign-born population. Although many US studies focus on Hispanic and Asian populations, it is rarely clear what percentage of the populations is foreign- versus native-born.

While a systematic analysis of the overall picture of injuries in immigrants has not been done, we do know that injuries disproportionately affect the young and the poor and that the causes of injury vary by age and by sex. There are some studies in specific immigrant populations that examine a specific type of injury in a specific locale. Some of these findings illustrate higher risks for immigrant than native populations. These include:

- Drowning in California irrigation canals, mostly in the process of illegal entry into the USA
- Motor vehicle fatalities among Mexican-Americans in Imperial County, California
- Severe scald burns from hot water and oil among children of mostly Middle Eastern and Balkan immigrant families in Sweden
- Burns from hot water, tea, or oil among children of foreign-born mothers in Denmark
- Severe scald burns from hot food in young Hispanic children whose parents were immigrant farmworkers in Washington state
- Pedestrian hospitalizations and deaths among Latino children in California
- Escalation of partner violence in Latinas since emigration to the USA
- Intimate partner violence among young, foreign born, and minority women in NYC
- Homicide among Nicaraguan born immigrants versus Costa Rican natives
- Gunshot injury among immigrants in Sweden
- Homicide among White, Hispanic, and Asian immigrants' ages 15–34 years in California

In general, it seems that border communities in the USA have higher risks of injury. It has been suggested that enforcement has pushed illegal immigrants into more physically challenging areas with mountains, deserts, and irrigation canals. Heat stroke and heat fatalities are one outcome. Overcrowded motor vehicles, high speeds and poor vehicle maintenance have led to deaths and injuries of illegal immigrants being smuggled into AZ.

Immigrants may also be at higher risk of occupationally related injuries. They often are hired in lower paying jobs that may be dangerous and safety issues may not be explained or understood.

In the USA, studies indicate that immigrants seem to have a lower risk of *unintentional* injuries with the exception of transportation-related injuries. This difference in injury risk between foreign-born and native-born has **not** been attributed to socio-demographic characteristics, such as age, sex, education, poverty status, region of residence, family size, and health insurance coverage status. Foreign-born persons are less likely to be injured outside the home or at school and more likely to be injured at an industrial/construction area. They receive significantly more injuries working at a paid job and significantly fewer injuries during sports or leisure activities.

Foreign-born individuals 25 years and older in the USA also have a reduced risk for suicide when compared to those native-born. Although there is research indicating a relationship between acculturative stress and physical health problems such as cancer, hypertension, and coronary artery disease, such research has not been done for injury and violence. One hypothesis is that less acculturated children in the USA may be protected from injury. Sociocultural factors in immigrants that may be protective of unintentional injury include stronger behavioral, familial, and social support than US born persons as well as other lifestyle factors and cultural practices.

In the USA, studies indicate that male immigrants have a 66% higher risk of *homicide* than US-born men. However, the excess risk is entirely accounted for by nativity differences in socioeconomic characteristics, including urban/rural residence.

Immigrants are less likely to be involved in risk taking behaviors related to injury, but equally likely to receive an injury if they are involved in risk-taking behaviors. Little is known about the association between behavioral risk factors and injuries among immigrants in the USA. However, risk factor data from the National Epidemiological Survey on Alcohol and Related Conditions indicate that immigrant adults are less likely to be involved in ten selected risk behaviors for unintentional nonfatal injuries than US-born counterparts including: driving a motor vehicle while drinking, driving after three alcoholic drinks, riding in a vehicle while a driver is drinking, receiving more than three tickets for reckless driving, receiving a license suspension for a moving violation, and doing things that could have easily hurt someone. A protective effect of being an immigrant disappears for immigrants engaged in more than four of the ten risk behaviors;

the latter have similar injury prevalence as their US born counterparts. There does not appear to be an association between years of US residence and injuries.

These latter findings for unintentional injuries seem somewhat contradictive of studies that show an increased risk of transportation-related injuries among immigrants.

Given the lack of solid data and discrepancies in reported injuries and risk factors among immigrants, where should the focus be for prevention efforts?

Injury Prevention Interventions

The general approach to successfully reducing injuries is to implement comprehensive interventions that include a combination of:

- Education that changes knowledge, attitudes, and beliefs and fosters safer, and less risky behaviors; often directed at an individual, policy-makers or the Sociocultural environment (e.g., media campaigns to persuade people or change norms regarding seat belt use or counseling by physicians on the same topic)
- Engineering design of products to make them safer (e.g., removing lead paint from toys, self-extinguishing cigarettes to reduce fires, airbags that absorb energy in a car crash)
- Environmental changes that modify the environment and surroundings to make behavior change easier or, better yet, make behavior change unnecessary (creating pedestrian walkways and bicycle paths, safe playground alternatives to playing in the street)
- Enactment and enforcement of regulations and laws to promote behavior change and reduce injury risk (specify speed limits, institute graduated driver licensing law for teens, school enforcement of rules to reduce bullying).

The framework that is most often used to understand injuries and how they can be prevented is the Haddon Matrix. It analyzes events that can cause injuries with an epidemiological model to create a matrix that identifies aspects of the host, the agent or vector, the physical environment and the social environment with three time phases – pre-event, event, and post-event (Table 1).

There are many interventions that have been successful in reducing injuries and deaths including: use of motorcycle helmets, seat belts and child booster seats; tai chi to prevent falls and their sequelae; installation of smoke detectors as a warning to escape from fires; four-sided fencing around swimming pools; personal flotation devices when boating, etc. The trick is to be able to adapt the implementation of proven methods to the culture, health beliefs, and practices of the foreign born.

Most injury prevention programs fail to target immigrants as a unique population. Large-scale interventions relating to immigrants have addressed other adverse health outcomes with little or no emphasis on injury and violence prevention. And the majority of interventions relating to immigrant health and injury risk have occurred at the local level without grant money or formal program evaluation.

Notable exceptions have occurred, including a program to increase child restraint usage among

Injuries. Table 1 Example of a Haddon Matrix for motor vehicle crashes

Phases	Host factors	Agent or vector factors	Physical environmental factors	Social environmental factors
Pre-event	Driver training/ driver vision/ fatigue	Maintenance of brakes, tires	Roadway markings and lighting/rain	Public attitudes on text messaging/drinking and driving
Event	Use of a seat belt or child restraint	Crashworthiness/no dashboard protusions/ airbag/vehicle size	Presence of a fixed object like a tree too close to road/ guard rail	Enforcement of mandatory seat belt–use laws
Post-event	Crash victim's general health/ sobriety/age	Gas tank design to minimize likelihood of a fire	Availability of effective EMS/ distance to trauma care	Public support for trauma care and rehabilitation

Hispanic pre-school children in Dallas, Texas; a program to decrease carbon monoxide poisonings in immigrant populations in the Pacific Northwest; and the Home Safety Council's Home Safety Literacy Project to understand and apply fire protection and disaster preparedness measures in the home. A low budget, small organization example is that of a local refugee injury prevention group in Concord, New Hampshire that created some materials and a home safety kit that were used by volunteers to work with the refugees they were assigned to through Lutheran Social Services. The group also assisted with providing car seats to refugees; spoke at English as a Second Language (ESL) classes on topics such as poisoning and pedestrian/bike safety; collaborated with a fire department on fire prevention, worked with refugees about whom to call in an emergency; collaborated with the Northern New England Poison Center and 911 to actually pose scenarios and then practice calling into the centers; and presented to nurses at a local community college to help raise their awareness around injury prevention issues for refugees.

Future Directions

There are many health and service programs for immigrants, but it is unknown whether preventing risks from injury are included. State health agencies often have a department of immigrant or refugee health. In Hawaii, the health department has bilingual health aides, who do home visits and provide health education to immigrants on immunization, nutrition, and chronic disease prevention. It seems logical that such programs should include injury and violence prevention as part of the visit. What is required for integration within existing service provision is training on injury prevention for staff, culturally relevant information, local data on the most frequent causes of injury in this population, and the political will to get what we know works for injury prevention put into practice for immigrants.

Related Topics

- ► Built environment
- ► Childhood injuries
- ► Falls
- ► Occupational injury
- ► Safety

Suggested Readings

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Suggested Resources

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INS

- ► Immigration and Naturalization Service

Insomnia

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Insomnia is the most common of the sleep disorders affecting 10–30% of the population depending on the criteria used to define insomnia. The term “insomnia” may refer to a symptom of a larger sleep, medical or psychiatric disorder, or as a primary disorder. The definitions of insomnia vary but most often, insomnia is defined as an inability to remain asleep throughout the night and reflects an assessment of sleep quality. Insomnia, as a primary disorder, has been further defined by subtypes based on frequency, duration, and etiology. Acute insomnia refers to insomnia lasting from several days to a few weeks. Episodic or infrequent insomnia is referred to as transient insomnia. Chronic insomnia refers to insomnia lasting 1 month or longer.

Diagnosis

The diagnosis of insomnia is based on an individual’s description of his or her sleep schedule. The majority of individuals with insomnia are diagnosed based on self-report. Individuals who do not respond to initial treatments or report an inconsistent history may be referred for objective testing. Objective tests include actigraphy and polysomnography. Actigraphy is a technique that uses an actigraph, an instrument worn on the body, to measure body movement. Actigraphy characterizes rest-activity patterns, which is useful in evaluating sleep–wake cycles. Polysomnography is a sleep study that monitors stages of sleep, blood oxygen levels, brain waves, breathing rate, eye movement, heart rate, and the electrical activity of muscles. Actigraphy and polysomnography are reserved for cases of treatment failure, unclear diagnosis, and sleep-related breathing disorders.

Pathophysiology

Insomnia is thought to arise from a hyperarousal state. This hyperarousal state is defined by increased brain glucose metabolism and increased adrenocorticotropic hormone (a hormone produced by the pituitary gland) activity. Sleep studies demonstrate that individuals with insomnia have increased brain arousal measured by increased beta activity and lower delta activity on electroencephalography. Individuals with insomnia also have an increased whole body metabolic rate compared to individuals without insomnia.

Risk Factors

Several risk factors or precipitants of insomnia in individuals predisposed to the disorder have been identified. Age and sex are the most well-studied risk factors with an increased prevalence of insomnia in older adults and women. Sleep studies in the elderly suggest that the primary change in the sleep of older adults is an inability to sustain sleep throughout the night. Insomnia in women is associated with the onset of menses and menopause. Comorbid medical disorders, psychiatric disorders, and working night or rotating shifts are additional risk factors. Psychiatric disorders, specifically depression and anxiety, are the most common comorbid disorders associated with insomnia. The relationship between cultural influences and sleep is not fully understood. Immigration studies suggest that the prevalence of insomnia in women immigrants is higher than that reported in most epidemiologic studies of women in Western societies. More specifically, immigrant women who make efforts to assimilate into their new culture were found to have the highest rates of insomnia.

Impact of Insomnia

Individuals suffering from insomnia may develop medical conditions, psychiatric disorders, impairment in the ability to function during the daytime (work time productivity), and are at increased risk for motor vehicle accidents. Individuals with chronic insomnia commonly report a decreased quality of life. Chronic insomniacs are more likely to experience bodily pain and psychiatric symptoms. The high rate of psychiatric symptoms experienced by chronic insomniacs raises the question as to whether insomnia leads to psychiatric disorders. It is unclear whether insomnia causes psychiatric symptoms or vice versa. However, it is clear that the treatment of insomnia results in the improvement of psychiatric symptoms. In community-based studies chronic insomniacs reported more heart disease, hypertension, chronic pain, and gastrointestinal, neurologic, urinary and breathing difficulties. Studies have also identified a relationship between cardiovascular disease and insomnia. Men with chronic insomnia were shown to have an increased risk of death secondary to coronary heart disease.

The socioeconomic cost of insomnia is related to health care utilization as well as work absenteeism in insomniacs. Health care utilization, namely, office visits and hospitalizations, is higher in individuals with insomnia compared to individuals without sleep disruption. Individuals with insomnia have high rates of work absenteeism and lower work productivity compared to individuals without insomnia.

Treatment

The treatment of insomnia is based on the etiology or cause of the insomnia. For example, if the insomnia is a symptom of depression or pain, the treatment should be aimed at the underlying diagnosis. In most cases of insomnia, however, the etiology is multifactorial. As such the treatment should be multimodal combining nonpharmacological and pharmacologic intervention. Nonpharmacologic interventions included education about sleep hygiene, light therapy, exercise, and behavioral modifications including cognitive behavioral therapy, and relaxation training. Cognitive and behavioral methods have been shown to be the most effective for the short-term treatment of patients with insomnia. Pharmacologic treatments include FDA-approved medications for insomnia, off-label use of medications, and alternative (herbal) medications. The use of off-label medications refers to the use of psychiatric medications, which have a hypnotic side effect. Alternative medications included herbal remedies such as valerian and melatonin. Pharmacologic treatments are recommended for immediate symptoms reduction, when insomnia causes serious impairment in functioning and when nonpharmacologic interventions do not produce an amelioration of symptoms.

Related Topics

- ► Chronic disease
- ► Chronic pain
- ► Depression

Suggested Readings

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Roth, T. (2009). Comorbid insomnia: Current direction and future directions. *American Journal of Managed Care, 15*, S6–S13.

Voss, U., & Tuin, I. (2008). Integration of immigrants into a new culture is related to poor sleep quality. *Health and Quality of Life Outcomes, 6*, 61–66.

Suggested Resources

American Academy of Sleep Medicine. http://www.aasmnet.org

National Sleep Foundation. (2011). www.sleepfoundation.org

Intelligence Testing

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Historically, the use of intelligence tests with immigrant populations, and the ways in which those tests have been interpreted and used, have been controversial. In the early nineteenth century, a hereditarian theory of intelligence dominated academic and popular thought in the United States. This hereditarian position viewed intelligence as an inherited, biologically determined trait. As such, an individual's level of intelligence was directly reflective of his or her genetic, and therefore ethnic, lineage. Although not unchallenged, popular fears maintained that the acceptance of immigrants believed to be of genetically lower levels of intelligence into the United States would, through partnering and procreation across generations, lead to a general degradation of intelligence throughout the country. While the influence of intelligence testing on actual passage of immigration laws has been debated, a wide perception remains that eugenics-based arguments against admittance of the "feeble-minded" were used by many to justify early nineteenth century US policy that favored immigrants from northern European countries to the exclusion of those from other parts of the world. Although no country currently administers intelligence tests to potential immigrants, nor does any country impose a minimum IQ to filter immigration, the history of misinterpretation and misappropriation of IQ testing with immigrant populations may well influence the opinions and experiences of modern-day immigrants with whom intelligence testing is suggested and/or performed.

Broader theories of intelligence were formulated in the second half of the nineteenth century, and with them came recognition of the limitations of intelligence testing. Dominant hereditarian ideas were largely replaced by theories that understood intelligence to be influenced by a dynamic interaction of biological, cultural, historical, sociopolitical, and environmental factors. Through these theories, intelligence came to be considered contextually, and the variety of skills and knowledge that constitute intelligence between and within cultures became apparent. Research into the relationship of culture and intelligence has shown that societies value differing abilities, types of knowledge, and cognitive processing traits. What is deemed valuable in one culture is then instructed, supported, and fostered in members of that society. As a result, an individual's mastery of these culturally-approved skills and abilities becomes viewed as reflective of intelligence. As an example, whereas dominant US culture values speed in mental processing and considers such ability as reflective of intelligence, other cultures have been shown to view speed in decision-making as reckless and unwise. Using this example, if speed of processing is built into a measure of intelligence, and greater speed equals a greater score, administration and scoring of the measure with an individual from a culture that does not value or support speed would be problematic, raising issues of construct validity and cultural equivalence.

Intelligence tests are culturally dependent measures, created largely by and for majority populations, and are normed and standardized to a particular culture. In addition to issues of validity and equivalence, the performance of a culturally-different individual on a test of intelligence may reflect problems related to method bias, or the degree of familiarity a person has with the test-taking process. Language bias is also a significant issue in the administration of intelligence tests to migrants. Most measures of intelligence are heavily language-based, thus individuals who are not proficient in the language in which the test has been developed, normed/standardized, and administered are likely to have impacted comprehension and thus artificially lowered scores. Attempts have been made to make nonverbal measures of intelligence; however, many of these instruments contain passages of verbal instruction that can still influence and hamper individual performance.

Many measures of intelligence, such as the Wechsler Adult Intelligence Scale, have been normed and standardized for use with a variety of cultural groups. These groupings, however, are limited to larger minority groups, and these norms assume a level of homogeneity that in today's pluralistic and multicultural society often does not exist. Despite its limitations, there are occurrences wherein a measure of intelligence is needed for an immigrant individual. For such situations, Rivera Mindt et al. provide recommendations to ensure the greatest level of success. First, it is important to choose the most appropriate test available for administration, with clear recognition of the limitations of the instrument when scoring or making conclusions. Second, it is important to evaluate and include in interpretation a number of sociocultural variables unique to the migrant individual with whom the instrument is being used. Such variables for consideration should include: language, with concern for language preference, degree of test-language fluency, and bilingualism; quality of education, including years of formal education, place of education, and years of education within the culture in which the test is being administered; the processes and motivation for migration, such as forced versus voluntary migration; health status pre- and post-migration, both physical and mental; personal experiences of prejudice, racism, and transition to minority status that can often accompany the migration process; and degree of acculturation, loosely defined here as the assimilation of cultural traits and values dominant in the area to which one has immigrated. Lastly, if able, Rivera Mindt et al. recommend referring the migrant to a professional, familiar and competent in test administration with that population, and if unable to refer, consultation should be sought with such an individual.

Related Topics

► Acculturation
► Eugenics
► Language
► Scale validation

Suggested Readings

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Lohman, D. F. (1997). Lessons from the history of intelligence testing. *International Journal of Educational Research, 27*(5), 359–378.

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Suzuki, L. A., Ponterotto, J. G., & Meller, P. J. (2001). *Handbook of multicultural assessment: Clinical, psychological, and education applications*. San Francisco: Jossey-Bass.

Van de Vijver, F. J., & Phalet, K. (2004). Assessment in multicultural groups: The role of acculturation. *Applied Psychology: An International Review, 53*(2), 215–236.

Suggested Resources

Indiana University. Human intelligence, http://indiana.edu/∼intell/index.shtml

Intergenerational Differences

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Intergenerational differences are divergences between family members of different age groups in immigrant families, and they are due usually to variations in acculturation. As immigrant families meld the culture and values of their sending and receiving countries, family members experience this melding process individually and collectively. The results often are a function of varying interactions with the receiving country's culture and individual developmental differences. Intergenerational differences may occur between parent and child, grandparent and parent, and grandparent and child; it is inherent in the process that there are different generations from the nuclear and extended family structure involved. It is important to note that intergenerational differences occur in all families, but may be perceived differently or may have greater significance in immigrant families.

The more disparate the acculturation between family members, the more likely it is that they will perceive greater intergenerational differences. There are a variety of aspects to acculturation: language skills and preferences, values and beliefs, behaviors, and customs. To varying degrees, one may incorporate in each aspect characteristics of both sending and receiving countries, and even employ them differently according to the setting. For instance, immigrant youths may use exclusively at home the language of their sending country; conversely, they may use exclusively at school the language of their receiving country. However, when immigrant youth are among their peers, their verbal communication may be specific to that particular peer group. Regardless of their language choices, they may express consistently the same values in all settings; or, expecting the same freedoms as their peers in the receiving country, they may argue with parents about values, while not being comfortable acting just as their peers. Acculturation is not a uniform process, even for one individual, which is why intergenerational differences can vary widely.

An important influence on intergenerational differences is gender. Depending on how rigid the gender expectations are in the sending and receiving countries, and the degree to which they differ, conflicts between immigrant generations may be significant. Because many families become more conservative following immigration, this will impact children's experiences. Girls often are seen as the bearers of culture, because they are responsible for childrearing and the transmission of culture to the next generation. This likely will translate into a discrepancy in the rigidity of the limits for boys and girls: with boys being allowed a variety of peers, traveling and exploring freely; and with girls being monitored more closely, while their actions and behavior outside the home are curtailed. This dynamic may increase intergenerational conflict, or the girls may acquiesce to limits in some area, but find ways to do the things that are important to them. Some children, especially those who are supported by a larger immigrant group, may see these limits as an important way to maintain their connection to the sending country.

The dynamics related to having extended family or a larger immigrant community will effect interactions with the receiving country: they provide support for the continuity of culture. They provide resources also; so the family is less reliant on outside supports to meet their needs. This may minimize the interactions with outside systems and decrease potential influences that may lead to intergenerational conflicts. For families without a larger network, either there may be more interactions with and exposure to the culture of the receiving country or there may be increased isolation. If parents feel that they need to protect their child from the receiving country's culture, and they restrict opportunities for interactions, the child may live a life of isolation even as a young adult (going to work and coming home to spend non-work hours with their parents). Conflicts may arise if children resent the limits. Extended family may mean that there are elderly to be cared for, some of whom may have a difficult time adjusting to immigration. The elder members of the family may have the least acculturation. They may struggle with the loss of their advice-giving role and the accompanying respect that is traditionally associated with this role. They may become dependent on other family members, all of which contributes to intergenerational differences and possible conflicts.

Intergenerational differences also can develop owing to changes in parents' status and opportunities following immigration. If the parents' ability to provide for their family is compromised, family members will have to distribute responsibilities differently. Adults may lose social status if they do not have a peer group that knows them and respects them. Children may have more relevant information about the receiving country's culture than adults in the family, further diminishing parental authority. Additionally, children may become the family's translators for dealing with outside systems in the receiving country, shifting the distribution of power within the family. These dynamics may all contribute to intergenerational differences and conflicts.

Related Topics

- ► Acculturation
- ► Acculturative stress
- ► Cultural adaptation resources
- ► Ethnic identity
- ► Family
- ► First generation immigrants

Suggested Readings

Lowenstein, A. (1999). Intergenerational family relations and social support. *PubMed, 32*, 398–406.

Merz, E. M., Ozeke-Kocabas, E., Oort, F. J., & Schuengel, C. (2009). Intergenerational family solidarity: Value differences between immigrant groups and generations. *Journal of Family Psychology, 23*, 291–300.

Suggested Resources

For information on the U.S. Citizenship and Immigration Services. Retrieved January 11, 2011, from http://www.uscis.gov/portal/site/uscis.

Intermarriage

► Marriage

Internally Displaced Persons

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The United Nations Office for the Coordination of Humanitarian Affairs Guiding Principles of Internal Displacement defines internally displaced persons (IDPs) as, "…persons or groups of persons who have been forced or obliged to flee or to leave their homes or place of habitual residence, in particular as a result of or in order to avoid the effects of armed conflict, situations of generalized violence, violations of human rights or natural or human-made disasters, and who have not crossed an internationally recognized State border (Office for the Coordination of Humanitarian Affairs [OCHA])."

The United Nations *Guiding Principles* recognizes that IDPs have a right to physical and mental integrity and that if authorities undertake displacements, IDPs should be accommodated in conditions that would afford satisfactory health (OCHA). Furthermore, Principle 19 of the *Guiding Principles* states, "All wounded and sick internally displaced persons as well as those with disabilities shall receive to the fullest extent practicable and with the least possible delay, the medical care and attention they require, without distinction on any grounds other than medical ones. When necessary, internally displaced persons shall have access to psychological and social services (OCHA)."

Doctors without Borders displayed estimates that there are 26 million IDPs. More than half of the IDPs are from six countries including Sudan, Colombia, Iraq, the Democratic Republic of Congo, Uganda, and Somalia. The group characterized the situation of IDPs as "bleak" because although there may be local and international aid organizations, IDPs are under the jurisdiction of their national authority which may be the source of the violence from which they are fleeing.

Many agencies around the world have had significant experience dealing with IDPs and it is important to understand what they have learned in order to identify IDPs and provide an adequate healthcare response both during and after any displacement. The following are examples of what has been learned about IDPs by the International Committee of the Red Cross (ICRC). IDPs are likely to stay with friends and family in nearby communities in order to minimize the disruption to their lives. However, these persons may go unnoticed by international or government aid agencies and this places an enormous strain on communities. Camps have their benefits and risks. Camps may be able to provide food, water, and shelter when there are no other choices. However, it is possible that camps can promote violence and exploitation or foster resentment with persons in nearby communities when the services in camps are not available in the communities.

Internally displaced persons suffer from unique sets of healthcare challenges depending upon the reason that they are displaced, the resources that are available, and the resiliency of the country. The health needs of IDPs can be assessed and addressed on a population and on an individual level. On a population level, the most important and basic need is access to food and water. Sanitary and uncrowded conditions can lessen the risk of the spread of infectious diseases. Other needs include access to adequate shelter, medical facilities, and health care personnel.

Vulnerable populations of IDPs must be identified so that their needs can be adequately assessed and addressed. The UN has recognized a need to pay attention to the following populations of internally displaced populations: children, mothers, pregnant women, the elderly, and the disabled.

On an individual basis, IDPs can be triaged based upon the acuity of their medical illnesses. Acute care requires identifying and stabilizing those who are critically ill. Those persons with medical ailments who would typically be stable under normal circumstances may acutely decompensate in the face of a lack of adequate medical care or equipment. Even a simple infection can lead to a life-threatening illness without access to proper treatment. Emergent mental health problems include mental illnesses that lead individuals to want to harm themselves or others or will lead them to be gravely disabled (i.e., not eating food or drinking water).

Internal displacement can last for years, and untreated chronic or other health conditions can lead to significant morbidity or mortality without adequate assessment and treatment. For example, chronic malnutrition can lead to inadequate growth and development. Inadequate treatment for diabetes can lead to the loss of eyesight and the need for amputations. Inadequate treatment for mental illness can lead to a significant decline in functioning. Any needs assessment and treatment provision has to take into account the sustainability of resources over the course of displacement.

Although vulnerable groups may be identified, decision makers may not see these groups as a priority and this may lead to increased morbidity and mortality that could have been reduced or averted. For example, according to the World Health Organization (WHO), despite evidence demonstrating that conflicts have a devastating impact on mental health, many decisionmakers do not see mental health as a priority. However, the WHO has urged that community-based psychosocial interventions become integrated as part of both the emergency response and the public healthcare system including camps and national services. Therefore, it is important to identify and address any biases or lack of understanding on the part of decisionmakers in order to adequately address the needs of those who may otherwise be ignored or not able to advocate for themselves.

In summary, there are many reasons why persons become internally displaced, but once displacement occurs, it can last for years. The response to those who are internally displaced is limited by available resources. The provision of adequate treatment first requires that an including the identification of vulnerable populations be conducted. Efforts should be made to make resources to address identified needs are sustainable. Interventions should be consistent with the evidence-based. Furthermore, human rights must be respected in order to help ensure the best possible outcome given the circumstances on the ground.

Related Topics

- ► Displaced populations
- ► Doctors Without Borders
- ► Internment
- ► Refugees
- ► Survivor syndrome
- ► Trauma exposure
- ► Vulnerable populations

Suggested Resources

Doctors without Borders. *About refugees and internally displaced persons (IDPs)*. Retrieved March 3, 2010, from http://doctorswithoutborders.org/events/refugeecamp/about/

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OCHA. *United Nations Office for the Coordination of Humanitarian Affairs guiding principles of internal displacement*. Retrieved March 3, 2010, from http://reliefweb.int/sites/reliefweb.int/files/resources/AB752ABEA5C1EFFCC1256C33002A8510-idp.htm

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International Adoption

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International, or inter-country, adoption is a type of adoption that occurs following the transfer of all parental rights and responsibilities from a child's birth parent (s) to biologically unrelated, adoptive parent(s) who live in a country different from the child's country of origin. Once a family is formed through inter-country adoption, the child moves to a new home with his or her adoptive parents and becomes a citizen of the adoptive family's country. Inter-country adoptees may have lived some of their childhood with birth families, but become orphaned for a myriad of reasons (i.e., parental death, abuse, neglect, abandonment, or poverty). Children often end up in institutional settings like orphanages, foster homes, child-headed households, or are homeless. Typically, children's pre-adoptive lives are filled with a multitude of challenges that expose them to risk and trauma, a factor noted in the literature as having an instrumental effect on child development. Considerations must be made by parents and pediatric professionals when evaluating children's further development following placement. To promote the defining of such considerations, there must first be an understanding of the current framework that is used for child developmental evaluation.

International Growth and Development Criteria (IGDC) is a developmental screening tool endorsed by the International Pediatric Association (IPA). A standard for child growth and development like the IGDC serves parents and pediatric professionals when evaluating how healthy children should sequentially develop in their physical, emotional, and cognitive domains for their chronological age. This approach bases its standards on families' having ideal access to resources, a nurturing primary caregiver, and an environment where children are most likely to reach their developmental potential.

Applying tools like the IGDC to the internationally adopted, post-institutionalized child is valuable, as it gives firm standards to evaluate developmental delays and guide interventions. However, parents and care providers unfamiliar with the unique needs of inter-country adoptees may be too literal when utilizing the IGDC, encouraging myopic focus on the child's delay "catch-up." Understanding and incorporating the etiology of the children's delays into care is essential in formulating effective interventions. Exclusively using a standardized approach like the IGDC may also prompt unrealistic expectations in terms of the chronological timing and pace of the adoptee's milestone accomplishments, priming an environment for anxiety and frustration during critical periods that could impede child–family attachment.

With post-institutionalized children, it may be beneficial to utilize the sequential nature of the IGDC in combination with a more tailored approach, or an individualized child development trajectory (ICDT). The ICDT is an approach that would incorporate known experiences with pre-adoptive risk factors when formulating interventions and goals related to the child's expected timing/pacing of milestone accomplishment. This developmental evaluation method would also encourage the child and family in the adoptee's development without adding frustration and anxiety linked to "catching-up" pressures during critical stages of relationship and attachment formation.

The interrelatedness of impacts from pre-adoptive risk factors must be understood when formulating a child's ICDT. Genetics, prenatal toxin exposures (alcohol/drugs), and the institutions' environmental impacts (i.e., sensory deprivation; malnutrition; abuse) create what is known as pre-adoptive risk factors. Another common, damaging risk factor for institutionalized children is the lack of primary caregiver consistency/emotional warmth needed by infants and children for survival, safety, trust building, social cue learning, and relationship building. Introduction of such risk factors during the child's critical periods of sensitive brain development can promote long-term effects, impacting how the child thinks, feels, and behaves when coping with stressors throughout life. This can also affect health in other developmental systems for the child. For example, links have been made to increased risk for contraction of infectious diseases (i.e., parasites; tuberculosis; hepatitis B), growth retardation, early onset menarche/precocious puberty, sensory problems, quasi-autistic behaviors, attachment difficulties, and long-term relationship challenges.

Consequences of child neglect are delays in major growth domains such as gross/fine motor skills, cognition and learning, language, and social-emotional development. For every 3 months the child spends institutionalized, his or her growth will reportedly lag approximately 1 month. The longer a child remains institutionalized, the greater the negative impacts on cognition, brain growth/head circumference, psychiatric impairments, economic dependency, cognitive/executive functioning, attention, language, learning, memory, visual-spatial functions, and struggles with attachment and social relationships.

Physiologically, children's brains experience neglect similarly to traumatic events. The brain's amygdala is activated in the presence of neglect, triggering the biological stress response system (BSRS), or the "fight or flight response." Anxiety and distress can impede the child/parents in attachment formation and lowers immunity. The chronic nature of this activation contributes to adverse brain development, increasing levels of cortisol (stress hormone) that trigger survival behaviors associated with hyper-arousal/hyper-vigilance, as well as difficulty with normal age-related behavior/emotion regulation. This often manifests like typical acting out, prompting most parents to respond with traditional child-rearing practices in an attempt to remediate negative behaviors. These practices (i.e., rewards/punishments) are often ineffective, as the child's acting out is symptomatic of behavioral responses to the bodies' physiological cues conditioned during earlier traumatic experiences. Post-institutionalized children who experience such effects need parenting and pediatric professional support that aids them in building adaptive skills to their stress/trauma coping responses. To provide optimal support, parents and pediatric professionals must be informed and have appropriate expectations when it comes to the child's developmental needs.

Although children reportedly thrive in many ways after adoption and follow a sequential growth pattern much like the standards stated in the IGDC, differences also exist that require consideration when evaluating their development. For example, attempts to define children's ages may result in inconsistencies. Adoptees may have a chronologic age, a second developmental age due to delays, and/or a third reproductive age when there is an early onset of menarche/puberty. Also, the pace of milestone accomplishment can differ as crossover may exist with one delay impacting another. Attempts to ameliorate one area of delay may impede progress in another domain or trigger the simultaneous accomplishment of a delay in another, prompting an erratic pattern in milestones completion.

Assessment and monitoring growth/development in post-institutionalized children is essential due to their often fragile states upon leaving the institution. Incorporating a tool like the IGDC paired with an individualized child development trajectory would provide a "standard" as well as a "reference" for supportive goal-setting/measurement while taking into consideration the effects of pre-adoptive risk factor exposures on the ideal course of growth and development.

Related Topics

- ► Child
- ► Child development
- ► Child health and mortality
- ► Child rearing
- ► Trauma exposure

Suggested Readings

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O'Connor, T. G., Rutter, M., Beckett, C., Keaveney, L., Kreppner, J., & The English and Romanian Adoptees Study Team. (2000). The effects of global severe privation on cognitive competence: Extension and longitudinal follow-up. *Child Development, 71*, 376–390.

Suggested Resources

National Scientific Council on the Developing Child. (2005). Excessive stress disrupts the architecture of the developing brain: Working paper #3. http://www.developingchild.net

International Health Care

- ► Border health
- ► Cross-cultural health
- ► Cross-cultural medicine

International Health Regulations

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The International Health Regulations (IHR) are a legally binding agreement adopted by all 194 World Health Organization (WHO) member States on May 23, 2005, and officially in force since June 15, 2007. The primary goal of the regulations is to reduce and contain the risk of disease spread in international travel, trade, and transportation. The IHR replace the 1969 set of regulations that initially covered six "quarantinable diseases" but were amended in 1973 and 1981 to reduce the number of covered diseases to three (yellow fever, plague, and cholera) and to acknowledge the global eradication of smallpox. The newly revised IHR contain a number of changes with implications for immigrants and immigrant health. Motivated by concerns about novel and potential epidemics such as severe acute respiratory syndrome (SARS), H5N1 ("avian flu"), H1N1 ("swine flu"), and drug-resistant tuberculosis (TB), the IHR expand the range of events about which member states must notify the WHO. In this respect, the regulations increase the mandate (and legal reach) of states to conduct disease surveillance at airports, hospitals, immigration services, ports, postal services, and other settings.

The regulations contain new provisions for inspection at ports of entry of people, individuals, cargo, containers, luggage, parcels, and human remains that are contaminated or that might be contaminated and that, as a result, place the public health at risk. If sources of infection or contamination are found, the regulations advise for the containment, decontamination, and if necessary quarantine or refusal of entry of "suspect persons" or goods.

At the same time, the IHR provide greater authority to the WHO to recommend changes in existing state systems for public health monitoring and response. Member States are required to notify the WHO of any event "that may constitute a public health emergency of international concern," including new and evolving public health risks. The IHR 2005 also contain a number of changes with regard to the duties of States in terms of "global preparedness" including the creation of new surveillance systems to detect and respond to events by June 2012. Specifically, member States are required to set up National IHR Focal Points, or communication systems for the relay of information between States and the WHO and within member States. For example, in the USA, this would be between public health departments in each of the 50 states and federal agencies like the Centers for Disease Control and Prevention (CDC). In addition, the IHR 2005 introduce a new category of "event" called a Public Health Emergency of International Concern (PHEIC) whereby member States are required to use new "decision instruments" to assess risk and if necessary to coordinate with the WHO to declare a PHEIC. In 2009, the outbreak of influenza A (H1N1) led to the first declaration of a PHEIC.

While many in the public health community agree that the new IHR regime has led to a strengthening of global health security, others, particularly in developing countries, have expressed doubts both as to the use of surveillance data for their best interests and the extent to which the new IHR will synchronize with local or regional interests of human rights, diplomacy, trade, and development. Perhaps the best-known case of a refusal to participate in the new IHR regime occurred in 2007, when Indonesian scientists refused to send H5H1 ("avian flu") samples to the WHO's reference labs. The scientists explained in a 2008 medical journal article (see Sedyaningsih et al.) that they were concerned that samples provided freely by developing countries were being used by companies in wealthy countries to develop vaccines and other products that the developing countries could not afford. From a financial standpoint, public health advocates have voiced concerns about the cost of IHR implementation and enforcement. While the WHO provides grants for the development of National Public Health Institutes (NPHIs), the burden of cost for setting up and maintaining disease surveillance is primarily on member States. This has led to a concern among public health advocates in the USA that funds previously designated for community health services are being re-routed into national disease and bioterrorism surveillance systems. Concerns about cost are coupled with concerns about the adequacy of human rights provisions; and critics have pointed out that legal and ethical protections are only superficially mentioned in the IHR 2005. Supporters of the new IHR have argued that increased data gathering and sharing will enable member States to better detect and respond to health threats of global significance. Whether increased opportunities for data sharing translate into more robust systems of public health is not clear and is difficult to assess outside of the context of actual epidemic situations. As was the case in recent debates about changes in US Transportation Security Administration (TSA) airport screening procedures (e.g., the introduction of new full body scanners and more extensive pat-downs), groups like the American Civil Liberties Union (ACLU) have questioned whether more invasive screening procedures can be justified given increased risks for violation of travelers' civil liberties.

From a sociocultural standpoint, the IHR 2005 raise important questions about language, norms, and differences in how risk is defined. What may be perceived as practical or meaningful "risk assessment" in one cultural setting may not be in another; the actual social and institutional norms through which IHR 2005 are practiced (e.g., how health workers count cases of disease and according to what diagnostic criteria) can vary considerably across borders. In regard to language and meaning, terms such as "global health emergency" are controversial and not easily agreed upon, as was revealed in the context of debates about how many H1N1 cases were required before an "epidemic" could be upgraded to a "pandemic." In January 2010, Dr. Wolfgang Wodarg, who now chairs the health committee at the Council of Europe, came forward to argue that pharmaceutical firms had organized a "campaign of panic" to put pressure on the WHO to declare a "false pandemic" in order to sell vaccines, resulting in a medical scandal. It later emerged that one third of the experts advising the WHO about the pandemic had ties to drug firms.

By November 2009 there had been 622,482 lab-confirmed cases of H1N1 reported from 207 countries and territories, with a total of 7,820 lab-confirmed deaths. The H1N1 epidemic was a litmus test for the new IHR 2005; it provided a staging ground for the collection and reporting of surveillance data within and between countries. Despite demonstrably "high" compliance of US epidemiologists reporting to the CDC and WHO, reporting capacity was lower among community and primary care providers. And, although there has been growing international acceptance of a general idea of "health security," multiple and incompatible definitions of the term remain. Divergent understandings among policymakers of what or how much surveillance constitutes "security," combined with insufficient reconciliation of the concept with community based primary health care, have stymied efforts to implement the IHR 2005.

In the USA, where "health security" is increasingly aligned with hegemonic ideals of "prophylaxis" against immigrant or foreign-borne diseases – coupled with an increased emphasis on shielding the nation from risks of bioterrorism – the latest regulations (2005) present significant social and legal consequences for immigrants and immigrant health. In 2009 the response of authorities in Beijing to the appearance of influenza A (H1N1) virus illustrated a level of discrimination reminiscent of the 1980s–1990s when hundreds of Haitian asylum-seekers were tested for HIV and then imprisoned by the US Immigration and Naturalization Services (INS) in the Guantánamo HIV Camp, one the world's first and only detention centers for people diagnosed with HIV or AIDS. In 2009, travelers to China from Mexico, as well as Mexican residents living in China, were targeted for quarantine both in airports and at their homes in Beijing, including individuals in whom no flu symptoms had been detected. In the USA and Mexico, limitations to the effectiveness of the IHR were revealed somewhat differently: namely, in inadequacies in surveillance, in mixed response capacities, and in the potential for narrowing the scope of IHR application only to influenza pandemic events. Analysts have argued that such limitations could undermine the IHR's potential to contribute to national and global efforts to detect or mitigate future public health crises.

Yet this assumes another sort of agreement or gloss of the term "crisis." According to whom (which decision makers) and what interests (diplomatic, economic, humanitarian) is a crisis determined? Better understanding of the heteroglossia of crisis and its analogs (concern, risk, threat, event, emergency, epidemic, pandemic) and the uses of these concepts in different locations and contexts would likely lead to better chances for cooperation. Likewise a clearer articulation of "common good" (rather than simply obligations and rights) especially in the area of data and sample sharing is greatly needed. Collaborating laboratories and scientists will need to see evidence (e.g., contractual plans) rather than "good faith" that the data they hand over will be used for a global common good rather than the increased share value of Western pharmaceutical firms. Also, there have been few quantitative assessments of whether global outbreak detection and communication processes have actually changed over time, that is, before and after the implementation of the IHR in 2007. There are also no clearly established guidelines for how countries should conduct IHR surveillance, which emerging disease syndromes should be reported, or what means for enforcement should be used. A cost benefit analysis would likely help to reveal whether changes prescribed by the IHR justify the expense of new high-tech systems for data capture and surveillance for example.

The WHO will remain stymied in its efforts to enforce the IHR as long as health workers in developing contexts are focused on more immediate quotidian needs, such as access to essential drugs, sterile medical supplies, and clean water; training and retention of qualified health care workers; economic security for immigrants and refugees; and the promotion of legal protections for persecuted groups. These concerns are likely to remain higher priorities than "specialized disease surveillance," particularly if such tracking systems suggest the reassignment of funds or staff within resource-poor settings including the majority of immigrant communities in the USA.

Related Topics

- ▶ Border health
- ▶ Communicable disease of public health significance
- ▶ Global health
- ▶ H1N1 virus
- ▶ Human rights
- ▶ Infectious diseases
- ▶ Medical examination (for immigration)
- ▶ Quarantine
- ▶ Travel and travel health
- ▶ Tuberculosis
- ▶ World Health Organization

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Suggested Resources

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International Labour Organization

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The International Labour Organization (ILO) is a specialized agency of the United Nations and responsible for drawing up and overseeing international labor standards. The missions of the ILO are to promote rights at work, support decent employment opportunities, enhance social protection, and strengthen dialogue on work-related issues. Due to the nature of its missions, the ILO has a tripartite governing structure, representing governments, employers, and worker representatives. This tripartite structure enables the ILO to develop a forum, wherein the governments and their socioeconomic partners can openly debate and develop labor standards and policies. Today the ILO has 183 member states.

The focal point for the ILO's main activities is the International Labour Office. The Office has approximately 2,700 officials from over 150 nations at its headquarters in Geneva, Switzerland and in around 40 field offices around the world. These field offices collaborate to promote the "Decent Work Agenda" as an integral part of regional and national development policies. The executive body of the International Labour Office is the governing body, which decides the agenda of the International Labour Conference, adopts the draft programme and budget of the organization for submission to the conference, and elects the director-general. The governing body, consisting of 56 titular members (28 governments, 14 employers, and 14 workers) and 66 deputy members (28 governments, 19 employers, and 19 workers), meets three times a year.

The ILO defines "Decent Work" as adequate income, safeguarding of rights, and assured social protection and identifies the "Decent Work Agenda" as its major priority. The goal of Decent Work is not simply the creation of jobs, but the creation of jobs of acceptable quality. This "Decent Work Agenda" is related to the human rights of immigrants considering that many of them are primarily employed in unskilled manual labor and are generally assigned to arduous or dangerous work, which national workers are reluctant to do. Moreover, immigrant workers often experience discrimination at both the recruitment and post-hire stages, resulting in their underemployment. Decent Work is the key element to achieve a fair globalization, reduce poverty, and achieve equitable, inclusive, and sustainable development. In this context, the ILO provides support for member states to put the Decent Work Agenda into practice through integrated Decent Work Country Programmes.

Related Topics

- ▶ Employment
- ▶ International Organization for Migration
- ▶ Labor migration
- ▶ Occupational health

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International Organization for Migration

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The International Organization for Migration (IOM) is an intergovernmental organization that has been established in 1951 to promote humane and orderly migration for the benefit of all. Having 100 offices all over the world, 127 Member States, and another 17 holding an observer status, this agency works closely with governmental, intergovernmental, and nongovernmental partners being the leading intergovernmental organization in the field of migration.

As a core value, IOM is committed to the principle that humane and orderly migration benefits both migrants and society, as well. Therefore, the scope of the organization is to safeguard the management of migration flows, promote international cooperation on migration issues, and assist in finding the appropriate solutions to various problems raised by migration.

Having offices and operations on every continent, the Organization offers support for governments and civil society to find solutions to migration issues, such as: rapid humanitarian responses to sudden migration flows, post-emergency return, and reintegration programs; support to immigrants in building a new life; aid to immigrants in distress; identification of mechanisms to combat trafficking of children, women, and other groups at risk; measures to respond to medical and public health issues in relation to migration; and research, education, and information on immigration issues.

The Organization cooperates with governmental, intergovernmental, and nongovernmental partners in the four broad areas of migration management: migration and development, facilitating migration, regulating migration, and forced migration. Cross-cutting activities of IOM specialization are linked to the elaboration of international migration law, policy debate and guidance, protection of immigrants' rights, migration health, and the gender dimension of migration. Furthermore, IOM provides humanitarian assistance to immigrants that are in need of help, including refugees and internally displaced people.

In terms of regulating migration, IOM offers tailored technical assistance to governments in the development and implementation of migration policy and the proper legislation and necessary administrative mechanism that regulates migrant labor and other migratory movements, as well as training courses for public servants in terms of border management, visa systems, regulating entry and stay, and collecting and using biometric information.

Since the IOM Constitution gives explicit recognition to the link between migration and economic, social and cultural development, as well as to the right of freedom of movement of persons, the work of the Organization is centered on the promotion of an international policy dialogue and toward policy-oriented research and programs and activities to build capacity of governments, improve remittance management, build human capital through labor migration programs, facilitate return and reintegration, and promote empowerment of immigrant women.

In terms of forced migration, IOM offers assistance for refugees and internally displaced persons (IDPs) who are a different category of immigrants. These people are "on the move" but they need a different type of assistance. The Organization offers help for refugees after emergencies and facilitates their resettlement in a new country, if this is a durable solution. The Organization seeks also to find solutions for internally displaced persons (IDPs), former combatants, and populations in transition or recovery environments.

IOM also offers support and technical advice to governments with the aim of facilitating migration, so to have the capacity to properly regulate the migrant labor and other migratory movements. The Organization is active in offering assistance for governments and immigrants, as well, with issues such as: selection/recruitment, language and cultural orientation, consular services, training, reception, integration, and return.

As health issues affect all immigrants and potentially cut across all areas of IOM's work, the Migration Health Department within the Organization responds to the health needs of migrants throughout all phases of the migration process, and to the public health needs of host and home communities. The Department coordinates health operations, offers health policy advices, and contributes to public health research.

Some of the issues that the Department is in charge of include: control of infectious, emerging, and reemerging diseases; health activities in response to population movements caused by natural or man-made disasters, ecosystem change, chronic diseases, mental health, and psycho-social health concerns, including culturally appropriate health services; the human rights of immigrants and mobile populations; immigration health management; and many other issues that affect the immigrants' health and the communities they live in or transit through.

Related Topics

- ► Healthy immigrant
- ► Internally displaced persons
- ► International Health Regulations
- ► Refugees

Suggested Resources

http://publications.iom.int/bookstore/
http://www.iom.int
http://www.un.int/iom/
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Internment

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The term internment is used to refer to the confinement or imprisonment of large groups of people within the context of warfare. Typically, nonnaturalized immigrants are the subject of internment; however, at times this practice has been extended to those who hold different political convictions, belong to a group considered undesirable, or who the government perceives as a threat to wartime security. Such individuals are typically held without the benefit of a trial and with no specific charges, thus distinguishing internees from prisoners who are held for punishment after being found guilty of a crime and typically have access to a trial within the civil or military courts of the country.

In North America the best-known case of internment was that of Japanese-Americans during World War II. President Franklin D. Roosevelt signed Order 9066 into law on February 19, 1942 leading to the evacuation and relocation of an estimated 112,000 ethnic Japanese, most of whom were first and second generation citizens, from the West Coast of the USA. Numerous other examples of internment during World War II exist, including noncombat Allied citizens interned by the Japanese in the Philippines and China. The Nazi internment of Jews, those with mental illness and physical disabilities, homosexuals, and others in what became known as concentration camps will be dealt with in a separate entry (see ► Holocaust). Internment was also widespread in World War I. Examples include the USA in its internment of over 6,000 individuals, France's internment of German civilians, and Canada's internment of Ukrainians residing in Canada. This practice can also be traced back to the confinement and resettlement of native people by colonizing nations.

The experiences of those confined in internment camps vary both by the war and the country in which they were detained. The emotional consequences of internment are frequently long lasting. While living in internment camps, individuals are forced to leave their homes and jobs, are sometimes separated from family and support networks, and frequently housed in prison-like settings with armed guards. Unrest is common in internment camps and violence can occur both between those interned and their guards and amongst those confined. Posttraumatic stress disorder can occur as a consequence of experiencing and witnessing traumatic events within this setting. Individuals with posttraumatic stress disorder can experience problems relating to family and peers. They can avoid things and people that remind them of their trauma and experience flashbacks to their time in the camps. Other possible consequences of posttraumatic stress disorder include irritability, an inability to concentrate, and difficulty envisioning one's future.

Those who have lived through internment may also have problems with depression or anxiety disorders. If they escaped an internment situation while others did not they may have feelings of guilt or survivor's syndrome. They may have a difficult time trusting those in authority, have low self-esteem, feelings of pressure to assimilate, and either a loss of connection with their own culture or an over-identification with it. Earning potential and productivity may be affected both by anxiety and depressive disorders as well as the lack of formal education during time spent in internment camps.

The internment camp experience also has a significant impact on an individuals' physical health. Lack of proper sanitation and close quarters in camps can lead to rampant spread of infectious diseases which both sicken the immigrant and those who come in contact with him or her after release. Harsh climates and lack of access to medical practitioners, medications, and equipment can lead to lack of diagnosis and proper treatment of chronic medical conditions and poor prenatal care that can have long-term negative health consequences. A 2006 study by Hahn et al. showed an increase risk of cardiovascular diseases including hypertension and chronic ischemic heart disease in such populations.

One of the main physical consequences of internment is malnutrition. During wartime, resources are frequently scarce and those who have already been identified as a potential threat to the State are typically of low priority for dwindling food supplies. Immediate consequences of long term, severe malnutrition can include refeeding syndrome in which the body is unable to properly metabolize nutrients during the first several days of food availability resulting in fluid and electrolyte disturbances. If not properly treated, this can lead to seizures, coma, or death. Malnutrition can also increase ones susceptibility to infectious disease including active tuberculosis. Longer-term sequelae of malnutrition can include osteopenia and osteoporosis with its associated increase in risk of bone fractures as well as overall increased mortality rates. Malnutrition in childhood has also been associated with lower educational achievement. Even in internment camps where food is adequate, if the diet is lacking in specific essential nutrients individuals may have mental impairment, heart disease, or bleeding disorders, and pregnant women may give birth to children with birth defects.

In summary, the consequences of internment both on physical and emotional health are significant and should not be overlooked. The 1949, the Geneva Convention outlined appropriate treatment of internees, giving special attention to issues of hygiene, access to food and medical attention. Public criticism of internment has grown since World War II. In the USA, attempts were made to address the "significant human suffering" caused by the internment of ethnic Japanese during World War II. On August 10, 1988, President Ronald Reagan signed a law issuing reparations payments of $20,000 to those Japanese-American citizens and permanent residents who had been subject to the internment process. Additional monies were set aside to fund education programs related to these experiences.

Related Topics

- ► Holocaust
- ► Posttraumatic stress disorder
- ► Survivor syndrome
- ► Trauma exposure

Suggested Readings

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Interpreter Services

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When compared to patients who share the same language with their providers, language-discordant patients experience lower quality of care, including but not limited to worse interpersonal care, less communication, and lower patient satisfaction even in areas unrelated to language. Translators (i.e., individuals who work with written documents) and interpreters (i.e., individuals who provide oral communication) often are considered the standard solutions to provide culturally appropriate and sensitive care. Interpreter Services, which may be a contracted independent agency or a division housed within a health care organization, often provide services for both medical translation and interpretation.

Medical interpreting is not only well organized but is also extensively studied in various multiethnic societies (e.g., Australia and Canada) and in countries that represent a destination of intensive immigration (e.g., Denmark, Germany, the Netherlands, Spain, Switzerland, the United States, and the United Kingdom). In the United States, starting from the late 1970s, there have been federal and state legislative efforts to require physicians to provide interpreters for patients with limited English proficiency (LEP). At the federal level, the White House issued an Executive Order on *Improving Access to Services for Persons with Limited English Proficiency* on August 11, 2000, which resulted in written guidelines being provided, by the Department of Health and Human Services in 2003, to health care providers to ensure language assistance for persons with LEP. The guidelines were rooted in the Title VI of 1964 Civil Rights Act, which prohibits discriminations on the basis of race, color, or national origin by any recipient of federal financial assistance. In short, health care providers who do not provide interpreter services will be cut off from federal reimbursements, including Medicare, Medicaid, and the State Children's Health Insurance Program. Because by law the cost for interpreters cannot be transferred directly to the patients, health care facilities often struggle to find sufficient funding through federal/state-level sources, insurance companies, and private funds. In early 2009, California became the first state in the United States to pass a law requiring health insurance organizations to pay for interpreting and translating services. Although the American Medical Association (AMA) and health maintenance organizations often raise concerns about the high costs of interpreter services, recent studies have demonstrated that providing interpreter services as a part of standard care often increases the overall number of immigrant patients, resulting greater revenue for the hospitals.

As of 2010, many national and regional interpreter associations in the United States have advocated for a national certification although a standardized process is still a work-in-progress. A national survey in 2010 showed that nationally certified American Sign Language interpreters are better compensated than spoken language interpreters in health care settings. The efforts to push for national certification reflect the interests in recognizing medical interpreters not only as bilingual go-betweens but also as health care professionals. The local certification requirement for medical interpreters often differs from state to state. In states where the certification tests are required, they often are limited to a few languages (e.g., Spanish). As a result, there are no federal or state regulations in place that prohibit the use of noncertified/professional interpreters in health care settings.

The cultural and linguistic diversity of patients make it unrealistic for health care organizations to provide professional interpreters in all languages at all times and/or all points of contact. The AMA, in fact, has provided guidelines to providers for the effective and appropriate utilization of different types of interpreters, including on-site professional interpreters, telephone interpreters, ad hoc interpreters, family interpreters, bilingual staff, and bilingual health care providers. Professional interpreters are typically defined as individuals who have received a minimum of 40 hours of training in medical interpreting. Different health care organizations may have additional requirements, including intern hours or (internal) certification. Several recent reviews have found that on-site professional interpreters appear to raise LEP patients' satisfaction and quality of care to approach or equal that for patients without language barriers. However, researchers have also found that even in states that institute interpreter legislation, health care providers often underuse on-site professional interpreters, citing time constraints and lack of availability of interpreters as primary reasons. On-site professional interpreters can also be unrealistic if the patient population cannot support such services.

Most health care facilities also use other types of interpreters, which are not without flaws. For example, telephone interpreters do not have access to other speakers' nonverbal cues and tend to have concise talk that centers on medical information (as opposed to rapport-building). Ad hoc and family interpreters, including bilingual children, may not understand complex medical procedures, pose additional risks to malpractice lawsuits and patient privacy, and/or experience unanticipated stress. Bilingual staff and providers need to manage other institutional roles and responsibilities that may conflict with that of interpreters.

It is important to note that providers and patients do not share the same preference for interpreters. Generally speaking, both providers and patients prefer on-site professional interpreters; however, they do not share the same attitude for other types of interpreters. Other issues (e.g., trust, interpreter availability, and specific tasks) may influence their preferences. For example, patients may prefer family interpreters because they can assist them after medical encounters and have their best interests in mind. In addition, in small immigrant communities where privacy can be a concern, minority patients may feel reluctant to disclose information to individuals outside of their social network, including a professional interpreter. In contrast, health care providers often are concerned that family interpreters may side with patients and become a liability in malpractice lawsuits. Many providers argued that in situations that require emotional support (e.g., disclosing poor prognosis), they prefer nonprofessional on-site interpreters over professional telephone interpreters. Some providers cited the convenience, medical knowledge, and institutional role of bilingual staff and colleagues as reasons why they are preferred choices in the absence of on-site professional interpreters. Several researchers recently have noted that family interpreters can be very valuable for specific tasks (e.g., obtaining medical history and patient advocacy). Finally, although providers generally are satisfied with medical encounters conducted through their (limited) second language skills, patients often find the interaction biased toward the providers' informational needs and does not allow them to communicate freely.

In addition to different types of interpreters, health care facilities also have introduced various modes of medical interpreting, including video medical interpreting, computer-based preprogrammed screening, and remote simultaneous medical interpreting. These interventions primarily aim to improve interpreting services to rural areas and emergency rooms, which traditionally have difficulties in providing on-site professional interpreters at all hours. Although the different types of interpreters and modes of interpreting are not interchangeable as they each have their own distinctive strengths and weaknesses, they serve as valuable resources in complementing and/or supplementing on-site professional interpreters' services.

By recognizing the variety of interpreters and modes of interpreting available in health care settings, researchers have explored their corresponding impacts on patient satisfaction, provider expectations, patient–interpreter relationships, institutional costs, and clinical consequences. It is important to note that researchers and providers have shifted away from the argument that only professional interpreters should be used in health care settings. Rather, they have proposed that the ability of providers to work with different types of medical interpreters is critical to the efficiency, quality, and informal economy of bilingual health care. For example, for routine care, providers may feel comfortable to communicate through nonverbal communication, limited second language skills and/or family members; however, they should use on-site professional interpreters for interactions that may be complex or have high stakes. Recent studies on medical interpreters have centered on identifying the contextual factors and guidelines that allow providers to develop effective and appropriate strategies when working with different types of interpreters.

Currently, there is no standardized code of ethics for medical interpreters although many interpreter associations and health care organizations have proposed various forms of code of ethics for interpreters. Reviews of the codes of ethics for medical interpreters have concluded that many of the codes emphasize a mode of interpretation that calls for an objective and neutral role for interpreters. Professional medical interpreters are trained with a default role, which is often called the conduit model. In the conduit model, interpreters assume a passive and neutral role, faithfully transferring information from one language to another without any agency or distortion. The prevalence of the conduit model also is reflected in the public's and providers' attitude and expectations for interpreters, envisioning interpreters as neutral translating machines. Interpreters often viewed the conduit role as a mechanical, robotic performance in which interpreters are prohibited to intervene in the interactions or to have personal opinions. Although professional interpreters often identify strongly with the conduit model, they also report significant dissonance and/or distress if they believe a strict adherence to the conduit model may lead to, if not worsen, miscommunication, prejudice, bias, and/or problematic care.

The research and health care communities, as a result, increasingly have recognized the complexity of interpreters' functions, which is reflected in the emerging trends in reexamining and expanding interpreters' roles and code of ethics. Researchers have demonstrated that interpreters do not assume a passive or neutral role as prescribed by the conduit model. Rather, they are active participants who systematically adopt purposeful strategies to improve a patient's health literacy, to protect institutional resources, to reduce the cultural gap between the provider and the patient, to reconcile provider–patient conflicts, to reinforce provider–patient relationship, and to ensure the quality of provider–patient interactions. Many researchers have concluded that the complexity of bilingual health care makes the conduit model impractical, if not unrealistic. As researchers noticed interpreters' active involvement in the communicative process, however, they also have questioned interpreters' ethics and raised concerns about how some of their communicative strategies may infringe on providers' authority or patients' autonomy. It is important not to romanticize interpreters' active role in interpreter-mediated medical encounters and examine their performance and communicative strategies critically.

There is a growing attention on viewing medical interpreting as a goal-oriented activity (i.e., achieving optimal care for patients). Interpreters are not necessarily expected to remain passive or neutral. Rather, they should actively shift between various roles (e.g., from the least intrusive role of conduit, to clarifier, to culture broker and finally, to the most intrusive role of advocate) in response to the tasks, issues, and contexts emerged during medical encounters. Interpreters are encouraged to actively evaluate other speakers' communicative goals and to modify their strategies and role performances accordingly. Interpreters, thus, are a part of a health care team and share the responsibilities in ensuring the quality of care.

A successful interpreter-mediated encounter is a coordinated accomplishment of all individuals involved. All participants (e.g., the provider, the interpreter, the patient, and even the family members) in the interpreter-mediated medical encounters can influence the process and quality of bilingual health communication. Interpreters can play a significant role in this process by overtly and covertly enhancing the patient and/or provider communicative competence. For example, to ensure effective and appropriate provider–interpreter interactions, interpreters may conceal the providers' problematic behaviors or ask questions on behalf of the patient. One study found that, when interpreters are friendly and emotionally supportive, Latino patients are more receptive to providers' suggestions of amniocentesis. A neutral/slightly cheerful interpreter can act as a buffer to the patient in reducing the negative moods caused by a despondent therapist. In fact, interpreters actively provide emotional support by noting the needs to bridge cultural differences and to ensure quality care. Conversely, interpreters' behaviors may compromise other speakers' communicative competence. For example, when interpreters focus on medical information and ignore providers' rapport-building talk, providers may appear emotionally detached. These studies highlight the fact that medical interpreters play a critical role in patients' health care experiences and in shaping provider–patient communication and relationship.

Providers' communicative behaviors may create dilemma for interpreters in managing medical encounters. For example, providers often feel comfortable in saying things that they would not have said during a monolingual medical encounter (e.g., showing confusion about the actual diagnosis or making disrespectful comments about the patients) believing that the patient would not understand them anyway. An interpreter may feel obligated to relay such information but fear that doing so may worsen the provider–patient relationship. In addition, interpreters may be motivated to bias toward providers (as opposed to patients) and to accomplish providers' communicative goals (e.g., pressuring patients to accept the providers' treatment suggestions) due to the lack of job security. Both interpreters and providers have reported instances in which an interpreter was sanctioned or even fired because they fail to meet the providers' expectations. The hierarchy of health care teams privileges physicians' status and perspective. As a result, researchers have argued that successful bilingual health care requires providers to create an environment in which others (e.g., interpreters and patients) are comfortable to voice their opinions without fear of retribution (e.g., getting fired or reprimanded). In other words, both providers and interpreters should feel empowered to challenge each other's perspectives and derive mutually acceptable solutions based on open discussion of the optimal utilization of their medical, cultural, and/or linguistic expertise.

This is a perspective that has been neglected in the conceptualization of bilingual health care until very recently. Traditionally, interpreters are believed to be the persons who are solely responsible for the success of an interpreter-mediated medical encounter, which is accomplished through their neutral, faithful, and accurate relay of information from one language to another. The emerging perspective, however, highlights the importance of providers' and patients' roles in contributing to a successful medical encounter. Many health care organizations now offer workshops on cultural competence and interpreter-mediated interactions to providers and/or patients, aiming to improve their communicative competence in cross-cultural health care.

A national survey in 2006 found that roughly 50% resident physicians reported no training on adapting their communicative strategies when working with interpreters and 67% reported no training to manage situations in which they suspect the interpreter has misinterpreted. The lack of training can lead to provider–interpreter miscommunication and problematic collaboration. When providers are familiar with interpreters' practices (e.g., first-person, emotionally detached, and/or simultaneous interpreting style), they can understand the purposes of interpreters' specific behaviors and, if necessary, negotiate with interpreters about other alternatives to achieve optimal care. In 2004, New Jersey became the first state in the United States to adopt a law requiring medical schools to include cultural competency into curriculum, which include working with medical interpreters. Cultural competency education also was required for physician relicensure. Since then, many other states have also adopted laws or introduced bills on similar topics. These legislative efforts provide strong support to recognize successful bilingual care as a coordinated accomplishment between the provider, the interpreter, and the patient.

Related Topics

- ► Access to care
- ► Cultural competence
- ► Cultural humility
- ► English as a Second Language
- ► Language
- ► Language acculturation
- ► Language barriers
- ► Limited English proficiency
- ► Medical interpretation
- ► Telephone interpretation services

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Suggested Resources

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International Medical Interpreters Association. http://www.imiaweb.org

Occupational Outlook Handbook (2010–2011), Bureau of Labor Statistics, USA: http://www.bls.gov/oco/ocos175.htm

The National Board of Certification for Medical Interpreters. http://www.certifiedmedicalinterpreters.org

Intestinal Parasites

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Infections with intestinal parasites are one of the most common medical conditions observed among immigrant populations coming from endemic areas. Although many individuals report to have little or no symptoms, intestinal parasitic infections may lead to severe health problems if left untreated. Commonly detected pathogenic intestinal parasites through routine stool examinations are: *Entamoeba histolytica (Amoebiasis)*, *Giardia intestinalis*, *Ascaris lumbricoides, Trichuris trichiura, hookworm, Strongyloides stercoralis, Schistosoma mansoni*, *Schistosoma haematobium*, and *tapeworm (Taenia* species*)*. Some parasites may be less frequently observed in stool samples, but instead, detected through an elevated number of eosinophils in response to the infection. Prior to departure, presumptive therapy is recommended for immigrants originating from endemic areas, for example, Middle East, South/Southeast Asia, and Africa. Respective oral drug regimens of albendazole, ivermectin, and praziquantal are provided. Pre-departure treatments have reduced parasitic infections among newly arrived immigrants. Special considerations are recommended in administering presumptive treatment to the following populations: infants, under five children, pregnant women, women who are breastfeeding, and immunocompromised individuals. Despite treatment during medical screenings, some intestinal parasites can persist years after resettlement. Comprehensive health exams are recommended post-resettlement to detect persistent infections and prevent more serious complications from developing.

Commonly Detected Intestinal Parasites

Commonly detected intestinal parasites fall under two general categories: protozoa or helminth. Frequently observed pathogenic protozoan infections are *Giardia Lamblia* and *Entamoeba histolytica*. Helminth infections are further classified into three main groups: nematodes, flukes, and tapeworms. Nematodes are intestinal parasites transmitted through oral-fecal route or skin penetration with infective larvae. These parasites include hookworm *(Necator americanis, Ancylostoma duodenale)*, *Trichuris trichiura*, *Ascaris lumbricoidis* and *S. stercoralis*. Flukes are parasites that require an intermediate host and are associated with chronic infections contributing to severe mortality and morbidity. Infections with the *Schistosoma* species are frequently diagnosed in immigrants originating from sub-Saharan African countries. Transmission occurs via skin penetration by infective larvae resulting from exposure to water sources proliferating with infected intermediate hosts, that is, snails. Infection with tapeworms (*Taenia* species) occurs through the human consumption of eating undercooked beef, pork, or fish with the parasite larvae.

Risk Factors

While infections with intestinal parasites are common medical diagnoses among newly arrived immigrants, these infections are preventable and easily treated with access to medical services particularly the availability of oral medications. A significant risk factor for the presence of intestinal parasites is residence in areas with high disease burden for parasitic infections. Contributing to the disease burden, these areas are located in resource-poor countries in which access to clean, protected water sources, sanitation facilities, and medical services is limited or nonexistent. These infections correlate to impoverished living conditions, social and economic upheavals, and gaps in the health systems of the originating countries. Specific regions place individuals at greater risk for particular parasitic infections. For example, immigrants arriving to Canada from East African countries were more frequently observed to be infected with schistosomiasis and strongloidiasis, while clonorchiasis infection was often seen in immigrants coming from Southeast Asia.

Epidemiology

The pattern of intestinal parasitic infections observed in different countries varies according to length of residence in the host country and the country of origin. Besides these two factors, prevalence rates observed ranging from 20% to 80% are also dependent on age and parasite type. Helminth and protozoan infections present different epidemiological patterns. Helminth infections are more commonly detected in newly arrived immigrants. Newly arrived immigrants from specific regions and originating from resource-poor communities are at greater risk. Surveillance data from Toronto, Canada between 1997 and 2003 recorded 29% of returned travelers and new immigrants with parasitic infection. Diagnoses with parasitic infections were more likely to be observed in newly arrived immigrants as well as having multiple parasite infections. In 2000 and 2002, surveillance data in Australia from East African and Cambodian immigrants assessed disease burden of intestinal parasites and found the following results: 77 of 117 fecal samples from East Africa were positive for intestinal parasites compared to 25 of 204 fecal samples from Cambodian immigrants who were positive. In addition, 15% of East African immigrants and 42% of the Cambodian immigrants tested positive for *S. stercoralis.* Eighteen percent of children from East Africa were infected with pathogenic parasites; 11% of these children were positive for *S. stercoralis* and 2% for schistosomiais. In 2003, 50% of stool samples from East Africa were pathogenic. Twenty-five percent had multiple species detected. However, of the 133 children providing stool samples, all were asymptomatic. Also in this sample, intestinal parasites were more likely to be observed in older children. *S. stercoralis* and schistosomiasis were also documented in immigrants coming from East African countries to USA, Europe, and Israel. In the USA, specifically Santa Clara County in California between 2001 and 2004, 1,174 referrals for medical screenings were recommended to recent refugee arrivals. Sixty-six percent were selected to receive these health assessments. Of these individuals, 14% of the stool samples assessed were found to be positive for a parasite. Nine percent of these infections were classified to be protozoan, while 6% were helminthic. Twelve percent of these individuals had multiple species infection. The most common infections observed were *Giardia lamblia*, *Entamoeba histolytica* hookworm, *A. lumbricoides, and S. sterocoralis.* In this sample, different species were concentrated in refugees from specific regions. Individuals from South Central Asia were more likely to be diagnosed with hookworm and *A. lumbricoides*, while *S. stercoralis* was frequently found among refugees originating from African countries. In addition, immigrants from Africa were observed to be infected with a wider range of helminth species. Protozoan infections were more likely to be found among children. The prevalence for Santa Clara County was found to be lower compared to 22% in Minnesota and 56% in Massachusetts. A probable explanation for the observed lower prevalence is the health impact of providing drug treatments prior to departure. In San Francisco, 96 children were screened for intestinal parasites at a local health center serving immigrants from Central America. Sixty-five percent of the foreign-born children had parasitic infection. Forty-six percent of these infections were from pathogenic parasites, while 14% of the children were infected with multiple parasite species. The most common parasites were *Trichuris trichiura, A. lumbricoides, and Giardia lamblia.* In contrast, of the 32 children born in the USA who were tested along with the foreign-born children, only four tested positive for parasites; none of the parasites were pathogenic.

Among immigrant populations in Europe, 80% originated from sub-Saharan Africa. During medical screenings, 25% tested positive for filariasis and 22% for intestinal parasites. Of the individuals who tested positive, 33% were children and 70% were adults. Furthermore, 30% of the individuals who tested positive for intestinal parasites were co-infected with multiple parasite species. Twenty-seven percent of the individuals infected reported symptoms of diarrhea and abdominal pain, while 53% of infected individuals were observed to have increased eosinophils. Among the individuals observed to have elevated levels of eosinophils, 43% was attributed to filariasis, 17% with coinfections with filariasis and intestinal helminthiasis, 3% intestinal helminth infections, and 2% with schistosomiasis. Eleven percent of immigrants were asymptomatic during the medical screening and of these asymptomatic individuals 40% of the stool samples were observed to be positive for a parasite. African immigrants showed a higher prevalence of parasites compared to other regions. Although the symptoms of fever, stomach pain, weight loss, and diarrhea were often reported, the presence of symptoms did not necessarily indicate a positive diagnosis for parasitic infections. However, the presence of increased eosinophils correlated to a positive diagnosis for *S. stercoralis.* This marker is currently under investigation as a possible screening tool to detect *S. stercoralis* infections.

Immigration and Health Screenings

In many countries, medical screenings for recently arrived immigrant populations are prioritized due to the high prevalence rates of intestinal parasitic infections documented from refugees entering the USA in the 1980s and 1990s. Based on the findings, 38% of individuals living in refugee camps were found to be infected with pathogenic intestinal parasites, the Centers for Disease Control and Prevention (CDC) regulated the administration of pre-departure drug treatments prior to entering the USA in 1999. Predeparture drug therapy in the form of single oral doses of 600 mg of albendazole has been estimated to reduce infection rates and health care expenses. Overseas, these treatments are coordinated by the International Organization for Migration (IOM). During 1991 and 2001, 81% of refugees from Africa were given albendazole treatment prior to entering the USA which corresponds to reduced prevalence rates observed in later years. Implementation of universal intestinal parasitic therapy prior to immigration has drastically lowered prevalence rates of intestinal parasitic infections among newly arrived immigrants. However, previous presumptive therapy programs have been criticized for inadequate treatment of strongyloides and schistosomiasis, intestinal parasites that were associated with severe mortality and morbidity among immigrant populations. Furthermore, parasite detection through stool examinations, although widely available, may not serve as sensitive tests to detect these two parasitic infections. An alternative test, for example, ELISA, is needed, but is not widely available or cost effective. The CDC guidelines for presumptive therapy have been revised accordingly. In addition to albendazole, immigrants from specific regions at high risk for strongyloides or schistosomiasis are also provided with either ivermectin and/or praziquantal.

Upon arrival to the USA, the Department of Health and Human Services Office of Refugee Resettlement under the Immigration and Nationality Act is responsible for providing refugees with medical care while undergoing the immigration process in the USA. With the cooperation of state health agencies, health assessments are provided including screenings for parasitic infections. Immigrants with refugee status are offered comprehensive health exams through participating state and county health clinics. These health assessments are recommended due to findings of persistent infections observed in immigrant populations and to prevent serious complications from developing attributed to untreated parasitic infections. For example, persistent infections were reported in Cambodian immigrants despite receiving treatment 2–6 years after resettlement in Canada. Furthermore, untreated parasitic infections may result in anemia (hookworm), intestinal obstruction (roundworm), pulmonary hypersensitivity (*Ascaris*), bladder cancer (*S. haematobium*), and severe tissue inflammation (*Stronglyoidiasis*). Low education levels, language barriers, and cultural factors contribute to reasons for nonparticipation among immigrant populations in these health assessments.

Related Topics

- ▶ Africa
- ▶ Central America
- ▶ Global health
- ▶ Infectious diseases
- ▶ Medical examination (for immigration)
- ▶ Refugee health and screening
- ▶ Southeast Asia
- ▶ Travel and travel health

Suggested Readings

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Suggested Resources

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Intimate Partner Violence

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Intimate partner violence (IPV) includes not only physical violence but also emotional and sexual abuse. The "partner" can include a spouse, but also a live-in partner, or even a date – and may be part of a heterosexual or a homosexual relationship. Beating, raping, or murder may occur and weapons may be used. Some studies suggest that the rate of IPV committed by women may be equal to that committed by men. However, male batterers often commit the more serious violent acts.

A "cycle of violence" has been put forward to describe a frequent pattern. In the tension-building phase, verbal and emotional abuse occur. The victim tries to placate the batterer. But, it inexorably leads to the acute battering phase. This often unpredictably timed violence is usually triggered by a stressor for the batterer – such as problems at work. During the final "honeymoon" phase, the batterer apologizes and may give gifts and make promises. In the cycle, the victim stays because the victim wants to believe in the partner's commitment to change.

There are many theories for why violence occurs in relationships. A culture of violence theory suggests that subcultures develop their own norms which allow the use of physical violence in relationships. Another theory, of marital power, indicates that if one partner lacks power, he or she may use physical abuse toward his or her partner to gain some power. Control over the resources outside of the family unit may be protective, according to the resource theory. Alternately, the exchange theory posits that partners use violence to reach their goals if the benefits outweigh the costs. Finally, the evolutionary theory holds that violence is a way of securing obedience, and that partner violence evolved to ensure sexual dominance and sexual proprietariness related to the female's reproductive value. Women's violence toward their partners occurs for various reasons as well, such as self-defense, but also control, anger, and revenge.

Emigrating from a more patriarchal society (such as China) to the USA may change some relationship dynamics, such as the decrease in decisionmaking power by the man. The subjective loss of power may relate to the batterer's attitude about IPV perpetration. In the study of IPV, it is critical to consider not only the individual relationship, but also the broader culture and subculture. Even across Latino immigrant subgroups, for example, rates of IPV are quite variable. "Role strain" related to immigration and acculturation, as well as male dominance, requires futher consideration vis-á-vis various immigrant groups.

Studies indicate that the lifetime prevalence of physical abuse by an intimate partner against US women ranges from 9% to 30% depending on the study and methods used. The prevalence of rape by an intimate partner is 8%. Older persons are not exempt from IPV. A recent study of older Chinese immigrants on the US west coast found the 7% of the women and 6% of the men experienced minor physical violence by their spouse in the previous year. It was recommended that interventions explore hostile attributional bias.

Factors increasing risk of IPV victimization borne out by research include: younger age, lower education, lower income, urban residence, personal history of abuse (including as a child), alcohol or drug use, and current pregnancy. Further, mental illness may increase risk of being battered, by various mechanisms.

Risk factors for the perpetration of IPV include: past violence, physical victimization as a child, parental rejection, fears of abandonment, alcohol or drug use, anger, mood swings, blaming others, need for excessive control, insecurity, jealousy, and low self-esteem. A recent Boston study of Caribbean and Cape Verde immigrants found that those men who reported exposure to political violence were more likely to report that they themselves perpetrated IPV.

Screening is important, particularly in the emergency room, community health centers, and community mental health centers. Dental offices and pediatrician's offices also are opportune locations for screening; mothers may bring their children in for care whilst neglecting their own healthcare. IPV victims may be reticent to discuss their abuse because they are ashamed (male victims in particular), have low self-worth, think it is normal or private behavior, or have not disclosed even their relationship to others. Therefore, routine inquiry into victimization experiences can be helpful in screening and diagnosis. Asking about violence can occur in several contexts: asking about fears, discussing decision making, and direct inquiry. The risk of violence by same-sex partners should not be forgotten by the practitioner. In addition to the obvious physical sequelae, IPV may also lead to psychological symptoms including anxiety, posttraumatic stress disorder, depression, and an increased risk for substance misuse. Children's exposure to relationship violence will also increase their own risk.

Emotional isolation, mistrust of others, and self-esteem are often topics for the clinician to address with the patient. Information about shelters, domestic violence services, and crisis management services should be made available. Complex issues including the development of a safety plan and legal options such as protection orders are important to consider and educate victims about. Immigrants' knowledge about local services and restraining orders may be limited. The decision to leave a violent relationship should not be made lightly. Separation and pursuing restraining orders could potentially increase the risk of harm to the victim. Arrest rates vary even when IPV incidents are reported to the police. Restraining orders can decrease risk but do not guarantee safety; up to two-fifths are violated.

In the USA, some states require health care providers to report injuries from IPV and other crimes. However, many providers are unaware of these laws. Others argue that the mandatory reporting could increase risk of retaliation, deter victims from seeking health care, and change the expectation of confidentiality.

A recent California survey investigated immigrant versus US-born participants' perceptions of a scenario of IPV. Immigrants from various groups were more likely to describe behavior as illegal and to believe in the removal of guns.

A recent study of battered Latinas found that they conceptualized their role as a mother as central in their decision making – including their decisions about how to manage the abuse and avoiding disclosure. They may be concerned about losing custody of their children, their immigration status, protecting their partner, and not want to worry their family. Latinas who experienced IPV more often lacked social support and had children. Another recent study, by the Centers for Disease Control and Prevention, found that Latino immigrants were less likely than those born in the USA to seek help from IPV agencies. Overall, a lower prevalence lifetime for IPV was found among Latino immigrants, but they had a higher victimization rate over the past year.

Social support is critical in responding to IPV; yet, this may be difficult for immigrants. A recent Canadian study noted that other barriers to care for abused immigrants included: poor service coordination, lack of awareness of services, and discriminatory/racist practices. They recommended that to improve care, health care professionals must work together with settlement workers and social workers.

In sum, partner violence could be perpetrated by either sex against their heterosexual or homosexual partner, spouse, or date. Abuse may not be readily disclosed because of shame, fear, and embarrassment. It is important that health professionals ask about violence and are aware of referral resources that could help the victim.

Related Topics

- ► Child abuse
- ► Violence Against Women Act

Suggested Readings

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IOM

► International Organization for Migration

Iran

- ► Islam
- ► Muslim

Iraq

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In 2010, the population of Iraq was estimated to be 31.5 million. Iraq is a country of great ethnic and religious diversity. A number of ethnicities are represented in Iraq including Arab, Kurdish, Turkoman, Chaldean and Assyrian. In addition, Iraqis practice a range of religions such as Islam, Christianity and others. Recent conflict and instability in the country have altered demographic composition and rendered some population parameters difficult to estimate because, for example, there has been no national census in Iraq since 1997. However, some estimates of migration are available. From the perspective of migration, Iraq has undergone a shift in the last three decades from being a country of immigration to becoming primarily a sending country. Iraq has most recently become a refugee-producing state, with Iraqi refugees among the largest number of forced migrants in the Middle East and North Africa (MENA) region and with Iraqis making up a high proportion of asylum-seekers and refugees in North America, Australia, and Europe. Estimates of Iraqis abroad vary, but recent estimates suggest that from the most recent wave of forced migration alone, there are nearly two million Iraqis who have been forced to leave their country.

Migration to Iraq

Before the 1991 Gulf War, Iraq was mostly a country of immigration in the Middle East, hosting migrant workers and some refugees. For example, between the establishment of the state of Israel in 1948 and the first Gulf War in 1991, some 35,000 Palestinian refugees migrated to Iraq of whom only 15,000 now remain in the country as a result of more recent persecution and unrest. Before its invasion of Kuwait on August 2, 1990, it is estimated that Iraq was host to at least 1.3 million migrants, more than 70% of whom were Egyptians. These migrants were primarily men who had traveled to Iraq for work, especially agricultural work or for the purpose of fighting in the Iraqi army in the Iraq–Iran War.

Currently, the United Nations High Commissioner for Refugees (UNHCR) estimates that there are some 42,350 registered refugees and 2,500 asylum-seekers in Iraq. Among these are Palestinians, a small number of Sudanese and ethnic and ideological dissidents from Syria, Iran, and Turkey. Some of these migrants live in urban areas, mostly in Baghdad or the Kurdish-administered regions, while others have sought refuge in camps. In these camps, especially those on Iraq's borders, security, health and basic infrastructure are lacking. Refugees have often been unable to access needed health services, although there have been instances where Jordan or Syria have allowed particularly grave cases to enter for treatment. Under the 1971 Refugee Act, refugees have access to the same health care as nationals, but in practice this has only occurred in some areas of the country, and food and medicine shortages have been reported in the desert camps. In addition to refugees, there are more than 1.5 million internally displaced persons in Iraq, bringing the total population of concern in the country for UNHCR to more than two million people.

Migration from Iraq

Since the 1940s, Iraqis have emigrated from their country in a number of waves and for a variety of reasons including economic betterment, the pursuit of higher education, political repression, and fear of persecution. Political repression, persecution, and war have been major determinants of Iraqi migration throughout history. However, in the Iraqi case, the distinction between forced and voluntary migration is often blurred as Iraqis may have left for complex and varied reasons. The most recent reasons for emigration from Iraq include the 1980–1988 Iraq–Iran war, the Gulf War in 1991, the invasion of Iraq in 2003, and the sectarian violence and unrest that followed and which continue to this day. Throughout this period, political repression and humanitarian problems as a result of the economic sanctions imposed on Iraq further impelled people to leave the country. The result is that there are currently at least 1.5 million internally displaced persons in Iraq as well as more than two million refugees displaced throughout the region, with the largest number in Syria and Jordan.

Historically, Iraqis have migrated from their country for a range of reasons, including political, ethnic, or religious repression, as occurred with the majority of Iraqi Jews in the late 1940s and early 1950s, and among political dissidents when the Ba'ath party later came to power. The first Gulf War led to widespread population movement in Iraq and in the region as a whole, and marked a turning point for Iraq in terms of migration. Just 4 months after the Iraqi occupation of Kuwait in 1990, many foreigners in Iraq left the country in a mass exodus, including European, North American, and Japanese citizens who had been kept as hostages or "human shields" in Iraq following the invasion of Kuwait. By the end of 1990, of the three million foreigners who had been residents in Iraq and Kuwait, only one million remained. Some, such as Kuwaitis, were forcibly repatriated. In 1991, between the outbreak of open hostilities and the ceasefire, another 65, 000 people emigrated from the region. Following the liberation of Kuwait, Shi'i uprisings in the south of Iraq and Kurdish uprisings in the North of Iraq led to one of the fastest moving forced migrations in the history of the United Nations High Commissioner for Refugees (UNHCR) in which up to two million Kurdish and Shi'i people fled Iraq for Turkey and Iran. Many of these forced migrants subsequently returned to Iraq about a month later as a result of a coordinated international response to the forced migration.

More recently, emigration has included the mass exodus of Iraqis fleeing persecution, war, and instability, which has led to massive, prolonged forced migration particularly in the countries surrounding Iraq. In 2010, the United Nations High Commissioner for Refugees estimate their "population of concern" (comprising refugees, asylum-seekers, internally displaced persons (IDPs), stateless persons, and other forced migrants) originating from Iraq as 3,565, 375 persons. Estimates from nongovernmental organizations (NGOs) suggest that these numbers may be low. The majority of Iraqi refugees reside in Syria and Jordan with smaller numbers in other countries in the region, including Egypt and Lebanon. Many of these refugees, most of whom have been living in exile for several years, face difficulties related to socioeconomic status, access to services, recovery from violence, and uncertainty. While some Iraqi refugees are returning to their country of origin, those who do go back face threats to their security, economic hardship, a lack of opportunities, and difficulties accessing services. In 2010, a survey conducted by UNHCR found that the majority of Iraqi refugees who had repatriated regretted their decision to return to Iraq, primarily because of concerns related to safety.

The Iraqi Diaspora

There are large Iraqi communities in many countries throughout the world, most notably in neighboring countries in the region, the United States, and a number of European countries, including Sweden and the UK. The Iraqi diaspora was estimated to account for three million dollars in remittances in 2008. Since 1965, Iraqis have made up the fourth largest group of immigrants from the Arab Middle East in the United States. At first, these immigrants primarily included Assyrians and Chaldeans who immigrated for reasons of family reunification. In the 1980s, some Iraqis came to the United States to avoid being forced to serve in the Iraq–Iran War. From the 1990s until the end of the regime of Saddam Hussein, Iraqis who immigrated to the United States were fleeing political repression or the hardships associated with economic sanctions in Iraq. Among these, many were politically active Shi'i Iraqis who fled the repressive and Sunni-dominated government of Saddam Hussein. Because of the variation in ethnicity, religion, political opinion, and length of stay of the Iraqis in the United States, the extent of acculturation varies.

Given the recent history of conflict in Iraq, research on the health of Iraqis has largely focused on mental health and recovery from traumatic experience. Among Iraqi refugees in the United States, studies have found a high prevalence of posttraumatic stress disorder (PTSD) and other mental disorders, which is perhaps not surprising given the legacy of war in Iraq. The psychological response to war violence and trauma is complex and may be affected by conditions in exile, such as social support, economic opportunity, discrimination, and other factors. Among the Iraqi diaspora, religion and social support have been particularly identified as important factors in health status and well-being.

Related Topics

- ► Arab-Americans
- ► Chaldean Americans
- ► Emigration
- ► Internally displaced persons
- ► Islam
- ► Muslim
- ► Posttraumatic stress disorder
- ► Refugee
- ► Trauma exposure

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IRCA

► Immigration Reform and Control Act of 1986 (U.S.)

Ireland

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Introduction

The island of Ireland is the 3rd largest island in Europe and the 20th largest island in the world. In 1921, the island was divided into two jurisdictions between the Republic of Ireland, which comprises approximately 80% of the land, and Northern Ireland, a part of the United Kingdom, located in the island's northeast region. The population of Ireland is approximately 6.2 million people, with nearly 4.5 million residing in the Republic of Ireland, and slightly fewer than 1.8 million residing in Northern Ireland. The content of this article is limited to information on the Republic of Ireland.

History

The Irish Free State, a self-governing province within the British Commonwealth, was formed on December 6, 1922, and gained increasing autonomy through the Statute of Westminster 1931. With a few exceptions, the Statute established legislative equality for the self-governing dominions of the British Empire and the United Kingdom. A new constitution introduced in 1937 declared the Irish Free State an entirely sovereign nation named *Ireland*. The remaining link with the United Kingdom was severed in 1949 as Ireland's national parliament passed the Republic of Ireland Act. The Act declared Ireland as a republic and established for the President of Ireland executive authority of any executive function of the state and in external relations of the state.

Geography

The Republic of Ireland shares its only land border with the UK's Northern Ireland; otherwise, it is bounded by the Atlantic Ocean, the Irish Sea to the east, St. George's Channel to the southeast, and the Celtic Sea to the south. The nation is northwest of continental Europe and is surrounded by hundreds of islands and islets. The Irish Sea separates the Republic of Ireland from its neighbor to the east, Great Britain.

The Republic of Ireland covers an area approximately 70,280 km^2. Key urban centers include Dublin in the east, Cork in the south, Limerick in the midwest, Galway in the west, and Waterford in the southeast. With a varied terrain, the western landscape consists mostly of cliffs, hills, and mountains. The country's highest point is located in the western region in County Kerry; standing at 1,038 m, it is the central peak of the Macgillycuddy's Reeks range. The nation's interior is relatively flat, traversed by rivers, numerous lakes, or *loughs* – a long inlet of the sea. The large central lowlands feature limestone enclosed in glacial deposits of clay and sand. The River Shannon watershed contains large bogs from which peat is extracted and produced. Also, Ireland possesses some small off-shore deposits of oil and gas.

Climate

Ireland's climate is classified as a temperate oceanic climate. Generally, oceanic climates are characterized by cool summers and warm winters, a narrow annual temperature range, little to no dry season, and precipitation that is more evenly dispersed through the year. Ireland's weather follows that climate pattern temperately, with temperatures rarely lower than $-3°C$ in winter or higher than 22°C in summer. The Atlantic Ocean and the warming influence of the Gulf Stream serve to shape the country's weather patterns, with central and eastern areas tending to be more extreme. The extreme north and west are two of Europe's windiest regions, providing great potential for wind energy generation. The highest temperature recorded in Ireland was 33.3°C in June 1887 at Kilkenny, while the lowest was $-19.1°C$ in January 1881 at Sligo.

Culture

There are cultural distinctions noted between geographical regions in the Republic of Ireland, for example, between urban and rural areas, between the capital city of Dublin and the rest of the country, and between regional cultures that are discussed frequently in terms of the West, the South, the Midlands, and the North. While the vast majority of Irish people identify with being ethnically Irish, some Irish nationals see themselves as Irish of British descent; some refer to this group as the *Anglo-Irish* or *West Britons*.

The *Travellers*, an important cultural minority, live predominantly in Ireland, although they can also be found in Great Britain and the United States. The itinerant ethnic group has been known historically for their roles in the informal economy as artisans, traders, and entertainers.

Economy

Since the 1980s, Ireland's economy has transformed from being a predominantly agricultural one to one focused on high-tech industries and services. It is characterized more as a knowledge economy that seeks to leverage knowledge technologies to produce economic benefits and job creation. A 2005 study by *The Economist* found Ireland to have the best quality of life in the world.

The country relies heavily on foreign direct investment (FDI), and with its highly educated workforce, low corporation tax rate, and as the sole English-speaking country within the Euro zone, Ireland has attracted several multinational corporations. Companies such as Intel invested in Ireland in the late 1980s; Microsoft and Google followed. According to *Tax Notes*, a US tax journal, Ireland is the world's most profitable country for US corporations. The country is one of the largest exporters of pharmaceuticals and software-related goods and services in the world, the 7th largest producer of zinc concentrates, and the 12th largest producer of lead concentrates. The country contains significant deposits of gypsum, limestone, and smaller quantities of copper, silver, gold, barite, and dolomite.

Ireland is ranked as the world's 7th most "economically free" economy according to the Index of Economic Freedom, a series of ten economic measures designed to measure the degree to which an economy protects the liberty of individuals to pursue their own economic interests, resulting in greater prosperity for the larger society. In terms of GDP per capita, Ireland is one of the wealthiest countries in EU and in the 34-member Organization for Economic Cooperation and Development (OECD). However, Ireland ranks below the OECD average in terms of GNP per capita, which differs from GDP in that it allocates production based on ownership rather than on geographic location. Naturally, Ireland's GDP is significantly greater than its GNP owing to the large amount of multinational firms based in the country.

A dramatic rise in consumer spending, construction, and business investment led to rapid economic growth between 1995 and 2007, an interlude that became known as the Celtic Tiger period. However, Ireland's economy has been significantly affected by the global financial crisis that began in 2007, including a major property bubble burst in 2008, dramatic reductions in domestic and commercial property values, and an ongoing Irish banking crisis. The country officially exited recession in 2010; however, its economy remains fragile.

Government

Ireland is a constitutional republic with a parliamentary system of government. The Oireachtas, the national parliament, is a bicameral parliament comprised of the President of Ireland, Seanad Éireann as the upper house, and Dáil Éireann as the lower house. The President serves as the head of state, is elected for a 7-year term, and may be reelected once. The President is primarily a figurehead, although the office is entrusted with certain constitutional powers with the advice of the Council of State. In some matters, the President has absolute discretion, for example, referring a bill to the Supreme Court for a judgment. The President appoints the Prime Minister, and most have served as the leader of the political party that gains the most seats in national elections. It has become customary for coalitions to form a government, as there has not been a single-party government since 1989.

Education

Ireland's education system features three distinct levels: primary, secondary, and higher or *third level*. Recently, further education – known in the United States as continuing education – has grown immensely. Much of the change in Ireland's education system has been driven by growth in the economy since the 1960s. Notably, for students applying from the EU, education is free at all levels, including university studies.

Health Care

The average life expectancy in Ireland is 79.2 years – 76.8 years for men and 81.6 years for women. It has the highest birth rate in the EU at 16.8 births per 1,000 inhabitants, compared to an EU average of 10.7. Additionally, Ireland has achieved a very low infant mortality rate at 3.5 per 1,000 live births.

Every resident in Ireland is entitled to receive health care through the public health care system, which came into operation at the start of 2005 and is funded by general taxation. A subsidized fee may be required for certain health care services; the fee depends on income, age, illness, or disability. Provided free of charge are maternity services, care for children up to 6 months of age, and emergency care to any person admitted through the emergency department.

A European Health Insurance Card entitles the holder to free maintenance and treatment in public beds in government-supported and voluntary hospitals, while outpatient services are provided also for free. The majority of patients on median incomes or above, however, are required to pay subsidized hospital charges. Private health insurance is available for purchase.

Migration

Until the recent past, Ireland was characterized as a country of emigration; from the Great Famine of 1845–1847 to the 1950s, the natural increase in the population was offset by out-migration. This continual emigration was relatively higher than any other European country and led to an almost continuous population decline for more than a century.

At the close of the 1950s, Ireland adopted new economic policies in an effort to encourage FDI from the multinational corporate sector. Over the following decade, the country realized increased job creation, a dramatic drop in emigration, and a consequent rise in marriage and birth rates.

Ireland's entrance into the European Community in 1973 led to net in-migration, which was largely explained by the return of Irish migrants to meet specific skill shortages in the Irish economy. With the increase in the marriage rate in the 1960s and the net immigration in the 1970s, the population grew by almost 22% between 1961 and 1981.

Today, Ireland has evolved from a nation of emigration to a nation that frequently receives migrants. The country is experiencing an upward trend in numbers of immigrants, both short- and long-term, from non-EU countries. The recent in-migration flows have been primarily from the following groups: Irish migrants returning home; migration from other EU and EEA (European Economic Area) countries: asylum-seekers; programme refugees; high-skill migrants from non-EEA countries; and other migrants from non-EEA countries.

From 1820 to 1920, five million Irish immigrants settled in the United States. They were not received well by some in the larger culture. Nativists criticized the Irish for their social behavior, their impact on the economy, and their Catholic religion. Even still, the Irish assimilated successfully by the early twentieth century, so much so, that they comprised almost half of all immigrants in the United States in the 1840s and one-third in the 1850s. Between 1846 and 1855, due to repeated massive failures of the potato crop, 1.5 million Irish immigrants fled to the United States alone.

The Irish who emigrated because of the famine were the most disadvantaged the United States had ever seen. Some of the poorest lived in the Five Points district of lower Manhattan in New York City. The English novelist Charles Dickens' sentiment regarding the city was that *all that is loathsome, drooping, and decayed is here*. The Irish poor accounted for a grossly disproportionate number of admissions to poorhouses, public hospitals, and prison. In New York City in 1859, for example, 55% of all people arrested were of Irish origin.

Frequently, the Irish immigrants were unskilled, and, when they could secure work, were paid low pages. At times, they were used even as substitute labor to break strikes. Many Americans feared that the Irish would never advance socially and would threaten the central principle of nineteenth-century American life: upward social mobility through hard work. The nativists of the larger culture were also disturbed by the Irish immigrants' religion; they questioned whether Irish Catholic immigrants would be loyal ultimately to the United States or to the church in Rome. Further, did a church headed by a pope, cardinals, archbishops, and bishops have a legitimate place in a democratic republic? However, Irish immigrants insisted that they could become successful Americans, and that they would do so on their own terms.

Until 1960, when John F. Kennedy was elected President of the United States, anti-Catholicism remained part of the American culture. His election underscored that, indeed, Irish immigrants could become good Americans without sacrificing their religious and cultural heritage. Their incorporation into the American culture established that assimilation is not a one-way process in which immigrants must conform to a dominant culture while forsaking their own traditions.

Related Topics

- ► Ethnic enclaves
- ► European Union

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Suggested Resources

For information about Ireland's migration history and policy. http://www.migrationinformation.org/index.cfm

For information about Ireland from the United Nations. http://www.un.org/en/index.shtml

For information about Ireland from the World Health Organization (WHO). http://www.who.int/en/

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Irregular Immigration

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Migration and health are major concerns of human society. Historically, health and people on the move have a long and intertwined association. For example, diseases were carried with armies, explorations, conquests, trade, and new settlements. According to most scholars, epidemic diseases represented the overwhelming reason for the population decline of the American natives. Also by the mid-seventeenth century, a common strategy to prevent the spreading of the plague and other communicable infections, especially in trading ports such as Genoa and Venice, was quarantine. Throughout the nineteenth century and during the first half of the twentieth century, newcomers to the Americas were regularly screened for diseases. In this line of prevention, the International Health Regulations came to formalize the rights of the nation-states to manage and restrict the movement of people. By examining immigrants and excluding, detaining, or treating individuals who were considered to pose a health threat, nations took measures to safeguard the public health of their citizens.

The terms of irregular, undocumented, unlawful, and illegal migrants are often used interchangeably to refer to persons without a residence permit authorizing them to legally reside in the country of destination. The discussion regarding their health deals with arguments and considers problems that are similar to the health issues in regular migration.

The process of migration can be thought of as occurring in three phases: origin, journey, and destination. When people move from their country of origin they bring with them, among other things, their health conditions and profile. Irregular migrants from less-developed regions may have higher probabilities of contracting the typical illnesses that are common in less-developed environments but are less prevalent in more developed nations, such as tuberculosis. Yet broad indicators of underdevelopment are to be used with caution in defining the medical problems of immigrants because individual characteristics, such as social status and economic privileges, may operate as intervening factors.

The second element of the paradigm, that is, the journey, constitutes a relevant component in the consideration of the health of irregular migrants. This journey requires a series of painful breaks with the world left behind. Family members, friends, habits, familiar places, and food are abandoned for an uncertain future in nations that are becoming increasingly intolerant of illegal migrants. The illegal crossing, either with the help of a *coyote* (smuggler) or with fraudulent documents, leads to additional tension and anxiety. Increasing border security, especially in the most common places of unlawful trespassing, often pushes people toward the most dangerous and in some cases deadly areas. These and related transit challenges seriously impact and deteriorate the immigrants' physical and psychological conditions.

With respect to the third geographic element of migration, that is, destination, illegal migrants tend to move to wealthier countries, settling in low-status neighborhoods with poor living conditions. Frequently, they live in overcrowded houses and take on difficult and dangerous jobs in construction, mining, and agriculture. All of these factors may contribute to the development of impairments in their physical and psychological health. When injured or ill, for example, irregular migrants often do not seek medical care due to lack of health insurance, language barriers, and fear of being reported to authorities. Even in countries that provide universal health care, language and cultural barriers, along with administrative regulations, might discourage irregular aliens from accessing medical services. Adapting to a social environment with different habits, a new language and an unfamiliar bureaucracy creates additional challenges for irregular migrants. They are likely to feel lonely, homesick, and excluded from mainstream society. These circumstances may sometimes lead to tobacco, alcohol, or drug use. Some studies have found that irregular migrants are more susceptible to chronic stress; in conjunction with poor dietary habits and rapidly changing lifestyles, they may become increasingly vulnerable to certain diseases, such as type 2 diabetes, hypertension, and stroke.

Also, it is important to keep in mind what scholars have identified as "healthy immigration effect" and "Americanization." Immigration seems to operate according to a selection process whereby healthier individuals are more likely than others to leave their country and migrate elsewhere. Once these newcomers have settled, however, the previous health advantages may diminish because immigrants tend to adopt the less healthy behaviors of the destination society. The health status of women and children may be particularly impacted. In particular, a gender perspective offers novel elements that the neutral approach often neglects.

In conclusion, irregular migration and health are critical concerns of governments and the general public. The transit and destination countries may be concerned not only about the health status of the irregular migrants within their borders, but also about the health consequences of illegal migration to their own citizens. This suggests the need for improved health screening and basic medical care regardless of individuals' legal status.

Related Topics

- ► Access to care
- ► Acculturative stress
- ► Border health
- ► Healthy immigrant
- ► Occupational health
- ► Stress
- ► Trafficking
- ► Undocumented

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The Center for Migration Studies. www.cmsny.org

The International Centre for Migration and Health. www.icmh.ch

Islam

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Introduction

The word Islam derives from the Arabic 3-consonant root s-l-m, which it shares with the word *salaam* (= peace). The standard Muslim greeting "*As-salaam* *alaykum*" means "Peace be with you," to which one responds "*Wa alaykum as-salaam*," "And peace be also with you." Literally, Islam translates to the English words "surrender" or "submission" that refer to a believer's predisposition toward God's kindness and mercy. A person who submits to God's will and follows his teaching is a Muslim (male) or a Muslima (female) – again based on the Arabic root s-l-m. Arabic shares with all other Semitic languages the system of deriving word clusters from three-consonant stems, where vowels are not always put in writing. This linguistic feature leads to inconsistent renderings of Arabic names and concepts in English (i.e., Muhammad vs Mohammed; Muslim vs Moslem; Qur'an vs Koran), which can be confusing.

Foundational Texts: Qur'an, Hadith, and Shari'a

Arabic is central to Islam because its main text, the Qur'an, was revealed in Arabic. Muslims regard the Qur'an as God's final revelation, surpassing and completing previous revelations that came to the world in the form of God's laws to Moses and Jesus' ministry recorded in the Old and New Testaments, respectively. Islamic rulers throughout history – of course there have been exceptions – have considered Jews and Christians to be "People of the Book," and have granted them special rights, such as autonomy over family affairs and religious practice. Those who have pointed out that Islam practices tolerance often cite a verse at the beginning of the Qur'an that states "there is no compulsion in the matter of religion" (2: 256).

The Qur'an was revealed to Prophet Muhammad (570–632 C.E.) over a span of 20 years via the archangel Gabriel, who appeared to him and spoke the verses of the Qur'an, which Muhammad memorized and then recited to his followers who wrote them down. Muhammad himself is said to have been illiterate, an orphan who was raised by an uncle, and who became a respected merchant through hard work and his marriage to the successful business woman Khadija, the first convert to Islam. The Qur'an is organized into 114 chapters (or *suras*), which are subdivided further into verses (or *ayat*, literally signs [of God]). Suras are arranged from the longest to the shortest, and each sura is known by a name or title, such as "Abraham," "Mary," "The Feast," or "The Cow." The very first sura in the Qur'an, however, has only seven verses, and it is called "The Opening" (or *al-fatiha*). It is recited each time a Muslim or Muslima conduct his or her daily prayers, and therefore it has been compared in significance to the Lord's Prayer in Christianity.

The verses in the Qur'an instruct believers how to lead an ethical life that is pleasing to God. They do not tell the life story of the Prophet that follows a narrative structure with a beginning, middle, and end. Westerners, accustomed to the stories of prophets and kings in the Old Testament, or the life story of Jesus in the New Testament, can find the Qur'an difficult to grasp. What is often not understood is that the Qur'an is not to be read quietly, but it is to be recited out loud. The sound itself is believed to carry a divine message. Islam scholar Michael Sells published his study of the early revelations of the Qur'an with a companion CD, since he believes that mere textual study of Islam cannot transmit the meaning of the religion. (There are a variety of Internet sites today that make Qur'an recitations easily accessible to a non-Muslim audience.)

The second most important book in Islam is the Hadith, a collection of sayings and deeds of the Prophet Muhammad, compiled in the eighth and ninth centuries by several Islamic scholars. Since these collections were written down more than a century after Muhammad's death, there were some disagreements over the accuracy and reliability of certain hadith accounts. Scholars investigated not only the content of the account, but also the reputation of the persons who had transmitted it. Different branches of Islam today rely on slightly different Hadiths. Together with the Qur'an, the Hadith serves in administering Islamic justice. When a contemporary dispute arises, scholars or jurists turn to the Qur'an and to the Hadith to deduce a just verdict. Certain laws are clearly spelled out in the Qur'an, such as the right to divorce (2: 228–242). But if the issue under question is not addressed directly, sayings and deeds of the prophet are consulted. For instance, is a woman allowed to initiate a divorce? The Qur'an does not clearly answer that question. But according to one hadith, Habiba, the wife of Thabit bin Qais, once approached the Prophet to tell him that she and her husband could not get along, so the prophet told the husband to leave her. This hadith played an important role in the rewriting of the Moroccan Family Code in 2004, which gave women more rights in making their own marriage and divorce choices. (Not all Islamic jurists interpret this particular hadith in the same way.) Over the course of many years of adjudicating based on the Qur'an and the Hadith, Islamic scholar and jurists accumulated a third important body of Islamic texts: the Shariʿa, or Islamic Law.

The Arabic word Shariʿa translates to "path" or "pathway to be followed." There is no centrally codified and agreed upon body of Islamic Law; rather, within Islam, there are multiple schools of law, which differ on the question of process of legal interpretation. Some Islamic jurists believe that they must solely rely on the Qur'an and Hadith in formulating judgments, while others allow for independent reasoning by analogy and inference. There are four main schools of Sunni legal thinking, named after the medieval scholars that founded them: Hanafi, Shafi'i, Maliki, and Hanbali, and two main schools of Shiite legal thinking: Jafari and Zaidi. The Hanbali legal school is primarily practiced in Saudi Arabia and is considered the most conservative, while Hanafi legal scholars in South, South West, and Central Asia are considered more open to independent reasoning. In other words, there is considerable variation in Shariʿa Law as it is practiced across the Muslim world.

Branches of Islam

Islam can be divided into two distinct confessional groups – the Sunnis and the Shiites – each of which is further subdivided into smaller denominations, similar to the division between Protestants and Catholics in Christianity, or the division between Reform and Orthodox Judaisms. The reasons for the internal splits within each of the monotheistic religions need to be found in their specific historical and political contexts, yet it might be fair to say that the question of legitimacy and authority of the leader at the time played an important role in most of them.

In the case of Islam, the divide between Sunnis and Shiites happened very shortly after the death of Prophet Muhammad. Since he died without a male heir who might have been his unquestioned successor following existing conventions in patriarchal societies, his closest companions ended up in a dispute: should they elect a respectable elder from the community (in this case, Abu Bakr, the prophet's father-in-law and one of the earliest converts), or should the mantle of the prophet pass on to a blood relative (in this case, his cousin as well as son-in-law, Ali)? Both Abu Bakr and Ali had leadership qualities that their supporters valued. The group that supported Abu Bakr and his successors Umar and Uthman became known as the Sunnis. The group that was on the side of Ali as well as his direct descendants came to be known as the Shiites. Both groups came into armed conflict in a battle in 680 C. E. in Karbala (present-day Iraq), where the forces of Sunni Caliph Yazid routed the outnumbered Shiite forces of Ali's son Husayn. As a result, in contemporary practice, Sunnis begin each Islamic New Year (they follow a lunar calendar) with joyful celebrations, whereas Shiites commemorate Husayn's death with passion plays and tearful remembrance of his defeat. Shiites consider the sayings and deeds of Ali and his descendents as worthy of emulations, while Sunnis maintain that only the Hadith of the Prophet Muhammad should guide a Muslim believer. Shiites cite a saying of the Prophet Muhammad on his deathbed that designated Ali as his successor, while Sunnis dispute the reliability of this hadith account. Sunni and Shiite prayer practices vary slightly, as does their call to prayer.

Both groups, however, adhere to the so-called five Pillars of Islam, or five distinct ritual practices, that mark believers publicly as Muslims: (1) the declaration (or witnessing) of the oneness of God and Muhammad's status as prophet (*shahada*); (2) the performance of daily prayers (*salat*); (3) the annual payment of a fixed percentage of one's income to charity (*zakat*); (4) the commitment to fast during the month of Ramadan (*sawm* or *siyam*); and (5) the pilgrimage to Mecca (*hajj*) at least once in a believer's lifetime. Each of the rituals described above can be carried out with sincere intention or by rote, with enthusiasm or with reluctance, or not at all, and the actual disposition of the believer matters to many Muslims more than the difference between Sunni or Shiite traditions.

Approximately 85–90% of the world's Muslims are Sunnis and 10–15% are Shiites. Currently, the Islamic Republic of Iran is the only country with a clear Shiite majority and a Shiite religious government, while countries like Iraq, Bahrain, and Lebanon have sizable or majority Shiite communities that have significant influence in multi-sectarian or Sunni governments. In most other Muslim countries, Shiites constitute a small minority. At different points in history, Sunni majority governments persecuted members of the Shiite faith, and Sunni and Shiite conflicts persist in many countries until today.

In both Sunni and Shiite Islam, there are members of the communities that practice Sufism, which is not a separate branch of Islam, but a different philosophy about Islamic practice. Sufism emphasizes spiritual principles over religious dogma and Islamic Law. Sufism also has a monastic tradition with a strong emphasis on simplicity and asceticism. Historically, Sufis often criticized established Islamic rulers for their pursuit of riches and power rather than salvation. Probably the best-known Sufi figure in the West is Jalal ad-Din Muhammad Rumi, or simply Rumi, who lived in the thirteenth century in what is now Turkey. From his order came the so-called whirling dervishes (they call themselves *semazen*) who meditate while rotating on the same spot, an exercise that takes significant bodily and spiritual practice. A lesser known figure is Rabia al-Adawiyya, a woman who lived in eighth-century Iraq and who became an important Sufi saint. Men and women both play important roles in Sufism. Music, poetry, and decorative arts are part of Sufi practice, which is frowned upon by strictly orthodox practitioners of Islam. However, it is possible to incorporate both traditional and Sufi practices in one's life, and many Muslims do, which is why it is impossible to draw a clear line between them. It is difficult to ascertain how many followers Sufism has at this time, but scholars posit that Sufism is what currently attracts most converts to Islam in the West, as well as Africa and Asia.

Islam and/in the West

Islam came to Europe in 711 C.E. with the arrival of the Umayyad forces in what is today southern Spain and Portugal. The Umayyad Empire was the first Islamic dynasty established in Damascus in 611 C.E. and it rapidly spread westward. The Umayyads remained in Spain even after the end of their reign in Damascus, and were expelled from European soil in 1492 C.E. Prominent reminders of Spain's Islamic heritage are the Great Mosque in Cordoba and the Alhambra palace in Granada.

The second significant encounter between Islam and the Christian West occurred at the time of the crusades between the eleventh and thirteenth centuries. The European crusaders were defeated by the forces of Saladin (*Salah ad-Din*) in 1187 C.E., and the encounter between Saladin and the English king Richard the Lionheart became the stuff of legends and movies. Several more crusades were undertaken after that defeat, but they did not manage to reconquer Jerusalem. Instead, in 1204 C.E., crusaders sacked the then still Christian metropolis of Constantinople (present-day Istanbul), rather than attacking their Muslim enemies in the "holy land." French-Lebanese author Amin Maalouf wrote a fascinating account of the crusades as Europe's "holy war" against Muslims.

The third most important historical encounter between Islam and the West occurred in the sixteenth century, when Suleiman the Magnificent, the ruler of the Ottoman Empire from 1520–1566 C.E., laid siege to Vienna with a heavy death toll on both sides. While the Ottoman conquest of Europe was ultimately halted, it had a profound impact on the way Europeans viewed Islam as a powerful and threatening force.

From the turn of the eighteenth century onward – and more systematically after the end of the Ottoman Empire in 1918 – much of the Muslim world came under European colonial rule. Islam was seen as an obstacle to modernization and (industrial) development, and European rulers expected Muslims to follow Europe's lead in embracing secularism. Quite a few did. The most prominent example is Mustafa Kemal Ataturk, who embarked on a path of Westernization of the newly created nation of Turkey. In order to break from what he regarded a backward and reactionary Ottoman past, he ordered Turkish citizens to wear Western clothing (and asked women to abandon the veil), to write in Western script instead of Arabic, and to follow secular laws. Arab intellectuals and politicians who opposed European colonial rule similarly embraced secular, left-leaning, nationalist ideologies. The most prominent proponent of Arab Nationalism was Egyptian President Gamal Abdel Nasser. In South Asia, tragically, religious identities became conflated with nationalist aspirations, which led to the bloody 1947 partition of India and Pakistan after the British had given up their control over that part of their commonwealth.

In the immediate postcolonial era, Islamic political organizations had little mass appeal. It was only when the secular nationalists failed to deliver on their promises of better jobs and improved standards of living that Islamists became popular as possible political alternatives. Over the last two decades, Islamist parties grew and have been voted into governments across the Arab and Islamic world. Their appeal rests to a large extent on Islamic charitable organizations that provide much-needed services in education and health for growing populations. Some Islamist parties, such as Hizbollah in Lebanon or Hamas in the Palestinian Territories, have also organized sophisticated militias in addition to their political and charitable institutions. The most prominent face of militant Islam in the West is the organization of Al-Qaida under Osama Bin Laden, responsible for the attacks on the World Trade Center and the Pentagon on September 11, 2001. Their stated goal is to defend Islam, by all means necessary, against Western encroachment. The geopolitics of groups of armed Islamist extremists battling Western armies, as well as fellow-Muslims, in various parts of the world has created a climate of fear and suspicion that significantly affects Muslim immigrants who have come to live in the West.

The Nation of Islam

Islam's history in the USA dates back to the time of slavery and the arrival of West African Muslims on North American soil. Islam in the West grew primarily through the arrival of immigrants; however, in the twentieth century distinct American forms of Islam emerged, the most prominent of which was the Nation of Islam. The Nation emerged in 1930 in Detroit, Michigan, under the leadership of Wallace Fard Muhammad. After his mysterious disappearance in 1934, his successor Elijah Muhammad declared him to be God's manifestation on earth.

The Nation of Islam mixed Islamic teachings with Black empowerment politics, equating Christianity with White supremacy, and declaring that African Americans had no truly equal place in the religion of their former slaveholders. The notion of separating African Americans from the White mainstream resonated with some members in the US Civil Rights Movement. For instance, Malcolm X became a member of the Nation of Islam while serving a prison sentence. He worked with Elijah Muhammad for over 10 years before going on a pilgrimage to Mecca, where his experience of a multi-racial religious community tempered his Black separatist views. After his return from Mecca, he changed his name from Malcolm X to Hajj Malik al-Shabbaz.

After the death of Elijah Muhammad in 1975, the Nation of Islam split into two organizations, one led by Elijah Muhammad's son Warith Deen Muhammad, and Louis Farrakhan, who had been a member of the Nation of Islam since 1955. Warith Deen moved his group closer to Sunni Islamic practice, refuted the claim of Wallace Fard Muhammad's divinity, and gave up the name Nation of Islam in favor of American Society of Muslims. Louis Farrakhan continued to lead the Nation of Islam with a more explicit and radical Black empowerment politics. The majority of Muslims do not consider the Nation of Islam to be truly Islamic.

Islam After 9/11

Since the attacks of September 11, 2001, were carried out by men who carried copies of the Qur'an in their luggage and who promoted a violent form of jihad, Islam has come under increasing scrutiny in the West. To many, Islam has come to be synonymous with terrorism. Members of the Muslim faith have been profiled, interrogated, and jailed without recourse to the customary due process. In January 2010, the USA issued a terror watch list of 14 countries, which mandated automatic, additional airport screening of passengers from countries including Saudi Arabia, Afghanistan, Pakistan, Iran, Iraq, Syria, Lebanon, Nigeria, Sudan, Somalia, and Yemen. With each new act of violence perpetrated on US soil by a member of the Muslim faith, as in the shooting of American servicemen on a base in Fort Hood, Texas, in 2009 or the failed bombing of Times Square, New York, in 2010, Islam's reputation of promoting terror solidifies. It merits pointing out that the media did not draw a similar link between Timothy McVeigh and Christianity after he bombed the federal building in Oklahoma City in 1995.

How much in an act of terror is driven by religious rather than political, psychological, or other motives is difficult to ascertain, yet it appears that Islam is considered by many an immediate and satisfactory explanation of such an act. In other words, in the West, "Muslim terror" has much more currency than "Christian terror" or "Jewish terror," for instance. This widespread perception of "Islam equals terror" matters in everyday interactions between Muslims and non-Muslims, and leads to stereotyping and scapegoating. Even if Muslim holidays are now part of the American holiday calendar, Muslim prayers are used to open sessions of Congress, and Americans can buy postage stamps that commemorate Muslim holidays, Islam is not granted equal status and respect next to Christianity and Judaism. It will take significant political will and educational work to make it so.

Islam and Health

Different verses in the Qur'an instruct believers to lead a balanced life (55: 7–9), to eat a wholesome and balanced diet (2: 173; 20: 81), and to abstain from intoxicating substances (5: 90). The Qur'an also focuses on cleanliness and general hygiene, and Muslims wash their hands, face, and feet as part of their daily prayer rituals. Spiritual and bodily cleanliness are closely linked, as the prophet told his followers, "Cleanse your bodies and God will cleanse your hearts." Additionally, the hadith literature contains sayings and deeds of the prophet that directly refer to health. For instance, in one saying concerning the Day of Judgment the prophet explains that God will ask what kind of life each person lived, how they earned and spent their money, how they used their knowledge, and what they did with their bodies and their health. The prophet told his followers to seek health care in times of sickness, and enjoined them to ask God not only for forgiveness of sins but also for good health. Some Muslims believe that their daily prayer rituals – which involve several sets (*rakats*) of bowing, kneeling, and prostrations on the floor – have cardiovascular health benefits in addition to their spiritual meaning. Moreover, some scholars find health benefits in the annual practice of fasting during the month of Ramadan. Some also believe that the active recitation of the Qur'an by a sick person or for a sick person can have healing effects.

There are, however, also verses in the Qur'an that have been interpreted as preventing the active pursuit of medical treatment, for instance, "If God sends you harm, only he can remove it" (6:17) and it is God "who heals me when I am sick" (6:80). Some Muslim patients may consider their illness predestined by God and therefore may not make healthful life choices that might help prevent the onset of an illness, or, once they fall ill, they may not seek help or, if they do seek help, they may not follow treatment instructions. A health practitioner in the West may want to discuss a Muslim patient's belief system as part of the treatment, and may want to acknowledge that the efficacy of biomedicine does not preclude God's healing power – or in other words, God's work may manifest through the doctor's work. A practicing Muslim may respond to a doctor's encouraging words of, "with this treatment, you should feel better," with the words "*insha'allah*" (God willing), to which the health provider may want to respond "*insha'allah*," as a way of acknowledging the patient's belief system.

As explained earlier, Islam comes in many different forms. Therefore it is acceptable to ask a patient to explain their particular views and practices, rather than to assume that they have one standard set of beliefs. Without turning the doctor's office into a theological seminary, health professionals can show their cross-cultural sensibilities by asking how important Islam is in a patient's life. A practicing Muslim woman may not want a male gynecologist to treat her, or she may want her husband or male relative to stay with her in the treatment room. A Muslim man may prefer a male doctor to treat him. To ask a Muslim patient if she has a strong gender preference for her health care provider may be a good way to establish cross-cultural rapport. To ask a patient about the health of (extended) family members, or to share some details about one's own family, may help establish a more familiar and less intimidating rapport between doctor and patient.

Depending on the class and educational background of Muslim patients, as well as their length of residency in the USA or Europe, their attitudes toward biomedicine will vary. For some Muslim immigrants, a doctor may hold a position of absolute and unquestioned authority – in which case the patient may be reluctant to ask questions or demand clarification during a consultation. In other cases, a doctor may be considered a mere gatekeeper on the way to obtain needed prescriptions to get to the pills that will cure (or so the patient hopes). In the latter case, patients may be nonresponsive, or even resistant to suggestions that they can improve their situation by making lifestyle choices. In this way, Muslim immigrants may not differ much from non-Muslim immigrants or members of other minority groups. Some immigrants may continue to rely on traditional healing practices, while consulting with a Western doctor, and while holding on to a belief of the efficacy of prayer. In other words, the degree to which Islam matters during medical treatment – similar to Christianity or Judaism – will vary from patient to patient.

Related Topics

- ► Muslim
- ► Religion, religiosity, and spirituality

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Isolation

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Isolation is common among recently arrived immigrants and refugee populations. The isolation that these populations experience is typically in the form of social exclusion. Social isolation occurs when persons, groups, or cultures do not have open communication with one another. Social isolation is exacerbated in immigrant populations due to language barriers, transportation difficulties, lack of social support, and familial interdependence. These same reasons can hinder access to medical care and mental health services as well.

Language barriers are especially apparent in the USA, and the inability to speak English is a barrier for many immigrants. Because they do not speak English, it is difficult to form social bonds with other individuals around them. Language barriers are also more difficult for non-Spanish speaking immigrants due to the pervasiveness of the Spanish language spoken in the USA. Language barriers are present in most areas of life outside of the home until a basic level of English comprehension (or native language of the country in which the individual has immigrated) is achieved.

Transportation difficulties and community design also contribute to the social isolation of immigrant populations. Public transportation is often more efficient elsewhere in the world than in the USA. For immigrants living in smaller cities and suburban areas, transportation is a significant barrier to social engagement. Those who are used to walking everywhere may feel secluded to their residence in the USA. Community design may also contribute to the isolation of immigrants. Through zoning, the USA largely separates residential from commercial properties to the effect that few conveniences are within walking distance of each other further contributing to the isolation felt by many immigrants.

After migration many immigrants may feel a lack of social support in their new country. Shortly after immigration many lack the support of the extended family left behind and may feel socially isolated. Many feel they cannot discuss difficulties in their new country with those back home. They feel that they should be grateful for the opportunity given to them to start a new life and cannot burden those back home with their troubles. Immigrants have not yet formed social networks in their new country and do not have anyone in which to confide. Therefore, many do not have an outlet to discuss problems that they may be experiencing.

Immigrants display familial interdependence and are more likely to reside in extended family households than nonimmigrant populations; however, immigrants can become isolated within the family unit. They are less likely to have outside friends and often lack the knowledge or ability to navigate their new environment. Because of this, immigrants sequester themselves within their living quarters. While interdependence is capable of keeping the family in physical proximity of one another, it has the potential to ostracize certain members and the elderly in particular.

Few seniors would leave their native communities to start a new life in a foreign country if not for close family ties. The children of the elderly encourage their parents to migrate to share the benefits of life in a new country or so that they can receive the care that they may need. The elderly do not adapt to their new life as quickly as younger family members and can feel high levels of alienation. They are often quick to define themselves as subordinates in their children's households. In the many societies from which immigrants relocate the elderly are well respected and their knowledge sought by younger generations. The skills that youth once desired, however, may no longer be useful in post-migration settings, and the elderly may feel that they have little useful wisdom to impart on their children and grandchildren creating a disconnect between generations.

Elderly immigrants often experience isolation more so than younger generations. Younger generations acculturate to life in a new society more rapidly than the elderly, because they are more likely to be engaged in their new society due to immersion in school or work. The elderly can find their new environment intimidating and may stay at their place of residence as a result. Disabilities and infirmities may also prevent seniors from exploring their new environment. Social isolation among elderly immigrants can be mitigated by involvement in ethnic enclaves and traditional practices. Without social support, the elderly are prone to adverse cultural stresses.

Related Topics

- ► Communication barriers
- ► Cultural competence
- ► Depression
- ► First generation immigrants
- ► Illegal immigration
- ► Intergenerational differences
- ► Language barriers
- ► Loneliness

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Israel

- ► Jewish migration

Italy

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Italy's history of immigration is fairly recent. It became a destination country for immigrants beginning in the 1970s. Prior to that, Italians migrated from Italy in the millions. Beginning in 1860 and up to 1975, an average of one out of every four Italians migrated from Italy. Most of those immigrants were from agricultural areas, with the first waves of immigration from Northern Italy, followed by waves of immigration from Southern Italy. Northern Italians immigrated primarily to other parts of Europe, while Southern Italians tended to migrate to places such as the United States, Latin America, and Australia. The peak of immigration from Italy was in 1880. The Italian government began implementing laws restricting emigration in 1868 due to concern that too many citizens were leaving; however, the poor economy of Italy during that period was the major driving force for emigration. Northern Italian emigration tapered when industrial development and growth was concentrated in that area, yet agricultural underdevelopment in the South continued to drive more Southern Italians out of Italy in search of work.

Italy became an immigration destination beginning in the 1970s. As of 2002, there were more than 1.5 million immigrants living in Italy, 20% of whom are believed to be undocumented. Eighty-six percent of immigrants in Italy originate from outside of the European Union. Although the number of African and Asian immigrants has increased steadily since 1970, many more come from Eastern European countries such as the former Yugoslavia, Albania, and Romania. In fact, they accounted for more than 46% of all immigrants between 1980 and 2000. During the period of 1970 to 1985, Eastern European immigrants consistently constituted 50–60% of all immigrants moving to Italy. African and Asian immigrants increased noticeably beginning in 1980. During the period from 1980 to 2000, Africans accounted for approximately 24% of all immigrants and Asians made up roughly 17%. This was a drastic change in profile from that of the immigrants prior to the 1980s, who came primarily from other European countries. Beginning in 1990, Latin Americans began migrating to Italy at slightly more than 8% of the total number of immigrants.

Immigrants moving to Italy settle in areas that have the highest demand for their labor. The Northeast, which includes Venice and Trieste, Central Italy (Rome), and the Northwest area made up of Lombardy, Piedmont, and Liguria have absorbed the majority of immigrants. Southern Italy's immigrants number about 11%, and about 5% of immigrants settle in Italy's island territories, including Sicily and Sardinia. The cities of Rome and Milan, Italy's largest urban areas, contain 15% of resident aliens, but the fastest growing areas are Brescia, Vicenza, and Verona in the Northeast.

Immigrant males make up almost 55% of all immigrants to Italy, yet more Asian and Latin American women migrate to Italy than their male counterparts. Among Moroccans, Tunisians, and Senegalese immigrants, over 80% are male. Eastern Europeans are also predominantly male, especially among former Yugoslavians and Albanians; however, immigrants from Romania and Poland are mostly female, as are immigrants from Somalia and Ethiopia. The age range making up over 65% of immigrants is 18–39; 75% of immigrants do not have children. However, beginning in 1999, the number of immigrants going to Italy to reunite with family reached 40%.

Most immigrants work in manual labor jobs and most of those jobs are in the informal or "underground" employment networks. Rates of illiteracy are approximately 80%.

Health care is considered a fundamental right in Italy, and the country's constitution itself guarantees access to health care to all regardless of citizenship. One of the challenges, however, is that with so many immigrants from starkly different cultural backgrounds, practical issues such as language and cultural barriers hinder health care education, access, and delivery. Several steps have been taken by Italy's National Health System (NHS) to ensure that immigrants are informed about the health services available to them and that they are accessing them. The NHS has invested in many areas in an effort to meet immigrants' health care needs including conducting needs assessments, providing training to health care providers on cultural issues, and developing and training health mediators to help bridge the communication gap between health providers and patients.

Immigrants in Italy are often transient due to a desire for better work opportunities; consequently, it is difficult to follow their health status over time. A few health studies reveal some of the health issues immigrants in Italy face. A comparative study of the health status of immigrants and native Italians in early adolescence demonstrated that immigrant adolescents have poorer psychological health compared to their native Italian counterparts. Immigrant adolescents report feeling less satisfied about their health and lives in general, are less happy, feel more isolated, report more victimization and bullying, and have fewer friends and less support from friends than do native Italian adolescents.

A study of hospital utilization in the Lazio region indicates that hospital utilization rates are lower among immigrants than nonimmigrants, especially for acute care. When examining those hospitalized for injuries, infectious diseases, and abortions, however, the rates go up for immigrants. Immigrants are more prone to injuries which are usually related to poor living and working conditions – they often perform hazardous work with insufficient safety training. Infectious disease rates for HIV and tuberculosis are higher for immigrants as well. Reproductive health is a particular problem among immigrants in Italy as the number of abortions are high, typically three times that of nonimmigrant women. One explanation for this could be the challenges that immigrant women face in controlling their own reproductive health, living in poverty/lack of income stability, and lack of social support. Youth aged 18 years and younger have the same rates of hospitalization as nonimmigrants for respiratory diseases, injuries, and poisoning, but higher rates for infectious and parasitic diseases. In 2004, a study comparing the health of immigrants in 11 different European countries showed that in Italy, of the 2,508 people surveyed (all of whom had obtained citizenship), 52.3% reported functioning difficulties; 45.4% reported suffering from a chronic disease(s); 51.8% had low self-perceived health; 18.2% used tobacco; and 61.7% reported being overweight.

Although immigrants, even noncitizens, have the same rights to health care as Italian natives, they are facing more challenges recently with respect to acceptance and assimilation. Immigrants in Italy have become the target of frustration among Italians over a lagging economy and high unemployment. They have also been blamed for an increase in crime. They are facing more overt acts of discrimination and racism, sometimes resulting in violence. New legislation passed in 2008/2009 makes it mandatory for medical professionals to report illegal immigrants to Italian law enforcement authorities. The law also makes illegal immigration a criminal offense, punishable by fines up to 10,000 Euro, detainment, and/or immediate deportation. Jail terms are also imposed upon those who are found to offer housing to immigrants who cannot prove they are in the country legally. Furthermore, new legislation allows for the creation of citizen patrols to help police and the military identify illegal immigrants. Elected officials state that Italy is facing a crisis, having allowed too many immigrants into a country that does not have the infrastructure or the economic capacity to support so many additional people. This is in very stark contrast to the liberal immigration policies that Italy has held for many years. The new legislation was spearheaded by the Northern League, a political party known for its anti-immigration philosophy and its strong alliance with the ruling party of Prime Minister, Silvio Berlusconi. The European Commission and the United Nations High Commissioner for Refugees are currently investigating Italy's new anti-immigrant legislation. Since Italy is a member of the European Union (EU), the law may be in direct violation of EU policies.

Related Topics

- ▶ Discrimination
- ▶ Injuries
- ▶ Irregular immigration
- ▶ Labor migration
- ▶ Refugee health and screening
- ▶ Refugee resettlement
- ▶ Refugee status
- ▶ Refugee youth
- ▶ Tuberculosis

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Jamaica

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Jamaica, measuring 4,441 square miles, is one of four islands of the Caribbean archipelago. Initially claimed by Columbus in 1494, Jamaica served as a sugar plantation based on slave labor for hundreds of years. Limited self-governance was granted in 1944, and Jamaica became an independent nation in 1962. The country's motto, "Out of many, one people" illustrates its diverse history and population. Ninety percent of Jamaica's 2.8 million inhabitants endorse African ancestry. The population is considered a Christian nation, representing 80% of Jamaicans. Eight percent of the population practice Rastafari, a religion founded in 1930 and based on a messianic interpretation of Christian scripture. Immigrants to Jamaica represent a small portion of the population, approximately 18,000 currently residing in the country. The rate of immigration is − 5.88/1,000 people. Economic hardship and a lack of economic diversity are postulated to impact immigration to Jamaica.

Emigration from Jamaica was largely tied to slavery and post-emancipation migration in the nineteenth century. Large numbers of Jamaicans were recruited by the USA to work in Panama and Costa Rica in the 1850s; after slavery was abolished in the USA in 1865, temporary workers were recruited to harvest crops annually. From 1881 to the start of World War I, ninety thousand Jamaican immigrants worked on the Panama Canal. The largest wave of Jamaican immigrants to the USA occurred from 1965 to 1984 after immigration laws were changed in the USA. Three hundred thousand Jamaican immigrants entered the country during that time. Prior to 1965, many Jamaicans immigrated to Britain. During the 1970s and 1980s, 15% of Jamaica's population immigrated to other countries, creating an acute lack of professionals, including skilled workers, doctors, lawyers, managers, and technicians. A failing economy based on plantation agriculture, lack of economic diversity, and a scarcity of professional positions are blamed for this mass emigration. In the 1990s, Jamaica offered incentives for these professionals to return to their home country. There remains a Jamaican cultural mentality of emigrating to gain success and riches and then returning to show evidence of their wealth; most emigrants do not return to permanently reside in Jamaica.

Assimilation of Jamaican immigrants in other countries is complicated by adaptation to different cultures and weather, as well as adjusting to social roles of racial and ethnic groups in predominantly White countries. Jamaican immigrants tend to become more conscious of their race, transitioning from being a majority to a minority in other countries. In the USA, Jamaican immigrants have settled in all states across the country with a greater concentration in the northeast. The 1990 census reported 435,025 Jamaican immigrants; however, the actual number was estimated at close to one million; the difference is based on the high number of illegal aliens and Jamaican attitude toward the census. Jamaican immigrants tend to form smaller communities to provide support to each other and aid in assimilation. Many large Jamaican populations are present in large US inner cities; Jamaican youth have become involved in the gang and drug cultures of these areas. Overall, Jamaican immigrants tend to have good relations with other groups, despite some report of intraracial conflict between US-born African Americans and Jamaican immigrants.

The overall health of Jamaican immigrants in the USA tends to be better than US-born African

Sana Loue & Martha Sajatovic (eds.), *Encyclopedia of Immigrant Health*, DOI 10.1007/978-1-4419-5659-0,

Americans. Data indicate that Jamaican immigrants are less likely to report adverse health behaviors and are more likely to be uninsured. They tend to avoid health care visits for fear of hearing bad news and a desire for privacy. Jamaican men have the highest rate of prostate cancer in the world. Emigration from Jamaica is associated with increased survival rate, though Jamaican immigrants continue to have an increased rate of prostate cancer. Data indicate that the perception of cancer among Jamaican immigrants is that cancer is associated with death. Improved health education and screening can impact early detection of prostate cancer in this population. There are no other reported health problems specific to the Jamaican population.

The mental health of Jamaican immigrants reveals an increased prevalence of psychotic and affective disorders over native populations. Second and third generation Jamaican immigrants are more susceptible, presumably due to the increased age of first generation immigrants. Another contributing factor is postulated to be the increased exposure to minority status and the downward social mobility in the USA and Britain. Mental health literacy and early intervention can be helpful in the Jamaican immigrant population.

Related Topics

► First generation immigrants

Suggested Readings

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Suggested Resources

Migration Information Source. www.migrationinformation.org. Accessed March 11, 2010.

Japan

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Introduction

Japan is an island nation in the eastern region of the continent of Asia. The island is located in the Pacific Ocean; is situated to the east of the Sea of Japan, China, North Korea, South Korea, and Russia; and extends from the Sea of Okhotsk in the north to the East China Sea and Taiwan in the south. Japan is an archipelago, a chain or cluster of islands, comprised of 6,852 islands. The four largest islands are Honshu, Hokkaido, Kyushu, and Shikoku; together they account for 97% of Japan's land area. With over 127 million people, Japan has the world's tenth largest population. The Greater Tokyo Area is the largest metropolitan area in the world, with greater than 30 million residents.

History

The first known habitation of Japan is the Paleolithic culture of around 30,000 BC.

The Jōmon period followed beginning around 14,000 BC, characterized as a semi-sedentary, hunter-gatherer culture, with pit-dwelling and rudimentary agriculture. Included in this period are ancestors of the contemporary Ainu and Yamato people. Around 300 BC, the Yayoi people began to enter the Japanese islands, intermingling with the Jōmon. The Yayoi period began around 500 BC, and employed new practices such as wet-rice farming, a new style of pottery, and metallurgy introduced from China and Korea.

The Nara period of the eighth century marked the emergence of a strong Japanese state, with an imperial court, the continuing adoption of Chinese administrative practices, and emerging literary works. A smallpox epidemic took place between 735 and 737; it is believed to have killed as much as one-third of Japan's population. The Heian period followed, marked by Emperor Kammu's decision in 784 to move the capital from Nara to Heian-kyō, modern-day Kyoto. During the Heian period, a distinctly indigenous Japanese culture emerged, noted for its art, poetry, and literature. The lyrics of Japan's national anthem *Kimigayo* were written during this time.

Japan's feudal era was typified by the emergence and subsequent dominance of a ruling class of warriors, the samurai, who were considered military nobility. In 1185, samurai Minamoto no Yoritomo was appointed *shogun* – a military rank, in most cases, a hereditary military dictator. Following Yoritomo's death, the Hōjō clan came to power as regents for the shoguns. The Zen school of Buddhism was introduced from China in the Kamakura period, 1185–1333, and became popular among the samurai class.

During the sixteenth century, traders and Jesuit missionaries from Portugal reached Japan for the first time ever, thus initiating commercial and cultural exchange between Japan and the West. This is known in Japanese history as the *Nanban trade period*, or the *Southern barbarian trade period*; it extends from the arrival of the first Europeans to Japan in 1543–1641 and their near-total exclusion from the archipelago.

Marking the beginning of the Edo period, a *closed country* policy was implemented in 1639; it spanned two and a half centuries and was characterized by weak political unity. *Rangaku,* the study of Western sciences, continued through contact with the Dutch enclave in Nagasaki. The Edo period gave rise also to *kokugaku*, national studies, the study of Japan by the Japanese.

On March 31, 1854, the US Navy, led by Commodore Matthew Perry, compelled the opening of Japan to the West with the Convention of Kanagawa. Ensuing treaties with Western countries during the period brought economic and political crises, eventually leading to the Boshin War, the resignation of the shogun, and the establishment of a centralized state that was unified somewhat under the Emperor. Adopting Western political, judicial, and military institutions, the Cabinet organized the Privy Council, an advisory council to the Emperor of Japan that operated from 1888 to 1947; introduced the Meiji Constitution, the organic law of the Empire of Japan, in force from November 29, 1890, until May 2, 1947; and assembled the Imperial Diet, Japan's bicameral legislature. This period saw the Empire of Japan transformed into an industrialized world power, which pursued military conflict to expand its sphere of influence. Japan's population grew from 35 million in 1873 to 70 million in 1935.

July 30, 1912, to December 25, 1926, the Taishō era, is a period in the history of Japan that corresponds with the reign of the Taishō Emperor. The new emperor's weak health drove the transition in political power from the former oligarchic group of elder statesmen to the Diet of Japan and the democratic parties. This era in Japan's history is considered a period of liberal movement known as the *Taishō democracy*. This period was brief, however, as it was overshadowed quickly by growing expansionism and militarization.

A member of the Allied forces during World War I, Japan increased its influence and expanded its territorial holdings; it continued its expansionist policy and occupied Manchuria in 1931. In response to international condemnation over the occupation, Japan resigned from the League of Nations 2 years later. Furthermore, the country signed three decisive pacts: in 1936 Japan signed the Anti-Comintern Pact with Nazi Germany, a pact directed against the Soviet Union's Communist International; in 1940 they signed the Tripartite Pact, which made it one of the Axis Powers; and in 1941 Japan negotiated the Soviet–Japanese Neutrality Pact.

Expansionism continued as the Empire of Japan invaded other parts of China in 1937; French Indochina in 1940; and on December 7, 1941, Japan attacked the US naval base at Pearl Harbor and declared war on the USA, the UK, and the Netherlands. Japan's attack on Pearl Harbor was the catalyst for the USA's entry into World War II; on December 8, those three countries (the USA, the UK, and the Netherlands) declared war on Japan. Following the Soviet invasion of Manchuria and the atomic bombings of Hiroshima and Nagasaki in 1945, Japan agreed to an unconditional surrender on August 15.

In 1947, Japan adopted a new constitution with an emphasis on liberal democratic practices. The Allied occupation ended with the Treaty of San Francisco in 1952, and Japan was granted membership in the United Nations in 1956. Eventually, the country achieved rapid growth; at one point, it was the second-largest economy in the world. However, in the mid-1990s, Japan suffered a major recession. While positive growth at the beginning of the twenty-first century signaled a gradual economic recovery, on March 11, 2011, Japan suffered the strongest earthquake in its recorded history. The devastation was made worse by a tsunami that affected the northeast area of Honshu, including Tokyo. While yet unfolding, doubtless, the impact of the disaster will be far reaching.

Geography

Japan has a total of 6,852 islands extending along the Pacific coast of Asia. The main islands, from north to south, are Hokkaido, Honshū, Shikoku, and Kyūshū. Approximately 73% of Japan is forested, mountainous, and unsuitable for agricultural, industrial, or residential use; hence, the coastal habitable zones have extremely high population densities. Japan is one of the most densely populated countries in the world.

The islands of Japan are located in a volcanic zone on the Pacific Ring of Fire, an area where large numbers of earthquakes and volcanic eruptions occur in the basin of the Pacific Ocean. Japan has 108 active volcanoes, while destructive earthquakes, often resulting in tsunamis, occur several times each century. The 1923 Tokyo earthquake killed over 140,000 people. The most recent major quakes are the 2004 Chūetsu earthquake and the 2011 Tōhoku earthquake, a 9.0-magnitude quake, which triggered a tsunami. The devastation for the most recent event is still being calculated.

Government

Japan is a constitutional monarchy where the Emperor acts as head of state, and his or her power is confined within the parameters of a constitution. This form of government differs from absolute monarchy in that an absolute monarch is the sole source of political power – not bound legally by a constitution of any form. As a ceremonial figurehead, the constitution defines the Emperor as "the symbol of the state and of the unity of the people." In the Japanese government, sovereignty is vested in the Japanese people, and the political power is held chiefly by the Prime Minister of Japan and other elected members of the Diet – Japan's bicameral legislature. Akihito is the current Emperor of Japan; Naruhito, Crown Prince of Japan, stands as next in line to the throne.

Japan's legislative body is the National Diet; it is a bicameral parliament consisting of a 480-member House of Representatives who are elected by popular vote every 4 years or when dissolved, and a 242-member House of Councilors who are popularly elected for 6 year terms. For all elected offices, there is universal suffrage via secret ballot for adults over 20 years of age. In 2009, the social liberal Democratic Party of Japan took power after 54 years of the liberal conservative Liberal Democratic Party's rule.

Culture

From the country's original Jōmon arts to its contemporary culture, Japanese culture has evolved significantly. Today's Japanese culture combines influences from Asia, Europe, and North America. Traditional Japanese arts include: crafts, folklore, performances, and traditions. Examples of Japanese crafts are ikebana, the Japanese art of flower arrangement; origami, the traditional Japanese art of paper folding; dolls; lacquer ware; pottery; and ceramics.

The folklore of Japan is influenced greatly by the country's two primary religions, Shinto and Buddhism. Frequently, the folklore involves humorous or bizarre characters and situations and includes also a variety of supernatural beings.

Japanese culture includes a variety of performances such as Bunraku, dance, Kabuki, Noh, and rakugo. Bunraku is a form of traditional Japanese puppet theater founded in Osaka in 1684. There are two types of Japanese traditional dance: Odori, which originated in the Edo period, and Mai, which originated in the western part of Japan. Odori grew out of Kabuki drama and is more oriented toward male sentiments, while Mai was influenced by Noh Drama and is performed traditionally in Japanese rooms rather than on stage. Kabuki is classical Japanese dance-drama known for the stylization of its drama and for the elaborate makeup worn by some of its performers. Performed since the fourteenth century, Noh or Nogaku is a style of classical Japanese musical drama in which many characters are masked; men play male and female roles; and a *performance* lasts all day – consisting of five Noh plays interspersed with shorter, humorous Kyōgen pieces. Rakugo means *fallen words*; it constitutes Japanese verbal entertainment, wherein the lone storyteller sits on the stage, uses as props only a paper fan and a small cloth, and depicts a long and complicated comical story involving always the dialogue of two or more characters. The story teller never rises from a seated position, and only through change in pitch, tone, or a slight turn of the head, are the different characters represented.

Japanese cultural traditions include games, tea ceremony, Budō, architecture, gardens, and katana. Traditional Japanese games fall within the following categories: children's, board, card, tile, dice, and word; within each category there can be dozens of particular games. The Japanese tea ceremony is known also as the *Way of Tea*. It is a Japanese cultural activity involving the ceremonial preparation and presentation of *matcha*, a powdered green tea. Zen Buddhism was a primary influence in the development of the ceremony. Budō refers to the idea of formulating propositions, subjecting them to philosophical critique, and then to following a "path" to realize them. Although Japanese architecture was influenced greatly by Chinese architecture from the Tang Dynasty, it has developed many unique differences and aspects indigenous to Japan. Gardens in traditional Japanese style are centered on the use of stones, water, and plantings. The Katana is Japanese for *backsword*. The katana, historically associated with the samurai, is characterized by its distinctive curved, slender, single-edged blade, circular or squared guard, and long grip.

Economy

Due to its overall economic growth, the period from the 1960s to the 1980s in Japan has been called a *Japanese miracle*, averaging 7.5% in the 1960s and 1970s, and 3.2% in the 1980s and early 1990s. Conversely, growth slowed considerably throughout the 1990s; the Japanese refer to this time as the *Lost Decade*. Government efforts to revive economic growth did little to reverse the economic turndown, and endeavors were hampered further by the global slowdown in 2000. The economy showed strong signs of recovery after 2005; GDP growth for that year was 2.8%, surpassing the growth rates of the USA and the EU during the same period.

As of 2010, Japan's national economy was third only to the USA and China in terms of nominal GDP and purchasing power parity. During that same year, it was also the world's fourth largest exporter and fourth largest importer. As of January 2011, Japan's public debt was more than 200% of its annual GDP, the largest of any nation in the world. The service sector accounts for three-quarters of its GDP. The nation has a large industrial capacity, and is home to some of the largest and most technologically advanced companies. Japanese agricultural businesses often utilize a system of terrace farming, and crop yields are high; 13% of Japan's land is cultivated. Japan accounts for approximately 15% of the global fish catch.

As of 2010, Japan had a low unemployment rate of approximately 4% and a labor force of greater than 65.9 million workers. However, nearly one in six Japanese, or 20 million people, lived in poverty in 2007. Housing is characterized by limited land supply in urban areas; more than half of all Japanese live in suburbs or more rural areas.

Education

During the course of the Meiji Restoration, primary schools, secondary schools, and universities were introduced in 1872. Since 1947, compulsory education in Japan comprises elementary and middle school; students attend from ages 6 to 15, although nearly all children continue their education at a 3-year senior high school. According to Japan's Ministry of Education, Culture, Sports, Science and Technology (MEXT), as of 2005 approximately 75.9% of high-school graduates attend a university, junior college, trade school, or other institution of higher learning.

Japan's education system is intensely competitive, particularly for entrance to institutions of higher learning. The two top-ranking universities in Japan are the University of Tokyo and Kyoto University. Currently, the Organization for Economic Cooperation and Development (OECD) ranks the overall knowledge and skills of Japanese 15-year-olds as sixth best in the world.

Health Care

Health care in Japan is provided by the national and local governments; patients are responsible for 30% of the cost of services rendered, while the government pays for the remaining 70%. Fees for services are set by a government committee, and remittance for personal medical services is offered through a universal health insurance system that provides relative equality of access. Those without employer-sponsored insurance may participate in a national health insurance program administered by local governments. Patients cannot be denied coverage and are free to select physicians or facilities of their choice. By law, hospitals are managed by physicians and must be run as nonprofit; for-profit corporations are not permitted to own or operate hospitals.

Since 1973, all elderly persons have been covered by government-sponsored insurance.

Enrollment in one of Japan's health insurance programs is compulsory; however, enforcement is somewhat lax. Of late, a growing number of individuals are not covered by insurance. This trend has come to the forefront as economic conditions have deteriorated and some Japanese companies have ceased paying for employees' insurance premiums.

Migration

Globalization, labor shortages, and an aging population are a few of the issues forcing Japan to consider how widely it should open its domestic labor market to foreign workers.

Some social and economic factors are pushing Japan toward a more open immigration policy, while other factors, such as mounting concerns about public security and growing apprehensions about international terrorism, are prompting Japan to enact stricter immigration controls.

Between six million and seven million Japanese migrated each year during the 1980s. About 50% of these moves were within the same jurisdiction, or prefecture, (Japan has 47); the others were relocations from one prefecture to another. During Japan's economic development in the twentieth century, and especially during the 1950s and 1960s, migration was characterized by urbanization as people moved in search of better jobs and education. Out-migration from rural prefectures continued in the late 1980s, but more slowly than in previous decades.

In the 1980s, government policy provided for new urban development away from the large cities, particularly Tokyo. Regional cities sought to attract young people to live and work there. While in comparison to larger urban areas, regional cities offered lower costs of living, shorter commutes, and, in general, a more relaxed life style, young people continued to move to large cities to attend universities and to find work. However, some returned to regional cities (a pattern known as U-turn) or to their prefecture of origin (a pattern known as J-turn).

Government statistics indicate that in the 1980s, significant numbers of people left the largest cities (Tokyo and Osaka). In 1988 more than 500,000 people left Tokyo, which experienced for the year a net loss through migration of nearly 73,000. Osaka had a net loss of nearly 36,000 in the same year. However, the prefectures showing the highest net growth are located near the major urban centers. This pattern suggests a process of suburbanization – residents moving away from the cities for affordable housing but still commuting there for work and recreation, rather than a true decentralization.

Japanese economic success has led to an increase in certain types of external migration. In 1990 about 11 million Japanese went abroad. More than 80% of these people traveled as tourists, visiting most often other parts of Asia and North America. However, about 663,000 Japanese were living abroad, approximately 75,000 of whom had permanent foreign residency, more than six times the number who had that status in 1975.

More than 200,000 Japanese went abroad in 1990 for extended periods of study, research, or business assignments. As the government and private corporations have stressed internationalization, Japan's historically claimed insularity has decreased. Frequently, individuals who have lived outside of Japan for extended periods have faced discrimination upon repatriation as fellow nationals have considered them no longer fully Japanese. By the late 1980s, these problems, particularly the bullying of returnee children in the schools, had become a major public issue both in Japan and in Japanese communities abroad.

The number of foreign nationals entering Japan has grown substantially in recent years. Including new and returning visitors and residents, the total number of entrants was 3.5 million in 1990 and 5.27 million in 2000. By 2005, the number had grown to 7.45 million, including 2 million Koreans, 1.32 million Chinese from Taiwan, 780,000 Chinese from the People's Republic of China, 250,000 Chinese from Hong Kong, and 221,000 Filipinos. Among Koreans, many were students; the Chinese were generally trainees and students; and nearly 40% of the Filipinos arrived with *entertainer* visas, given to actors, singers, dancers, and professional athletes. Japan continues to be relatively closed to asylum seekers, and the number of applicants has also been very small. Between 1982 and 2004, there were 3,544 applications; only 330 of them were approved. Of the 3,544 applications, 408 (11.5%) were filed by Indochinese, mostly before 1985.

Currently, Japan's population is estimated at around 127.3 million, with a linguistically and culturally homogeneous society, and only small populations of foreign workers. Zainichi Koreans, Zainichi Chinese, Filipinos, Japanese Brazilians, and Japanese Peruvians are among the small minority groups in Japan. In 2003, there were about 136,000 Western expatriates.

By 2050, almost 40% of Japan's population will be aged 65 and over, as projected in December 2006. Immigration and birth incentives are sometimes suggested as a solution to provide support for the nation's aging population. While Japan has a steady flow of about 15,000 immigrants per year, many do not stay on a permanent basis. Furthermore, according to the UNHCR, in 2007 Japan accepted just 41 refugees for resettlement, while the USA took in 50,000.

Related Topics

- ► Asia
- ► Health care
- ► Health outcomes
- ► Life expectancy
- ► Lifestyle

Suggested Readings

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Suggested Resources

For information about Japan from the United Nations. http://www.un.org/en/index.shtml

For information about Japan from the World Health Organization (WHO). http://www.who.int/en/

For information about Japanese migration history and policy. http://www.migrationinformation.org/index.cfm

Jewish Migration

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Jews trace their roots to the Middle East and particularly to the area known as Judea. The initial immigration of members of this tribe occurred during biblical times. However, in the annals of Jewish history, the most influential immigration occurred after the Judea region was occupied by Nebuchadnezzar, the king of Babylon. In 588 BC, following the destruction of the Jewish temple and the destruction of the Judean Kingdom, the inhabitants were exiled to what is now Iraq. Unlike other exiles, they did not assimilate and developed a more abstract religion that emphasized abstract and holy texts rather than physical worship. In 539 BC, when the Kingdom of Babylon was conquered by the Persians, the Jews returned to Judea, rebuilt the second temple, and reestablished their place of worship, the second temple. Not all of the Jews returned and some remained in Babylon, establishing what was the first Jewish Diaspora. This was the result of Jewish exile or forced immigration out of their original homeland.

By the second century BC, the Jews were immigrating to countries around the Mediterranean basin. Following the Jewish revolt against the Romans and the subsequent destruction of Jerusalem, the center of Jewish life shifted, although according to historical accounts, a large population remained in this Judea until the sixth century, particularly in the Galilee region. The migration of Jews continued during the post-Roman period. During the Middle Ages, Spain and North Africa became the center of Jewish studies. However, in 1492 the Jews were forced to convert to Christianity or leave Spain within 3 months.

The Expulsion Chronicles describe the wholesale killing of women and children. Following this expulsion, Jews from Spain migrated to Western Europe where they established several large communities. Persecuted and abused, the Jews in Germany were eventually expelled and moved to Eastern Europe. This move led to the development of a new language called Yiddish, a combination of medieval German and Hebrew.

In the mid-1600s, Jews were massacred in Poland, and some moved back to Germany and other Western European countries. During the 1800s, as nationalistic movements in Europe started to flourish, the European Jews started to assimilate into the mainstream of society. Jews viewed the period of "Enlightment" and started to pursue professions that emphasized intellectual rather than manual skills. Their Eastern European counterparts, who continued to be subjected to severe persecution and routine massacres, started to immigrate on mass to the USA, South America, and the Turkish- and later British-controlled Palestine.

Prior to World War II, the Nazi regime reinstated many of the anti-Semitic discriminatory laws in Europe. Jews who had foresight or were well known in their area of expertise, such as scientists, immigrated to the USA, British Palestine, and some even to China. These forced immigrations ended during World War II when the Germans perpetrated the Holocaust. After the destruction of the European Jewry during World War II when approximately six million Jews were systematically murdered, the majority of Eastern and Western European Jews immigrated to other countries including what later became the State of Israel.

Following the establishment of the State of Israel, Jews in Arab countries were subjected to massacres and persecution. Anti-Jewish riots involving the loss of life also took place in Libya in 1945, in Yemen in 1947, and in Egypt, Morocco, and Iraq in 1948. Jewish places of worship (synagogues) and property were confiscated. Those Jews who were forced to emigrate were not allowed to take their property. From 1948 to 1949, the Israeli government secretly airlifted 50,000 Jews from Yemen and from 1950 to 1952, 130,000 Jews were airlifted from Iraq. From 1949 to 1951, 30,000 Jews fled Libya to Israel. In these cases, over 90% of the Jewish population opted to leave, despite the necessity of leaving their property behind. Overall, approximately 900,000 Jews were forced to immigrate. The majority settled in Israel, while some settled in France, the USA, and South America.

In the late 1970s, with the rise of extreme Islam and anti-Semitism in Iran, people of the Christian, Zoroastrian, Bahai, and Jewish faiths were persecuted. These persecutions resulted in a new wave of Jewish immigration to the USA. After the Holocaust, a large center of Jewish population remained in Russia and other Eastern European countries. During the communist era, the Jews in these countries were subjected to subtle discrimination such as university quotas and random imprisonment. With the fall of the Soviet Union and the rise of ultra nationalism in these countries, anti-Semitism again flourished. As a result, between 1988 and 1999, a wave of Jews emigrated out of the former Soviet Union. During this decade, 700,000 Jews arrived in Israel becoming 15% of that country's population. These new wave immigrants, like their predecessors, reshaped their new host countries with their know-how and intellectual curiosity, leading to the formation of numerous high-tech companies both in the USA and Israel, including companies such as Google.

Related Topics

- ► Holocaust
- ► Judaism
- ► Zionism

Suggested Readings

Siacore, A., Mikhail, A. M., Kassan, A., & Lerner, A. (2009). Cultural transitioning of Jewish immigrants: Education, employment and integration. *International Journal Education Vocational Guidance*, *9*, 157–176.

Job Stress

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Stress can be defined as a state in which one's equilibrium has been disrupted by physical or psychosocial factors. This imbalance, as well as an individual's efforts to behaviorally, psychologically, and physiologically compensate, can exacerbate or contribute to various disease states. Stress can be further characterized by duration, sphere of life in which it occurs, severity, and its perception by the individual.

While all populations are prone to stress, immigrants face unique challenges that can make them particularly vulnerable. Researchers have cited three major variables within the immigrant experience that can provide a framework for stress: the migration process, employment, and general acculturation. One longitudinal study examined employment, duration of residence, and mental health of skilled immigrants from China, India, and South Africa to New Zealand. The authors found that unemployed and underemployed immigrants had poorer mental health when compared with those employed full time as well as the general population. Substantial research supports the notion that unemployment, particularly long term, adversely affects psychological and physical well-being. Immigrants face exceptional challenges to employment over their native counterparts, due in part to discrimination, lack of fluency in the dominant society's language/cultural nuances, and general selection bias by recruitment agencies and employers. Even those immigrants with full-time employment are susceptible given their need to adapt to the unfamiliar work environment of another country as well as the stress that accompanies learning to communicate effectively in a foreign tongue.

Acculturative stress refers to various aspects inherent to the immigrant experience: discrimination, language inadequacy, the lack of social and financial resources, employment barriers, feeling out of place in a new environment, and the conflict of trying to adapt to a new culture while still retaining the traditions, values, and customs of the old. High levels of acculturative stress have been correlated with depression and suicidal thoughts in Mexican and Central American immigrants. In addition to work stress, contributing factors such as family dysfunction, inadequate social support, low levels of religiosity, bleaker expectations for the future, lack of choice in the decision to immigrate, and low levels of education and income were predictors of psychological duress.

When looking specifically at migrant farmworkers in the Midwestern United States, of which there are over one million, one can see how the nature of the work plays a significant role in an individual's level of acculturative stress. By the nature of the work they do, migrant farmworkers are socially marginalized peoples. Many earn less than US$6,000 a year, endure strenuous labor conditions, find themselves subject to hazardous working conditions (e.g., pesticide exposure), and are forced to live in substandard conditions often without running water or adequate toilet facilities. In part due to the nature of their work and limited access to healthcare, the average life expectancy of a migrant farmworker is 49 years. Through health opinion surveys among migrant workers it was discovered that the immigrant experience, compounded with the rigors of their lifestyle, placed these individuals at particularly elevated psychological risk. Migrant farmworkers generally reported high levels of anxiety and depression in large part related to the discrimination and exploitation that they experience as a result of the service they provide.

One criticism of studies looking at job stress is that they generally fail to account for the potential effects of one's ethnicity and cultural background. In the late 1990s, the term *ethnocultural occupational stress* was introduced to reference stressors within the work environment that directly pertained to an individual's minority ethnic status with a strong emphasis on cultural self-identification. It was observed that among ethnic minorities job stress was particularly influenced by cultural conflicts, lack of social support, and perceived discrimination. One study that examined job stress ratings among Hispanic professionals compared to a normative group revealed higher levels of stress which were most closely correlated with the perception of poor support from peers, supervisors, and their organization rather than pressure such as meeting deadlines, damage control, etc. To the extent that these outcomes stemmed from cultural conflicts and/or discrimination is speculative.

Research indicates that stress has a significant impact on physical functioning and well-being. No organ system is spared from its impact. Initially, when confronted by a stressor, our bodies respond with an adaptive fight or flight reaction. Chemical mediators are released that facilitate energy, alertness, and an increased capacity to respond. Once the stressor has ceased, our bodies return to their baseline. Persistent stress, on the other hand, results in chronic activation of these chemical mediators and can result in suppression of growth and tissue renewal/healing, increased fat stores, and sugar dysregulation. When elevated, the stress hormone cortisol can also interfere with working memory and information processing in some individuals.

Those under a lot of stress often report difficulties related to the gastrointestinal tract. In affected individuals, stress can mediate a hyperreactivity to chemicals produced by the brain and result in increased transit time through the large bowel and delayed emptying of the stomach. Those suffering from irritable bowel syndrome often find symptoms of bloating, abdominal discomfort, and alternating constipation and diarrhea, worsened when under psychological duress. Peptic ulcers can also be mediated by stress. The presence of ulcers in those who test negative for infection with the *Heliobacter pylori* bacteria as well as the rate of persons infected who do not go on to develop ulcers emphasized the role of "negative health behaviors" fueled by stress – that is, smoking, increased alcohol intake, irregular sleep, and poor eating habits just to name a few. It is believed that stress and these behaviors physically alter the landscape of the gut increasing acid secretion, dampening motility, and making the inner lining more susceptible to colonization by bacteria, inflammation, and ulceration.

Acute and chronic stress responses and its effects on the cardiovascular system have been well established. Chronic elevations of stress hormones can contribute to hypertension with resultant heart enlargement and plaque formation within arteries. The INTERHEART study indicated that psychosocial stress (i.e., work, martial, low social support, financial, etc.) was a variable comparable to smoking and high blood pressure in its association with coronary artery disease and heart attack.

Psychosocial stress has also long been known to impact mental well-being. Chronic stress can contribute to the onset of psychiatric illnesses such as depression and anxiety as well as exacerbate preexisting conditions. Persistently elevated levels of stress-induced inflammatory markers play a role in dysregulation of sleep, appetite, energy, and concentration. Numerous studies have demonstrated a correlation between depressive symptoms and markers of inflammation with some implication that chronic stress can adversely impact the central nervous system's serotonergic system with resultant alterations in mood and behavior.

Although the impact of work-related concerns on well-being has not been systematically investigated in relation to immigrants, a few studies have attempted to look at this. In addition to examining Hispanics, which comprise the largest foreign-born population in the USA, other authors have examined stress in relation to Asian Americans. As of 2000, Filipinos comprised the second largest foreign-born population in the USA. A few studies have looked at the types of job stressors encountered by Filipino workers, which include management insensitivity, racism, and lack of mentorship. One study examining the association between work stress and health showed the strongest correlation for new immigrants. It has been suggested that over time immigrants may be better able to cope and adapt to their new environments and subsequently ameliorate the effects of acculturative stress. More studies are beginning to demonstrate that length of time spent in the USA lends itself to more job opportunities and occupational mobility and can perhaps mediate some of the stressors unique to the immigrant experience.

One final consideration is the impact of subtle discrimination of marginalized groups and its impact on general health once factors such as age, gender, region, income, employment, marital status, and social desirability bias are controlled for. One such study examined the association between self-reported everyday discrimination and chronic health conditions – particularly among the Asian subgroups of Chinese, Filipino, and Vietnamese. An increase in the number of chronic health conditions, particularly those affecting the cardiovascular, endocrine, and immune systems, correlated with the frequency of reports of discrimination. This data is supported by several other longitudinal studies that have found an association between discrimination and health issues.

While stress in the immigrant population can be multifactorial, work stress is a predominant component. The specific work-related stressors in the immigrant population and their affect on health should not be overlooked.

Related Topics

- ► Employment
- ► Farmworkers
- ► Migrant farmworkers
- ► Occupational and environmental health
- ► Stress

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Suggested Resources

http://www.hawaii.edu/hivandaids/Physiological_Stress_Responses_in_Filipino-American_Immigrant_Nurses.pdf

Judaism

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The Fertile Crescent is a region in Western Asia. It includes the regions of Mesopotamia and the Levant. Due to its unique climate, it gave rise to many edible plants that could be cultivated and animal species such as cows, sheep, and goats that could be domesticated. This unique ecosystem led to the emergence of complex societies and cultures, earning this region the nickname “The Cradle of Civilization.” Most of the societies and cultures that were formed in this region emphasized a system of beliefs or religions that associated the good fortunes of its members with supernatural protectors or gods. Those were represented in the form of statues and temples. When one tribe or kingdom was conquered by another, they would typically force the other tribe to adopt their gods, culture, and system of beliefs. One tribe, the Kingdom of Judea, which occupied the region known as modern day Israel, took a unique approach toward religion. They developed a system of beliefs that emphasized a single supernatural being that did not have a physical representation, and emphasized the importance of sacred writings (the Old Testament) to guide their day to day activities. In 587 BC, the ancient Kingdom of Judea was conquered by the Babylonians, a regional empire of that time. The Babylonians destroyed the Kingdom of Judea’s temple and exiled its inhabitants to what is now the northern region of Iraq. Unlike other tribes, members of the Kingdom of Judea did not abandon their religion or culture. In fact, the elimination of their political independence led to further affirmation of their abstract belief system and the development of religious worship that can be carried out wherever ten members of the tribe (Jews) were present. Additionally, the exiled members of the tribe developed a text recording discussions pertaining to Jewish law, ethics, customs, and history and made sweeping changes in their religion. These writings are known as the Talmud. The forced migration of the Jews to Babylon again strengthened their abstract belief system and written scriptures over physical representations of God. Fifty years after the Jews were forced to migrate from the land, the Babylonian Empire was destroyed by the Persians, and most but not all of the members of the tribe returned to Judea. Upon the return of the Jews to the Land of Judea, they rebuilt a new (second) temple for their God. However, unlike their previous temple, they deemphasized its religious centrality. Four hundred years later, when the Romans destroyed the second Jewish temple and forcefully exiled most of the Judea inhabitants, the Jews were already living across most areas of the Mediterranean region, and had developed a culture and religion that emphasized migration, allowing them to move from one location to another with great ease.

The ability of the Jewish tribe to employ inductive and deductive reasoning toward the interpretation of their scriptures also allowed them to adapt their laws to technological and climate changes wherever they resided. Often these adaptations addressed issues in public health such as strict dietary laws and hygiene practices. One such practice, for example, is the ritual of washing hands prior to touching food. This ritual involves pouring water out from a cup first twice over the right hand and then twice over the left hand. The unwashed hands are supposed to not touch the water used for the washing. The hands are then dried with a towel before partaking of the meal. Another ritual is the Jewish law of bathing regularly which requires complete immersion in a ritual bath as part of the end of the week preparation. Jewish rituals regarding grief and mourning have been conducive for mental health.

Another prime example of adaptations was introduced by Moshe Maimonides, a preeminent medieval Jewish philosopher, spiritual leader (Rabbi), and physician. Maimonides (1137–1204) was born in Northern Africa. When the Berber Muslims conquered the region, his family fled to Southern Spain and eventually settled in Morocco. Later, the family briefly immigrated to the Judea and eventually settled in Egypt. Maimonides's immigration experiences exposed him to Greek and Persian philosophy as well as medicine. In time, he became a renowned court physician to the Egyptian royal family. Maimonides's writings, which continued to be studied by Orthodox Jews, describe various medical conditions including asthma, diabetes, hepatitis, and pneumonia. He emphasized moderation and a healthy life style and living on a balanced diet. Moshe Maimonides also wrote one of the earliest toxicology textbooks. Maimonides's forced immigration experience also affected his sense of justice. One of his often cited legal maxims states that "It is better and more satisfactory to acquit a thousand guilty persons than to put a single innocent one to death." This principle was also applied to his medical practice. In a letter to one of his patients, a nephew of Saladin the Great in Cairo, Maimonides discussed the possible use of alcohol to treat bipolar disorder. In his letter to his Moslem patient, Maimonides quotes from the Koran and addresses the conflict between religious beliefs and the Muslim prohibition of alcohol consumption. Maimonides forged a link between religion and medicine and intercultural sensitivity and emphasized the common Jewish belief that saving life itself is a religious duty that supersedes virtually all other religious obligations.

The above example is particularly important in illustrating how immigrants' familiarity with various cultures and ideas provides them with the opportunity of fusing diverse ideas and approaching problems in unique and creative ways. A century after Maimonides's death, Jews of Spain were repeatedly discriminated against, persecuted, and forced to convert throughout Europe. In 1290, King Edward expelled the Jews from England, and in 1492 Queen Isabella expelled them from Spain. Many of the Jews from these countries immigrated to Western and later to Eastern Europe where they sought refuge. However, the tolerance in these countries to immigrants (Jews and Gypsies) did not last very long, and the local population often engaged in pogroms and persecution of the Jews. During the bubonic plague (*Circa* 1348), the Jews in Western and Eastern Europe were blamed for the outbreak and were massacred. In 1543, Martin Luther wrote *On Jews and Their Lies* and advocated their persecution. In the 1700s, during the uprising of the Ukrainians against the Poles, the Jews were persecuted and massacred. Finally, in the 1800s, anti-Jewish riots were common in Eastern Europe during various political upheavals. Similar massacres occurred in other parts of the world.

In the late 1800s, as Jews in Europe were being persecuted, Jews started immigrating to the USA. The Jewish American Immigration experience was also characterized by discrimination in the "New World." Jews were not allowed into certain professions including medicine. The first Jewish hospital, Mount Sinai, was founded in 1852. Other hospitals did not serve Kosher food or have Rabbis. In the 1920s, the children of Jewish immigrants pursued medical careers. However, most hospitals were closed to Jewish residents. As a result, most Jewish doctors completed their residency training in the various Jewish hospitals that were formed across the country such as Mount Sinai, Beth Israel, and Montefiore. In the 1930s, most colleges had a quota on the admission of Jewish students. At Yale, the dean of Yale Medical School, a Jew himself, formally limited Jewish faculty.

In 1933, German law restricted Jews from being reimbursed by the state health insurance funds. In 1939, Jews' licenses to practice medicine were revoked. As a result, Jewish doctors started immigrating to the USA. According to a Time Magazine article from that time, this led to Germany facing a shortage of doctors. Many of the remaining physicians committed suicide and others escaped to other countries. The American physicians were not hospitable to the new immigrants and many argued that they introduced “unfair competition” and “low standards of medical treatment.” Another argument was that many of these physicians were poorly trained in medical schools that “emphasize research and specialization rather than broad clinical experience.” Calls for restriction of practice were addressed by the Boston Committee on Medical Émigrés which stated that “There will be no placing of émigrés in competition with American doctors.” Hence, while famous immigrant researchers, such as the dermatologist, Wilhelm Frei, who developed the Frei test for the detection of syphilis, had no trouble in securing academic positions, other Jewish German immigrants had limited job prospects. Some were able to secure jobs at Jewish hospitals while others could not find work. Some doctors, such as the famous researcher Salome Gluecksohn-Waelsch, volunteered so as to get access to laboratories.

The effects of the European Jewish physicians and scientists’ immigration to the USA during and after World War II can be seen today in many areas. Many of these physicians blended their unique combination of training with that of American ideas to form new and exciting areas of science. Eugene Kennedy reflected on the contributions of Jewish immigrants to biochemistry by noting that “before the Second World War biochemistry in the United States had a strong flavor of clinical chemistry. It was much occupied with problems of analysis of blood and tissues and the determination of the structures of body constituents. This was important and indeed essential work, but American students had to go abroad to Germany or to England for training in what came to be called dynamic aspects of biochemistry. After the war, the flow of students was largely reversed. This transformation was in considerable part the result of new insights and new approaches brought to America by immigrant scientists.” In spite of these contributions, many prominent physicians, such as the biochemist Rudolf Schoenheimer, who pioneered the use of isotopes for the study of metabolism, committed suicide a few years after their arrival.

Throughout the centuries, Jewish immigration resulted from persecution and discrimination. Their attempts to acculturate to the host countries shaped their religion, philosophy, and their traditional professions. Because Jews were often persecuted and not allowed to own land, they often gravitated to professions that emphasized knowledge such as medicine, rather than more manual professions. In more recent times, as the world gravitated toward the licensing of various professions, minorities, including Jews, have found that traditional professions do not provide them with the mobility they expect. In Russia, for example, Jews could not pursue medical professions due to ethnic quotas. As a result, many of them gravitated toward other professions such as mathematics. With the advent of software and hardware engineering, these immigrants were able move from one society or country to another with ease. In Israel, the largest Jewish community outside the USA, as many as one million immigrants arrived between 1989 and 2000 as anti-Semitic activities became rampant in the former Soviet Union. Many of these immigrants arrived with exceptional mathematical training. Their training, combined with the knowhow of European immigrants who established most of the higher education institutes in that country, invigorated the scientific and medical community. It introduced new ideas, particularly in the field of software engineering which together with Israeli risk taking behavior led to various technological breakthroughs and the formation of hundreds of medical startups, many of which were later moved to the USA or Europe.

Related Topics

- ► Holocaust
- ► Jewish migration
- ► Zionism

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K

Karma

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Karma is popularly understood as the law of cause and effect, whereby an individual's actions or deeds shape their past, present, and future life and afterlife experiences. Karma is associated with Eastern religions such as Hinduism, Buddhism, Jainism, and Sikhism, each of which has its own way of viewing it. The effects of karma can be: (1) visible and invisible outcomes that are brought about by one's actions and (2) tendencies to act, think, experience, or interpret experiences in ways that are conducive to one's happiness or unhappiness that are brought about in the person by his or her actions. Associated with the doctrine of karma is the notion that the soul is reincarnated in a new physical body after death and that the particular body, family, as well as social and economic circumstances into which the soul transmigrates after a person dies is determined by that person's deeds during his or her lifetime.

The belief that former acts (even in a past life) have produced present realities has led to a differentiation between good karma and evil karma. Good karma in a past life is understood to result in superior current personal attributes, quality of life, and living environments. Evil karma in a past incarnation on the other hand condemns a human being to a life of suffering and sorrow. Merit can however be earned by virtuous actions and through good and moral conduct. An individual may therefore accumulate enough merit to be born in superior circumstances in the next life while righteous human beings who have reached an enlightened state of consciousness attain liberation from the cycle of birth, death, and rebirth.

Today, the bulk of immigrants to the major receiving countries, such as the USA, Canada, and Australia, are from the less developed world. All have large numbers of immigrants from Asia. These immigrants vary enormously in their cultural and educational backgrounds, their prior exposure to Western cultures and norms, and in their ability to integrate and adjust to a new and often, alien culture. Culturally embedded meanings of disease can shape immigrants' attitudes, interpretations, and responses to illness and to preventive and curative care in the Western biomedical tradition. Although the doctrine of karma posits that individuals can change their lives and their experiences through their actions, some may attribute chronic illnesses and disabilities to destiny or actions in a past life. Those who came from rural areas, with little or no education and are used to traditional methods of healing (such as immigrants from Cambodia and Laos, who fled genocide and sought political asylum in host countries) are less likely to wholeheartedly embrace biomedicine. Disconnections between physicians trained in the biomedical tradition and immigrants who may use multiple healing strategies or attribute ill health to causes beyond those that are scientifically based may result in mistrust on both sides and barriers to good health.

A belief in karma may affect preventive health care and referrals. For example, studies of Cambodian immigrant women in the USA showed that their experiences of domestic violence were attributed to negative karmic actions in a previous life and that those who believed in karma were less likely to have ever been screened for cancer that those who did not. However, other investigations have determined that it is possible for persons who believe in the existence of house and ancestral spirits and the doctrine of karma to avail of and use Western biomedicine and health, provided it is delivered in a culturally sensitive and culturally appropriate manner. Therefore, an understanding of the

Sana Loue & Martha Sajatovic (eds.), *Encyclopedia of Immigrant Health*, DOI 10.1007/978-1-4419-5659-0,

cultural background of immigrants and their beliefs regarding the cause of ill health (including karma) and adjustment of health care and service delivery to incorporate the beliefs of immigrants who maintain strong home-country cultural values would allow for better treatment and care and better health.

Related Topics

- ► Cross-cultural health
- ► Fatalism
- ► Health barriers

Suggested Readings

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Kennedy, Edward

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Born in Brookline, Massachusetts on February 22, 1932, Edward Moore "Ted" Kennedy was the youngest of nine children of Rose Fitzgerald and Joseph P. Kennedy, Sr. His father, a multimillionaire businessman, held many important governmental posts, including serving as US ambassador to Britain. These positions afforded the family many travel opportunities. By 11 years old, Ted had enrolled in ten schools at different locales.

Joseph and Rose Kennedy emphasized the importance of healthy competition and success in their children's development. Rose, especially, enforced high levels of academic performance in her children. During dinner, the Kennedy children often were quizzed on history, politics, and literature, with lively discussions highly encouraged by the parents. Ted, however, preferred sports to academics. He was noted to be the family prankster and an extrovert who planned family trips and entertained guests.

Ted was the youngest brother of Senator Robert F. Kennedy and President John F. Kennedy, who were assassinated while serving in office; Joseph P. Kennedy, Jr., who was killed during World War II; sister Rosemary who was institutionalized following lobotomy surgery; and sister Kathleen who died in a plane crash over the French Alps. These incidents became known as "The Kennedy Curse." His other sisters were Eunice, Jean, and Patricia.

For most of his life, Ted grew up in Bronxville, New York, and attended private boarding schools. In 1946, Ted attended a college prep boarding school, Milton Academy, near Boston. At Milton, Ted was heavily involved in sports, debate, drama, and the glee club. After graduating in 1950, he followed his brothers to Harvard University.

Kennedy left Harvard and enlisted for a two-year stint in the Army, where he served as a guard at the Supreme Headquarters Allied Command in Paris, France. He resumed his studies at Harvard and completed his degree. After graduation, he studied for a brief period at the Academy of International Law in the Netherlands and then entered Virginia Law School, where he received his law degree in 1959.

While studying at the University of Virginia, he met and married Virginia Joan Bennett in 1958. The couple had three children, Kara, Edward Jr., and Patrick.

Kennedy campaigned for his brother John in the 1960 presidential race. In 1962, at the age of 30, Ted was elected to John F. Kennedy's former US Senate seat in a special election. He was elected to a full six-year term in 1964, and was reelected seven more times throughout his career.

During his time in office, he advocated for voting rights, education, volunteerism, immigration reform, increasing minimum wage, the nation's first major legislation to combat AIDS, and equality for minorities, women, the disabled, and gay Americans. He also supported mental health benefits, cancer research, and children's health insurance. Kennedy and his staff wrote more than 300 bills that were enacted into law. Kennedy sponsored legislation on immigration reform, criminal code reform, fair housing, public education, health care, AIDS research, and a variety of programs to aid the poor. On the Senate Judiciary Committee, he upheld liberal positions on abortion and capital punishment.

As a Senator, Kennedy became known for his oration skills. Among his best-known speeches were his 1968 eulogy for his brother Robert and the 1980 rallying cry for modern American liberalism. Kennedy also was known for his bipartisan friendships with conservative Republicans, while maintaining his liberal roots. Ted supported governmental intervention that encouraged social justice, as well as finding compromises with Republicans where dissimilar views existed. For example, he partnered with Senators Nancy Kassebaum and John McCain to cosponsor legislation on worker's healthcare benefits, immigration, and funding for traumatic brain injuries.

Kennedy faced many troubles in his personal life. Accusations of philandering and alcohol abuse existed throughout his time in office. And, in 1982, after 24 years of marriage, he and wife Joan Bennett Kennedy divorced. Later, in 1992, he married Washington, D.C. lawyer, Victoria Reggie, a woman to whom he credits his alcohol abuse recovery. He had two stepchildren from that union, Grier and Caroline Raclin.

In May 2008, Kennedy was diagnosed with a malignant brain tumor and, on August 25, 2009, he passed away at his home in Hyannis Port, Massachusetts. When he died, he was the second most senior member of the Senate and the third longest-serving senator in US history, known as "The Lion of the Senate" as a result of his 47-year long tenure influence in Congress.

Related Topics

- ► Access to care
- ► Health care utilization
- ► Health policy
- ► Public health insurance

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Kennedy, John Fitzgerald

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John Fitzgerald Kennedy, born in Brookline, Massachusetts, on May 29, 1917, was the 35th president of the United States. Early in his life, John F. Kennedy attended Harvard, graduating in 1940. He then served in U.S. Navy in the South Pacific during World War II, as a Patrol Torpedo "PT" boat commander. While serving in the Navy, John F. Kennedy was awarded the Navy and Marine Corps Medal, the Purple Heart, the American Defense Service Medal, the American Campaign Medal, the Asiatic-Pacific Campaign Medal with two bronze service stars, and the World War II Victory Medal. On September 12, 1953, Jacqueline Bouvier became Mrs. John F. Kennedy. President and Mrs. Kennedy had three children, namely, Caroline Bouvier Kennedy, born in 1957; John F. Kennedy, Jr., born in 1960; and Patrick Bouvier Kennedy, born in 1963 and died in his infancy.

John F. Kennedy served in the U.S. House of Representatives from 1947 to 1953 and served in the U.S. Senate from 1953 until 1960. Then, at the age of 43, he was the youngest person elected to U. S. Presidency. The quote, “ask not what your country can do for you – ask what you can do for your country,” is a widely known quote from his inaugural address.

As President, he had many “firsts.” He was the first Catholic president as well as the first Irish American president. John F. Kennedy also is the only president to have won a Pulitzer Prize; he was awarded the 1957 Pulitzer Prize in Biography for his book “Profiles in Courage,” a book about U.S. Senators who fought for what they believed, and in doing so had had risked their careers. Kennedy also wrote “Why England Slept” in 1940, and an essay for the Anti-Defamation League, entitled “A Nation of Immigrants,” which was published in book form after his death. Further, he published an article, “The Soft American,” in the December 26, 1960 edition of Sports Illustrated.

During his presidency, John F. Kennedy addressed many difficult issues, such as the nuclear weapons situation, war, racial segregation and discrimination, immigration, and the physical fitness of the nation’s population. For example, Kennedy developed the White House Committee on Health and Fitness, which was supervised by the Department of Health, Education, and Welfare. He also instituted an annual youth fitness conference. His appointment of African-Americans to key administrative posts, such as Administrator of the Housing and Home Finance Agency, Associate White House Press Secretary, and Deputy Assistant Secretary of State for Public Affairs was groundbreaking.

The relationship between the United States and Cuba was an ongoing issue for the Kennedy Administration. Even though it was planned by the Eisenhower Administration, Kennedy ordered an invasion of Cuba to overthrow Fidel Castro in what would later be called the Bay of Pigs invasion. On April 17, 1961, some 1,500 U.S. trained Cuban exiles entered Cuba. However, the invasion failed and resulted in the survivors being released in return for U.S. medical aid and food. The U.S.–Cuba relationship would forever be tainted.

In October 1962, U.S. military intelligence learned that nuclear missile sites were being built in Cuba by the Soviet Union. The political tension between the United States and the Soviet Union, as well as the threat of nuclear war, created a “Cold War,” where communications between these two nations were frozen. Cuba’s close proximity to the United States caused John F. Kennedy to be concerned about the growing nuclear armament in Cuba. To prevent the Soviet Union from continuing to supply the missile sites, Kennedy put a naval blockade around Cuba. For a week, the United States and the Soviets teetered on the brink of nuclear war. However, the situation was ultimately defused. The Soviets agreed to dismantle the weapon sites and the United States agreed not to invade Cuba. On August 5, 1963, the Nuclear Test Ban Treaty was signed in Moscow, and on October 7, 1963, John F. Kennedy signed the ratified Treaty.

Vietnam also was a focus of Kennedy’s administration. During his time as President, he increased the number of U.S. military in Vietnam from 800 to 16,300. Even though there was no conclusive proof, it was generally believed that Kennedy planned to decrease the number of U.S. military personnel in Vietnam by the end of 1963, and eventually withdraw totally. The systematized declassification of certain governmental documents in the 1990 does tend to support this view. Additionally, at a press conference on November 12, 1963, Kennedy stated that his plans were “to bring Americans out of there.”

After Kennedy’s death, his successor, Lyndon B. Johnson, soon issued orders to reverse John F. Kennedy’s previously announced reduction plans. On August 2, 1964, in what is now known as the Gulf of Tonkin Incident, the USSS Maddox was engaged by the North Vietnamese in a naval battle. This was the catalyst that led to the Gulf of Tonkin Resolution, which gave the President the exclusive right to use military force without consulting the Senate. Johnson used this authority to begin America’s direct involvement in the ground war in Vietnam.

Civil Rights and women’s equality were topics for discussion in America during the early 1960s, and President Kennedy’s involvement led to greater freedoms for all Americans. He proposed what would become the Civil Rights Act of 1964. John F. Kennedy was instrumental in orchestrating the release of Martin Luther King from jail. He also provided Federal support for the integration of the University of Mississippi in 1962 and the integration of the University of Alabama in 1963. Also, in 1961, Kennedy signed an executive order to create the Presidential Commission on the Status of Women, whose report detailing the discrimination of women was issued in October 1963.

Though not as well-known as some of his other achievements, John F. Kennedy began the reformation of the nation's immigration policy. His efforts would later be the foundation for the Immigration and Nationality Act of 1965, which was sponsored by Senator Edward Kennedy, Kennedy's brother. He told congress that "no naturalized citizen will suffer discrimination because of legal disabilities" and asserted that "there is no place for second-class citizenship in America."

He also addressed economic and social progress issues at home and globally. For example, Kennedy created the Peace Corps by executive order in 1961, a program in which Americans volunteer to help underdeveloped nations in such areas as education, farming, and health care. Kennedy also expanded the U.S. space program. During John F. Kennedy's administration, Alan Shepard and Gus Grissom became the first two Americans to travel into space and John Glenn Jr. became the first American to orbit Earth.

Unfortunately, Kennedy's vision for America was cut short in Dallas, Texas on Friday, November 22, 1963, when, at the age of 46, John F. Kennedy was assassinated by Lee Harvey Oswald while riding in a motorcade with his wife, Jacqueline. On November 25, 1963, John F. Kennedy was buried in Arlington National Cemetery, Arlington, Virginia.

Related Topics

- ► Civil Rights Act of 1964 (U.S.)
- ► Discrimination
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Kidnapping

- ► Trafficking
- ► Violence

Korea

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History

The Republic of Korea (ROK), otherwise known as South Korea, is located on the southern half of the Korean Peninsula. It is called the *Land of the Morning Calm*. To the north lies North Korea, officially named the Democratic People's Republic of Korea (DPRK). South Korea is bordered by China to the northwest, Russia to the northeast, and it is separated from Japan to the east by the Korea Strait.

Korea was annexed to Japan in 1910 and was operated as a Japanese Colony until 1945, when the end of World War II brought about the end of the Japanese rule of the Korean people. At that time, the United States agreed to assist Korea by setting up a provisional government, with the goal of free and independent government. The Soviet Union also wanted to assist Korea to set up a provisional government, leaning toward communism. Though each side had differing political goals, the intention was to establish one unified Korea. However, due to the tensions between the United States and the Soviet Union, as well as the escalation of the Cold War, neither country wanted to abandon their efforts. The United States and the Soviet Union agreed to use the 38th Parallel as a demarcation zone – the United States would continue to provide assistance to the portion of Korea south of that line, and the Soviet Union to the north. During the Korean War, the 38th Parallel became a demilitarized zone, and is now commonly referred to as the DMZ.

On June 25, 1950, North Korea invaded South Korea, which led to the Korean War. From 1950 to 1953, the Korean War further divided the Korean people. Eventually, the DMZ became the separation between what is now the Republic of Korea, that being South Korea, and the Democratic People's Republic of Korea, that being North Korea. South Korea is a democratic state, while North Korea is a communist state. On July 27, 1953, at Panmunjom, a village on the DMZ, an armistice was reached. Even though a cease fire was agreed to, no formal peace treaty was ever signed; and therefore, the two Koreas are still technically at war.

In 1953, the United States and South Korea entered into the Mutual Defense Treaty, which resulted in the United States agreeing to help South Korea defend itself against external aggression. Since then, the US Military has maintained a sizable force located throughout South Korea. Since 2004, the United States has been reducing its forces on the Korean Peninsula; and in 2008, the United States and South Korea agreed to place a cap of no more than 28,500 US soldiers stationed in Korea. The relationship between the United States and South Korea remains strong. The United States maintains an embassy in South Korea located in Seoul, and South Korea maintains an embassy in the United States in Washington, D.C.

Population and Culture

As of 2009, South Korea has a total population of approximately 50 million, with around 1,106,884 foreign residents. South Korea's capital is Seoul, which has approximately 9.8 million inhabitants. The Seoul metropolitan area is the world's second largest populated metropolitan area. Other South Korean cities include Busan, with a population of 3.5 million; Incheon, with a population of 2.5 million; Daegu, with a population of 2.5 million; Daejeon, with a population of 1.4 million; and Gwangju, with a population of 1.4 million.

Over half of South Koreans have no religious affiliation. Of those that claim a preference, Christianity is the most common, with Buddhism being a close second. Also represented, but to a much lesser degree, are Confucianism, Korean shamanism, Taoism, and Islam.

Both traditional sports and western sports are commonly played and viewed in South Korea. Some traditional Korean sports are Korean wrestling, much like Sumo wrestling, bull fighting, and Taekwondo. Some popular imported sports are soccer, called football, golf, and baseball. Seoul was host to the 1988 Summer Olympics. Korea cohosted the 2002 World Cup Soccer Tournament with Japan.

The Cuisine of South Korea is comprised mostly of rice, noodles, tofu, vegetables, fish, and meats. Perhaps one of Korea's most widely known dishes is *Kimchi*. *Kimchi* is a fermented, usually spicy, vegetable dish that is commonly served at every meal. Typically, a Korean meal is accented with several side dishes, called "banchan." Many varieties of street food can be purchased, usually from vender's carts. One such food is "kimbap," which is made from steamed white rice and a variety of other ingredients, rolled in dried seaweed. Kimbap is similar to Japanese sushi. Another popular street food is "Ho-tteok," a Korean pancake with a sweet filling. "Bulgogi" is a popular Korean dish that usually consists of marinated beef, or sometimes chicken. Typically, Korean cuisine is eaten with "sujeo," a set of eating utensils that includes a spoon and chopsticks.

Economy and Government

Some of the economic areas in which South Korea excels in are electronics, automobile manufacturing, and robotics.

In 1991, South Korea joined the United Nations. South Korea is also a member of the World Trade Organization and the Organization for Economic Cooperation and Development (OECD). In June 2007, the United States and South Korea entered into the US-Korea Free Trade Agreement, having an active economic trade relationship with the United States.

The South Korean governmental design is set forth in the Constitution of the Republic of Korea, which was enacted in 1948. South Korea's government has three branches – the Executive, the Legislative, and the Judicial. The Executive branch is lead by the president, which serves one 5-year term, no additional terms being permitted. The Legislative branch is made up of the National Assembly of South Korea, which is a single large assembly with 299 members. The National Judicial branch is composed of the Constitutional Court, which has nine justices. The Constitutional Court deals with constitutional matters and with impeachments. Other judicial matters are overseen by the Supreme Court, which has 14 justices.

Citizenship, Immigration, and Emigration

South Korea's immigration policy is administered by the Korean Immigration Service which is a part of the Korean Ministry of Justice. Those Koreans who are natural born citizens are: those who, at the time of their birth, had at least one Korean parent who was a citizen, provided that if the Korean parent died before the child's birth, then the person is eligible for citizenship only if the Korean parent had maintained her/his Korean nationality at the time of their birth; or those born in South Korea, whose parents' citizenship was nonexistent or unclear; or abandoned children found in South Korea.

In order to become a naturalized Korean citizen, a person must: be domiciled in South Korea for a period of more than five consecutive years; be an adult according to Korean law; have good conduct; have the ability to financially support himself or herself or be a dependant of such a person; and have the basic knowledge befitting a Korean citizen, including the Korean language, culture, and customs.

To apply for permanent residency, a person must meet one of the following qualifications: be an adult by Korea's civil law and have stayed in Korea with resident status for more than 5 years, and have the financial capacity to support themselves and their family, have qualities such as being well-behaved and understanding Korean traditions; be a person who has invested more than 500,000 US dollars in Korea and have stayed in Korea with corporate investor status for more than 3 years, while contributing to creating employment opportunities for Korean nationals; be a person who has invested more than 5,000,000 US dollars in Korea and whose acquisition of Permanent Residency is deemed proper by the Justice Minister; be a person who has made special contributions to Korea that are recognized by the Justice Minister.

South Korea has a sizable emigration rate. There are approximately 2.4 million Koreans residing in China, approximately 2.1 million in the United States, approximately 600,000 residing in Japan, and approximately 534,000 residing in the countries of the former Soviet Union.

Related Topics

► Asians
► Dietary patterns

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Kwashiorkor

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The word kwashiorkor, originally introduced in 1935, comes from the Ga language of Ghana of West Africa. It can be translated as "disease or sickness of the displaced child." Kwashiorkor is a type of malnutrition that was commonly seen in older infants or young children after quickly weaning from breastfeeding, usually as a result of another child or pregnancy.

Severe protein and essential amino acid deprivation coupled with sufficient caloric intake can lead to kwashiorkor malnutrition at the time of weaning to a high-carbohydrate, low-protein diet. Superimposed bacterial, parasitic, or viral infection can exacerbate kwashiorkor malnutrition. This form of protein deficiency is more often seen in children in less developed countries with inadequate food supplies due to socioeconomic, political, religious, educational, sanitation, and environmental factors. In the USA, kwashiorkor malnutrition can also be seen in the chronically ill or elderly. Kwashiorkor malnutrition is also called protein malnutrition or protein-energy malnutrition and is considered a severe form of childhood undernutrition or macronutrient deficiency associated with increased morbidity as well as mortality.

Historically, the most severe forms of malnutrition are marasmus and kwashiorkor. Traditionally, kwashiorkor was distinguished from marasmus malnutrition by the presence of edema, lack of wasting, and sufficient caloric intake in an older infant or toddler. However, these disorders are now thought to exist on a spectrum of malnutrition with overlapping features, similar pathophysiological mechanisms, and underlying causes.

Kwashiorkor malnutrition can be primary or secondary. Primary kwashiorkor malnutrition is mainly due to poverty and is impacted heavily by season and climate conditions, cultural and religious food customs, breastfeeding habits and maternal nutrition, prevalence of infectious diseases and vaccination, the existence and effectiveness of nutrition educational programs and the availability and quality of healthcare services. When etiologies of secondary malnutrition are investigated, causes are usually due to chronic illness, for instance, cystic fibrosis, renal failure, congenital heart disease, neuromuscular disease, HIV/AIDS, failure to thrive, chronic diarrhea syndromes, malignancies, bone marrow transplantation, inborn errors of metabolism, and burns.

The pathogenesis of kwashiorkor is not completely understood, but it is likely a maladaptive response to the physiologic stress of an infection that induces a pro-inflammatory metabolic cascade in a chronically malnourished individual. In this way, kwashiorkor can be thought of as an acute illness or injury. This form of malnutrition affects most organ systems of the body, including the endocrine, immune, gastrointestinal, respiratory, neurologic, dermatologic, and hematologic systems. Specifically, endocrine manifestations of kwashiorkor malnutrition are decreased plasma insulin concentrations, decreased glucose intolerance, increased plasma cortisol concentration, increased growth hormone, decreased serum albumin, decreased levels of thyroxine, and decrease plasma leptin concentration. Cellular immunity is depressed and ventilatory response to hypoxia (low oxygen levels) is impaired. Intestinal malabsorption and pancreatic insufficiency are also commonly seen. There is an overall reduction in brain size and cerebral cortex atrophy, resulting in neurodevelopmental delays in global brain function, motor function, and memory which may not be reversible.

Distinct clinical features have been associated with kwashiorkor malnutrition such as: normal weight for age, marked generalized edema, dermatoses, hypopigmented hair, distended abdomen, decreased muscle mass, hypotonia, hyporeflexia, immune system depression, hypothermia, cardiac arrhythmias, hepatomegaly (liver enlargement), and cardiomegaly due to fatty infiltration. The abdomen is distended due to loss of abdominal muscle mass, intestinal distention from malabsorption, and hepatomegaly due to fatty infiltration. Hair is usually dry, brittle, sparse, and depigmented, appearing reddish yellow. Hair changes may demonstrate the “flag sign” with alternating bands of pale and normal color, indicating periods of poor and good nutrition. Cutaneous manifestations are characteristic and progressive. Depending on baseline skin pigmentation, children can have dry atrophic skin with hyperkeratosis and hyperpigmentation. Eventually, these skin lesions erode, resulting in hypopigmented erythematous skin. Sun-exposed skin is relatively spared, as are the feet and dorsal aspects of the hands. Nails are thin and soft.

Children with kwashiorkor malnutrition exhibit psychiatric symptoms such as lethargy and apathy when left alone, with increased irritability with physical contact. Other constellations of psychiatric symptoms may be more attributable to specific vitamin deficiencies rather than kwashiorkor malnutrition. Laboratory evaluation can reveal typical results such as anemia, hypoglycemia, intravascular volume depletion hyponatremia, hypokalemia, hypomagnesia, metabolic acidosis or alkalosis, low total protein, low album, or low pre-albumin, elevated creatinine, and elevated c-reactive protein. The serum zinc level is often low and, in some cases, skin lesions of kwashiorkor exhibit improved healing when zinc is applied topically.

Treatment of kwashiorkor malnutrition is based largely on the World Health Organization recommendations for managing severe malnutrition with important attention paid to treating underlying infections, treating dehydration, enhancing gastrointestinal tract recovery, and managing cardiac sequelae. Depending on the severity of the malnutrition, treatment can be initiated on an outpatient or inpatient basis with more symptomatic clinical presentations warranting higher level of care. A potential complication of treating malnutrition in general is the "refeeding syndrome" with decreased serum levels of potassium, phosphate, glucose, and magnesium. For this reason, small continuous meals or continuous nasogastric feeding should be done along with various vitamin supplementations such as thiamine to avoid encephalopathy. Nutritional rehabilitation, follow-up, and reoccurrence prevention are also important components of treating malnutrition after initial management strategies as described above have been undertaken.

Related Topics

► Nutrition

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Labor Migration

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Economic development relies on many factors: social, political, access to resources, trade, and labor. A key element that produced a shift in the old economic models is globalization, a process that has particularly important consequences for migration and human capital circulation. Labor migration influences the origin countries as well as the receiving ones and raises many issues regarding the labor market and the economic structure of the sending and host countries. In analyzing the effects of labor migration, positive and negative effects have to be taken into consideration. The remittances that reach the country of origin influence the economic structures, creating a dependency and development model that is not sustainable.

Labor Migration a Result of Globalization

Changes brought by globalization in the international economy generate challenges in the employment market. As international labor migration has been growing constantly for the last decades, many issues emerged in relation to the integration of workers in the host labor market. This has repercussions for the social and economic development aspects of that country and on employment relations. Migrants seek to improve their economic situation and this leads them to immigrate to developed countries that offer a higher income perspective. The workforce void in the originating country is compensated by the inflow of remittances sent by migrants, which has a significant impact on the regional development of the economy.

From a neoclassical theory perspective, economics globalization stimulates free trade and productivity fosters mobility, especially capital, and this generates a decrease of migration as the labor force is integrated in a sound and prosperous labor market. Moreover, implementing trade agreements that set a framework for the liberalization of trade between countries and free capital movements, at an international, regional, or bilateral level, should have as a result a significant low migration phenomenon. Agreements such as NAFTA, Mercosur, and all the World Trade Organization's policies facilitate international economic relations and trade. However, it seems that all these measures affect the labor migration differently than expected. The workforce movements are more frequent and this reflects on the income between the origin countries and the hosts. Instead of improving wage differentials between the countries, the commercial liberalization maintains or even increases the difference. Even so, international labor migration is a complex phenomenon and income levels or investments in the origin country fail to explain all the effects that foreign workforce has on economies.

As a manifestation of the globalization process, labor migration produces economic, political, and cultural changes in the societies of the sending and receiving states. Globalization brings the integration of international markets for capital, services, goods, and workforce. Of these, workforce is significantly restricted by existing immigration laws and state policies that enforce nationalism and promote protectionism in order to secure jobs for their citizens. Nevertheless, globalization opens frontiers and facilitates the cross border movement, having the effect of a catalyst. Advances in communication technologies and access to information make it easier for labor markets to interact.

Irregular Migration

Migrants' status in the receiving country varies depending on the lawful basis of their settling in another

Sana Loue & Martha Sajatovic (eds.), *Encyclopedia of Immigrant Health*, DOI 10.1007/978-1-4419-5659-0,

state. Terms like clandestine, illegal or undocumented are used to describe the migratory behavior and the act of entering a country in violation of the immigration laws of that territory. Irregular migration is a more accepted term, as the use of *illegal migration* suggests only negative consequences and overrides the migrants' contribution to the development of the receiving state.

Labor migrants actively engage in the economy of the host country. Often, their entry into the underground labor market is made possible due to the employer's commission of illegal acts. Employers may exploit individuals' irregular status in the country. Labor migration victims could suffer wage discrimination and be denied the right to work in a safe environment. In addition, when an individual becomes an irregular labor migrant as a result of a recruiting process, he is not solely to blame for breaching immigration laws. Moreover, his status may be a result of deception and monetary inducement and the developing countries' labor force is more likely to become a victim of such techniques. In this case, recruiting agents and intermediaries also commit illegal acts and are not less culpable than the migrants are. They receive monetary compensation for facilitating access into a country or as a liaison between employers and the migrants.

The labor migration phenomenon should not be approached only from a negative perspective, as it offers advantages and creates disadvantages for all the parts involved: the country of origin, the receiving country, and the worker himself or herself. Labor migration should not be viewed only as a criminal phenomenon. Migrants are easily abused as long as they are the subjects of an illegal status, not entitled to that state's protection.

The Phenomenon of Labor Migration Reflected in International Documents

One of the most representative organizations that address the status of migrant workers is the International Labor Organization in Geneva. The ILO's 1949 Convention on Migration for Employment defined the labor migrant as a person who leaves a country to seek employment in another one. The Convention stated that the migrant for employment does not include frontier workers or persons who exercise their profession in another country for a short period of time.

In 1990, the United Nations Convention on the Protection of all Migrant Workers and their families extends the definition and clarifies some aspects of the labor migration phenomenon. According to the UN, the migrant worker is any person who will be, is, or was previously employed in an activity for which he received remuneration. The Convention text clearly specifies that such a worker cannot be a national of the state that offered the employment opportunity. A major distinction from the ILO's document is that it includes in this category individuals who are currently unemployed.

In the context of globalization and the advances made in transportation, mobility has increased significantly, thus creating complex situations regarding migrants. Individuals travel not only for employment, but also for pleasure, for education, or because they feel forced to do so by extraordinary situations in their country (civil conflicts, wars, persecution). Making the distinction between all these categories of migrants is important in establishing their legal status and for analyzing the socioeconomical implications.

International organizations, and the UN in particular, pay special attention to the migration process and promote human rights in dealing with migrants. In this context, it is important to make the distinction between labor migration and any other type of migration. Labor migration is part of the migration process and migrant workers are only responsible for a part of the movement flows that take place internationally. The term "migrant" is general and does not separate voluntary migrants from the forced ones. The latter can be easily identified as an individual that faces some kind of coercion, without which he or she will not have moved across the state's borders.

The complex situations that appear at an international level concerning migrants and their status underscore the need for a clearer definition and being precise when making the difference between voluntary and forced migration. Therefore, the 2000 United Nations *World Migration Report* states that a voluntary migrant travels across borders motivated by a personal need/factor: employment, studies, joining relatives. Forced migrants cannot control the cause that pushes them to make the decision to settle in another country, as it is extrinsic. In most cases, forced migrants flee from conflict areas, for political reasons (persecution) or any other situation that arises and represents a threat to their physical and mental well-being.

Labor migrants are also called economic migrants and are easily associated with voluntary migrants. Within the labor migrants there is a distinction based on the nature of the work performed or the worker's skills. A correct distinction is between highly skilled workers and unskilled workers. In developed countries, there are segments of the labor market that became unattractive for the local population and which migrant workers are more inclined to accept. Unskilled labor specifically reflects this kind of work and includes the migrants that take it. Highly skilled workers, on the other hand, are professionals who often seek better pay and working conditions than they are able to secure in their home countries.

The distinction between these two groups is relevant for the social and economic consequences that their presence brings in the receiving countries. They adapt differently and have a substantially distinct effect on the labor market. Unskilled migrant workers are more likely to face rejection and social discrimination than the highly skilled ones.

Related Topics

- ► Brain drain
- ► Discrimination
- ► Irregular immigration
- ► Labor migration
- ► Undocumented

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Labor Programs

- ► Labor migration

Labor Unions

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Historical Aspects

Immigrant workers have contributed a great deal to the formation and development of labor unions in the United States for over 100 years. Important achievements of the labor movement, such as the 8-h workday, were the result of European immigrants' struggles for better working and living conditions. The famous Bread and Roses 10-week strike in Lawrence, Massachusetts, in 1912, exemplifies the participation and solidarity of immigrant families to fight mill owners' cut in pay to compensate for a state law that reduced the work week for women and children from 56 to 54 h. The Industrial Workers of the World, also known as IWW or Wobblies, organized the strike of 25,000 foreign-born, unskilled textile workers from dozens of different ethnicities.

The history of the relationship between unions and immigrants throughout the twentieth century is marked by racial and ethnic conflict and intense debates among union leaders about immigrant workers' right to preserve their own cultures while becoming Americans. While European immigrants were welcomed in unions, immigrants from Asia and South America were excluded from joining unions for decades. Jewish workers originally from Russia had a strong role in organizing universalistic industrial unions that overcame ethnic divisions fomented by employers to weaken solidarity between rank-and-file immigrant manufacturing workers. The creation of the Amalgamated Clothing Workers of America, led by Sidney Hillman, a founding father of the "Jewish labor movement," illustrates this legacy. The American Federation of Labor (AFL) had a long history of craft-based unionism, coupled with nativism and bigotry against non-European immigrants, while the Congress of Industrial Unions adopted in the 1930s an inclusive industrial union model that organized workers from all skills and trades into one single union. The merged AFL-CIO adopted a more pro-immigrant stance, especially after the Civil Rights movement of the 1960s. This position can be seen, for example, when the AFL-CIO joined Cesar Chavez in organizing immigrant Mexican farm worker strikes and grape boycotts in California, which resulted in the creation of the United Farm Workers (UFW).

Yet, in 1985, the AFL-CIO supported the Immigration Reform and Control Act (IRCA), which established sanctions for employers who knowingly hire undocumented workers and made it illegal for immigrants to work without legal documents. While this reform enabled millions of new immigrants to obtain documents and become American citizens, its enforcement created new problems because of discrimination against employees who appeared to be foreign-born and selective enforcement of immigration laws against workers who complained of labor standard violations. It became clear to union leaders in the mid - to late 1990s that employer sanctions regulations did not reduce unauthorized immigration to the United States. Thus, The AFL-CIO reversed its nativist position in the late 1990s by supporting immigrant amnesty, enforcement of labor laws, and immigrant family reunification. This new policy followed the universalistic tradition of the IWW and Jewish labor.

The 9/11 attacks in New York City brought about significant changes in immigration enforcement policy by government officials, who now operate in a political environment that accepts the criminalization of undocumented workers under the banner of considering them as potential threats to national security. Reform of immigration laws to provide a legal path to citizenship, labor protections, family reunification, and improved civil rights lost momentum and was downplayed in Congress in the last decade. Instead, unions that represent large numbers of immigrants, such as the United Food and Commercial Workers (UFCW) and UFW, have had to fight against raids, deportations, and persecution of their immigrant members throughout the country.

Despite the recent anti-immigrant climate, the demand for cheap immigrant labor in the meatpacking, poultry, agricultural, health care, construction, and hospitality industries, among others, remains strong though weaker given the economic recession of the last few years. This demand is actually structural to the U.S economy and can be explained by the restructuring that occurred after the 1970s, when decline of manufacturing and the rise of the service sector developed. Restructuring of manufacturing led to downsizing, contracting out, "lean and mean," and just-in-time production, coupled with deregulation of workplace rights and weak enforcement of labor laws. The expansion of service sector created low-wage, low-benefits, and contingent jobs in the informal economy, characterized by pay in cash and work under-the-table and off-the-books. This change in labor markets can be clearly seen in major U.S. metropolises, such as Los Angeles and New York, where manufacturing jobs were replaced by service sector jobs held by immigrant workers from Asia, Latin America, Eastern Europe, and Africa.

Immigrant Union Membership

There were 1.8 foreign-born members of unions in 2003, which represented about 10% of all foreign-born employed wage and salaried workers in the United States, i.e., one in ten foreign-born employed wage and salaried workers belonged to a union. In addition, another 202,000 were covered by a union or employee association contract. The number of immigrant workers with union representation increased from 1.6 million in 1996 to 2 million in 2003. The proportion of foreign-born wage and salaried employed workers who were union members decreased from 12% in 1996 to 10% in 2003. Therefore, there has been a trend of increase in absolute numbers but decrease in relative numbers for immigrant union membership, similar to what is happening with native workers. However, the percentage of all union members who are foreign-born increased from 9% in 1996 to over 11% in 2003, and the percentage of immigrants amongst all workers with

Labor Unions. Table 1 Union affiliation of employed native and foreign-born wage and salary workers, age 16 years and over, 1996–2003 (in thousands)

Year	Total			Native			Foreign born		
	Total employed	Members of unions[a]	Represented by unions[b]	Total employed	Members of unions[a]	Represented by unions[b]	Total employed	Members of unions[a]	Represented by unions[b]
1996	111,960	16,269	18,158	100,062	14,825	16,536	11,898	1,445	1,622
1997	114,533	16,110	17,923	101,710	14,605	16,237	12,824	1,505	1,686
1998	116,730	16,211	17,918	103,185	14,737	16,282	13,545	1,474	1,636
1999	118,963	16,477	18,182	104,981	14,910	16,421	13,982	1,566	1,762
2000	120,786	16,258	17,944	105,486	14,600	16,104	15,299	1,658	1,840
2001	120,708	16,276	17,880	104,976	14,561	15,992	15,732	1,714	1,888
2002	119,979	15,979	17,502	104,182	14,349	15,699	15,798	1,630	1,803
2003	122,358	15,776	17,448	104,703	13,978	15,448	17,654	1,798	2,000
Percentages									
1996	100.0	14.5	16.2	100.0	14.8	16.5	100.0	12.1	13.6
1997	100.0	14.1	15.6	100.0	14.4	16.0	100.0	11.7	13.1
1998	100.0	13.9	15.4	100.0	14.3	15.8	100.0	10.9	12.1
1999	100.0	13.9	15.3	100.0	14.2	15.6	100.0	11.2	12.6
2000	100.0	13.5	14.9	100.0	13.8	15.3	100.0	10.8	12.0
2001	100.0	13.5	14.8	100.0	13.9	15.2	100.0	10.9	12.0
2002	100.0	13.3	14.6	100.0	13.8	15.1	100.0	10.3	11.4
2003	100.0	12.9	14.3	100.0	13.4	14.8	100.0	10.2	11.3

Source: Migration Policy Institute 2004

Source notes:

The data are from the Current Population Survey, 1996–2003 (annual averages). Note the data series from 1996 to 2002 were weighted with population controls based on the 1990 census. By comparison, the 2003 data were weighted with population controls based on the 2000 census. This means that the 2003 data are not consistent with earlier CPS data series, and any conclusions about trends through time must be made carefully

[a] Data refer to members of a labor union or an employee association similar to a union

[b] Data refer to members of a labor union or an employee association similar to a union as well as workers who report no union affiliation but whose jobs are covered by a union or an employee association contract

union representation increased from 9% in 1996 to 11% in 2003 (Table 1).

The contribution of immigrants to the growth of unions has been particularly recognized by the Change to Win Coalition (CTW), which is composed of a group of five unions – representing 5.5 million members – which left the AFL-CIO in 2005. These unions are the United Food and Commercial Workers International Union, the United Farm Workers of America, the Service Employees International Union (SEIU), the Laborers' International Union of North America (LIUNA), and the International Brotherhood of Teamsters (IBT). In 2005, the CTW adopted a resolution about principles to organize new members that stated: "our movement must empower and unite today's diverse workforce, including millions of people of color, immigrant workers, and working women."

Unions protect the workplace health and safety of unionized immigrant workers by negotiating collective bargaining agreements that usually provide better wages, working conditions, and benefits, including health care, eye and dental insurance coverage, paid vacations, maternity leave, legal advice and representation, pensions, among others. According to Mishel and Waters, unions raise wages of unionized workers by about 20% and compensation, including wages and benefits, by 28%. In addition, unions reduce wage inequality, set a pay standard for nonunion members, improve fringe benefits – including an 18–28% higher likelihood for unionized workers to have employer-based and a 23–54% higher likelihood to be in employer-provided pension plans. In a word, unions may be a fundamental resource for immigrant workers and their families to maintain and improve their health through workplace rules and practices that protect basic human rights values, such as equality, justice, and democracy.

Unions also play an important role in advocating for and voicing the concerns of immigrant workers regarding job health and safety protections. Most workplace health and safety regulations adopted by OSHA were either proposed or strongly supported by labor leaders. Examples are the workers' right to know about the properties of chemicals used in the workplace, the requirement that employers provide adequate training about any number of workplace hazards, the language of the Occupational Safety and Health Act mandating that employers provide every worker a healthy and safe workplace, as well as the duty of employers to allow OSHA inspectors to talk to workers without management interference.

On the other hand, immigrant workers have also had to organize themselves in different economic sectors with labor union help, without help, or sometimes with opposition from organized labor. They created community-based grassroots organizations known as worker centers to defend low-wage workers' rights and fight for justice in the workplace. There are dozens of such organizations across the country, which tend to be geographically concentrated in large urban centers. For example, the Mexican American Worker Association (AMAT) organized grocery store workers in New York City, the Coalition for Humane Immigrant Rights of Los Angeles (CHIRLA) organized Mexican and Central American day laborers in Los Angeles, and the Chicago Interfaith Workers Right Center organized Mexican, Central, and South American workers. The dozens of existing worker centers led successful campaigns similar to union campaigns and proved that undocumented immigrant workers are not less inclined to join unions than native workers. Their advocacy, service delivery, and organizing approaches contributed to address the needs of a diverse ethnic/racial population that did not belong to unions.

The worker centers have some common defining features: they combine service delivery, organizing, and advocacy; operate at the metropolitan, city or neighborhood level; provide services that range from English for Speakers of Other Language (ESOL) classes to legal clinics that educate and file cases against labor violations; develop leadership training programs to empower workers to take action. As a result of these activities, the centers gave voice to a substantial group of immigrant workers who would otherwise have no mechanisms to redress their grievances. In addition, worker centers established alliances with churches, community groups at the local, regional and international levels, foundations, governments, and progressive employers to produce reports and exposés about working conditions in particular industries, e.g., the construction, restaurant, and garment industries.

These organizations have become important instruments for the new working class to build class, racial, ethnic, and religious solidarity, which are essential prerequisites for immigrants to hope for social mobility and feel integrated into the in the U.S. society, as was the case with previous waves of immigrants in the late nineteenth–early twentieth centuries.

Related Topics

► Labor migration

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Language

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Communication is vital to get by in this world. There are many forms of communication all with the goal of having one's needs addressed. Some forms include sign language, written communication, sounds, and words. This section will be focusing on spoken communication. Languages have been studied to assess if they are inherent in children or learned from the environment, and at what age learning another language becomes more difficult.

Most experts in language development acknowledge that children learn their first words near their first birthday, are at two word sentences by their second birthday, and by the age of 5 or so, have completed their linguistic development. Shore proposed that children develop languages differently accounting for the differing developmental schedules that children have. Two differing schools of thought described by Shore were empiricism and nativism. Empiricism emphasizes the role of the child's environment; the child will imitate the parents' speech and will respond to corrections by the parents, thus developing proper language. The other school of thought is nativism, which proposes that children are born with a "language acquisition device." Nativists state that children are born with the rules to speak any language but by hearing a specific language, then that specific set of rules get activated and utilized.

In looking at gender differences and the acquisition of language, small research samples showed girls having a more referential style, and boys having a more expressive style. Referential language acquisition is described as single words, often nouns, giving way to multiword combinations and eventually sentences. In distinction, expressive style is described as the use of phrases that have a more personal-social context. These differences are really seen in the early years before 3 years of age, but may be seen later in life as the child's preference in communication. Shore also noted that when birth order of children is looked at the oldest child tends to have a more referential style, that is, single words progressing to multiword sentences; whereas, the younger child in the family has a more expressive style, that is, the use of phrases heard in the environment. It is unclear if the differences are due to the fact that parents will spend more time with the first-born teaching words, and this attitude may be more relaxed with the second child.

Socioeconomic classes are also examined to see if there are different language acquisition styles. Middle-class mothers tend to be more verbally responsive to their children, and have higher linguistic expectations of the children than did the lower socioeconomic mothers. However, this could not fully account for the range of language acquisition in children of the same socioeconomic class. Another interesting finding was that children of parents with higher education tended to have a more referential style. And referential children tended to play more with books, records, and manipulatable toys.

Another reason for studying language acquisition is to understand the learning process of a second language. It is generally believed that second languages learned prior to 12 years of age will be spoken without a foreign accent. Scovel noted that learning the rules of a language is an intellectual process and can be learned at any age; however, pronunciation is a neuromotor process that is completed before puberty, thus making it difficult for a postpubertal learner to speak a foreign language without an accent. This is a generality and not an absolute. Thus, learning languages entails more than just memorizing words and sentence structure.

Related Topics

► Language acculturation

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Language Acculturation

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Acculturation is the process of two cultures blending, generally seen when an immigrant or minority culture acclimates with the dominant culture. Not only is there a blending of the cultural traditions, there is also a blending of the languages. Newer generations may initially substitute in words from the dominant culture with an eventual progression to full substitution of only speaking the dominant language, as in the example of "Spanglish." Initially, this is seen in a positive light where the family blends, fits in, and can advance in the dominant culture by predominately using the dominant language.

There are approximately 6,000 oral languages spoken in the world. The vast majority of those languages are spoken by communities of 10,000 speakers or less, representing approximately 5% of the world's population. And only 300 of the 6,000 languages are spoken by the majority of the world, representing approximately 95% of the world's population. Thus, one can see that the more than 5,000 languages spoken in the smaller communities are in danger of extinction through the process of language acculturation.

Language acculturation not only affects the diversity of languages, but it also affects the culture. Maffi noted that native Mexicans were losing centuries of knowledge of native medicine and relying solely on modern medicine. This is not to say that one practice is better than the other, but to look at the loss of this cultural aspect. Generally, folk tales, fables, and native medicinal remedies are passed on in the native tongue as they have cultural implications. It is important to note that languages and traditional customs are intertwined and as such when there is a loss of one, there inevitably will be a loss of the other. This process is subtle where the younger generations are exposed to more of the dominant culture's customs and languages, whether by a conscious choice or circumstance.

Across the world, children not only learn their native language(s) but they may also learn a dominant language that will make them more competitive and successful in the world job market. And as the future generations learn more of the dominant culture's language, and media information is in the dominant language, there is less of a need to continue speaking the nondominant language. Initially, people start to substitute in words that are more easily recognized and used from the dominant culture, and then as future generations are born they might not even be taught the minority language as it is so broken through the substitution of words. The concern with the loss of language is the subsequent loss of diversity in our cultures. Many traditions and customs are relayed in the native language, when only the elders speak these languages fluently then the traditions and folk tales die with them.

However, there are some benefits of language acculturation. The process of taking on the dominant language and attributes allows for professional advancements as well as personal advancements, that many not be obtainable if individuals were not able to change. More job opportunities are afforded to individuals that can speak multiple dominant languages. For individuals that come from small villages where they only have a few thousand people speaking their language, learning a dominant language offers them opportunities to advance in life.

While the need for preservation of cultural diversity and languages has been discussed, the reality is that by the simple act of interacting with one another we are influencing each other's behaviors. Everyone we meet will be affected by us and us by them. In order to maintain our diversities while learning and growing in a culturally rich environment, we need to be cognizant of our diversity and the need for it.

Related Topics

- ► Acculturation
- ► Language

Suggested Readings

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Language Barriers

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The provision of linguistically appropriate health care is essential in the prevention, diagnosis, and treatment of disease. To deliver equitable health care for all, the language barrier must be addressed. Numerous strategies exist to tackle the challenge of language discordance during the medical encounter.

According to census data, 33 million people who reside in the USA were born abroad. Of these, it is estimated that 22 million have "a limited ability to listen, speak, read, and write in English, and [speak] English less than 'very well'." They are considered limited English proficient or as having Limited English Proficiency (LEP). With the increase in the nation's plurality, the language barrier is no longer a challenge for metropolitan areas alone. It is a salient and growing national challenge. From 1990 to 2000, 46 states experienced an increase in their LEP population, 15 of which had an increase of over 100%, and 14 others of over 50%.

In the USA, health care facilities are mandated to address interpreting needs. Title VI, 1964 Civil Rights Act, requires that all federally funded institutions make "reasonable" attempts to provide meaningful access to services. States are increasingly adopting measures requiring health care providers to overcome language barriers. Forty-three states have laws to address health care access and quality for LEP patients.

Tasked with facilitating appropriate health care for its LEP populations, and cognizant of the quality and legal implications of not providing adequate and equitable health care for all, health care facilities employ a multiplicity of methods to bridge the language gap when caring for the foreign-born, limited English-speaking population.

The adequacy and quality of these methods and systems vary greatly. They include sophisticated systems composed of properly trained and qualified interpreters, telephonic in-house or commercial services, agency and trained staff interpreters, and the use of untrained bilingual staff members, volunteers, other patients, and family members, including children (the latter despite existing federal and state laws and regulations). Such nonprofessional practices are generally unaccepted in most settings and are regulated by state legislation and policy. Exceptions may include emergent or other special cases dictated by the patient's own choosing.

The failure of health care facilities to provide linguistically appropriate services has considerable costs, both medical and financial. The consequences of miscommunication, such as delayed health care seeking, diagnostic errors, missed appointments, the failure of patients to understand and adhere to treatment recommendations, and the failure of providers to obtain truly informed consent and to be sensitive to a patient's own cultural understanding of health and illness, can be costly and severe. Indirect costs can also result from a reduction in physician productivity, lack of patient adherence, and the ordering of unnecessary tests. The lack of widespread interpreter services poses a serious health and public health threat.

It is important to note that the provision of adequate language services may pose a financial challenge to institutions and providers who in many states do not receive reimbursement for the provision of interpreter services. As such, the following elements should be considered when devising strategies to facilitate linguistic access for the LEP patient population: (1) the development of a corps of, or access to, trained/qualified medical interpreters; (2) ensuring that the body of practitioners, health care staff, and administrators are cognizant of the issue generally and are trained in how to work with medical interpreters specifically; (3) advocacy for policy and legislative change at the state and federal levels to augment the implementation of effective systems; and (4) creation of innovative and diverse systems of interpreter service delivery that enable both efficiency and effectiveness.

Administrators should also be informed about national and state regulations and laws and urged to support innovative programs to accomplish such mandates. Successful programs designate LEP offices led by language experts. These experts usually educate the facility and institute internal policies to move their programs forward. Successful programs, as well, do not deny the multiplicity of approaches needed to face the challenge. These approaches may be comprised of trained interpreters, trained volunteers, and trained staff members, and may include use of telephonic interpreting services and remote simultaneous medical interpreting.

The field of medical interpretation has a relatively short history in the USA. While notable efforts are underway in more and more areas of the country, medical interpretation has not yet achieved the stature or widely acknowledged importance of other forms of interpreting (e.g., court, conference, ASL). A trained medical interpreter is someone who has been tested for bilingual proficiency and undergone a minimum of 40 h of training. Training should include: knowledge of the role of the interpreter in health care; ethical decision-making strategies; memorization, linguistic and cultural competency skills; self-evaluation and interpreting techniques; and learning of specialized terminology (medical and colloquial). Whereas much progress has taken place in the areas of training and professionalization, true standardization and curricula are fast approaching. National efforts such as the Certification Commission for Health Care Interpreters (CCHI) – a national certification process for medical interpreters – and the National Council on Interpreting in Health Care (NCIHC) have greatly contributed to the conceptualization of the young profession as well as toward the creation, lobbying for, and adoption of state and national policy to bring it to life.

As emphasized by the US Department of Health and Human Services, Office of Minority Health, overcoming the language barrier is an integral part of being culturally competent. Nationally, there is a growing recognition of the importance of incorporating education on cultural competence into undergraduate medical curricula, residency programs, and continuing medical education for practicing physicians.

The language barrier poses a serious impediment in the delivery of equitable health care for all. The professionalization of medical interpreting in the USA will lessen racial and ethnic disparities in health care, by increasing access, effecting patient and provider satisfaction, lessening medical errors, and producing improved medical outcomes. State and federal policy and funding, as well as research, that support this effort is of outmost importance.

Related Topics

- ► Cross-cultural health
- ► Cultural competence
- ► Health disparities
- ► Language
- ► Language acculturation
- ► Limited English proficiency
- ► Linguistic minority community
- ► Literacy
- ► Medical interpretation

Suggested Readings

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Suggested Resources

Certification Commission for Healthcare Interpreters (CCHI). http://www.healthcareinterpretercertification.org/

National Council on Interpreting in Health Care (NCIHC). http://www.ncihc.org

The National Health Law Program (NHeLP). http://www.healthlaw.org/

Late-in-Life Migration

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People who leave their country of origin later in life face a unique set of challenges. Compared to most immigrants who moved for work opportunities or political refuge, elders tend to move in order to join their adult children who had previously immigrated. Many times, these elders feel lonely and have a sense of family disruption that are the driving forces for their immigration. Much of the research in late-in-life immigration has been conducted in Sweden with Iranian immigrants.

Medical

People who immigrate as elders, as any other aged population, have a higher prevalence of chronic medical problems than younger cohorts. The ability to adequately care for these problems is largely influenced by the cultural competence of the health care system in their new country, and its interaction with the health care seeking characteristics of each individual. While health care seeking behavior is certainly influenced by the individual's culture, it is important to recognize that people from another country express as much variance, from individual to individual as persons from one's own nationality.

Psychological

Psychological Distress

As mentioned in the introduction, many times people who immigrate late in life do so to reunite with their adult children. Unfortunately, although there is this reunification, it does not necessarily mean that there is a restoration of the family as it was in the country of origin. It has been observed that elders and their children may experience a reversal of their traditional, previously held roles. The elders, had they remained in their country of origin, would often have been in a position of authority and respect, and they may now be expected to defer to, or even be subservient to, their children. This is likely a result of the elders being financially dependent upon their children upon arrival in a new country, as well as the greater familiarity with the local language and cultural norms and customs that their children will have acquired from their relatively greater exposure to their new cultural environment. This can, in itself, cause significant psychological distress. Their family may be one of the few things that may not be alien to migrant elders, but that one anchor to what was familiar has also changed as a result of immigration.

These elders can often have a sense of isolation. They may not speak the language and may not have many opportunities to learn it. Further, they do not know the normal, expected behaviors for elders in that culture, which can restrict these seniors from even attempting to decrease their isolation. This can create a self-reinforcing cycle of separation preventing familiarization with the new culture, and this lack of familiarization leading to ongoing seclusion.

Not only can elders be homesick, but they may also feel that they have no purpose in life. Most elders who migrate have retired and do not return to the workforce upon their emigration, which can easily contribute to a feeling of purposelessness. Also, the dependence upon their adult children that may occur as a result of immigration may lead some elders to go so far as to believe that they are a burden on their families.

Depression

Depression is common in the elderly, even without the stresses associated with immigration. Two studies have been conducted examining rates of depression in late in life Asian immigrants. One study was of Chinese immigrants to Canada, and a second study was that of Chinese immigrants to the United States. Both studies found that depression was higher in elders who had a shorter length of residence. This is somewhat reassuring, in that it suggests that, given time, elderly immigrants are able to adapt and cope better with the stressors they experience. It does not suggest, however, that depression in this population is something that is best left ignored. While there are few data on suicide rates amongst elderly immigrants, the elderly within our own culture experience a relatively high suicide rate, and there is little reason to expect that immigrants would be an exception. Unfortunately, the barriers to general health care that this population experiences also impede their ability to receive adequate mental health care. Cultural stigma regarding mental illness may be an even greater barrier.

Summary

People who choose to migrate later in life often face more and more varied challenges compared to their younger counterparts. This transition can lead to emotional distress, a reduction in quality of life, and, potentially, depression.

Related Topics

- ► Dementia
- ► Depression
- ► Intergenerational differences
- ► Life expectancy
- ► Menopause

Suggested Readings

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Latin America

- ► Brazil
- ► Central America
- ► Colombia
- ► Hispanics
- ► Latinos
- ► Mexico

Latinos

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Terminology

To be categorized as Latino in the USA means that a person has origins in one of the Spanish-speaking countries of the Americas or Spain. Latino is considered synonymous with the term "Hispanic." However, there are notable differences between the origins and meanings of the two terms. The term Hispanic was coined and put into official use in 1974 by the Office of Management and Budget, part of the Federal branch of the US government. The term was specified in *Statistical Policy Directive No. 15: Race and Ethnic Standards for Federal Statistics and Administrative Reporting*. It is used by the US Census Bureau in the collection of self-identified population level data. The Census Bureau defines "Hispanic or Latino" as "a person of Cuban, Mexican, Puerto Rican, South or Central American or other Spanish culture or origin regardless of race." In the USA, Latino is considered an ethnicity by the government, not a race. In the USA, race and ethnicity are considered separate and distinct, and Latinos, being a pan-ethnic group, can thus be of any race.

The term "Latino" is a grassroots term that emerged in contrast to the term Hispanic adopted by the US government. The term emphasizes self-definition and a desire to separate symbolically from Spain, the former colonial power throughout much of the western hemisphere and a historical commonality shared by all peoples from the world's many Spanish-speaking countries. People of Latin American origin also refer to themselves as Spanish, Latin, *Hispana/o,* Latin American, or *Latino Americana/o*. The term "La Raza" is also used. The term has origins in Latin American literature from the early twentieth century. The term literally translates into "the race," but more closely and accurately means "the people" in English. It is a concept that underscores the common heritage peoples from Latin America share with diverse people from around the world, and denotes the mix of cultures, races, and ethnicities that characterize Latin Americans. Regardless of the term used, "Latinos" are a distinct US demographic group and the term Latino is only used in the USA; it is not relevant or applicable to people outside the US context or in the Spanish-speaking countries of the Americas or Spain.

Demographic Characteristics

Latinos are a diverse pan-ethnic group that is immigrant, migrant, and native born. It is a young population with high birth rates, which along with a steady stream of immigration and migration is driving its rapid and sustained population growth. According to the 2006–2008 American Community Survey (ACS) estimates, Latinos comprise 15.1% of the population, making Latinos the largest minority group in the USA (Blacks and Asians account for 12.3% and 4.4%, respectively). Although the total US population grew by 13% during the 1990s, the US Latino population experienced a significantly faster growth rate of 61% during that period. This trend is projected to continue as the Latino population grows steadily throughout the twenty-first century. From 2008 to 2050, the Latino population is projected to triple and its share of the total population to double and account for a projected 30%. Thus, by mid-century, approximately one in three US residents would be Latino. The Latino population is expected to continue growing past 2,100 and continue to grow thereafter. Therefore, Latinos are and will remain the largest minority and ethnic group in the USA well into the future.

The median age for Latinos was 26.9 in 2004, 13 years younger than that of non-Latino Whites (40.1 years), and one in three Latinos is a child under 18, illustrating the youthfulness of the population. Latino children accounted for 17% of all children under age 18. This means that Latino children constitute a small, but nevertheless greater percent of the population under 18 than Latinos as a group account for in the total US population, illustrating the young age of the population. Latino children will soon constitute the largest segment of the overall child population, as it is projected that 39% of all children (<18 years) will be Latino by mid-century.

In 2004, the vast majority of Latinos (80%) lived in nine US states. The largest populations are found in California (30.3%), Texas (18.9%), Florida (8%), and New York (7%), accounting for approximately two-thirds of all Latinos. Among Latinos age 25 and older, 60% had graduated high school compared to 89% of non-Latino Whites. About 13% had earned a bachelor's degree or higher compared to 30% of non-Latino Whites, while 40.4% of Latinos had completed less than a high school education. Latinos had a lower median income, $36,000, which was less than three-quarters that of non-Latino Whites. A larger proportion of Latinos lived in poverty (22%) compared to non-Latino Whites (9%). Latino children had a higher poverty rate, about 29% compared to 11% of White children. The poverty rate among Latinos age 65 and older was 20%. More Latinos rented instead of owned their homes, 52% compared to 48%, respectively.

More than half of Latinos age 15 and older were married in 2004, and were less likely than non-Latino Whites to be divorced (8% compared to 11%). Latino women have higher fertility rates than non-Latino White women. Approximately 75% of 1,000 Latino women ages 15–50 had given birth in the past year, compared to about 50% of Whites. Additionally, about 33% of Latino women who gave birth were unmarried, compared to 20% of non-Latino women. Latinos had larger household sizes on average, 3.4 people compared to 2.5 for non-Latino Whites. Fifty percent of Latino households were headed by a married couple, and 19% were single-female headed households.

In 2004, most Latinos spoke only English at home (22.8%) or did not speak English at home but spoke English very well (38.5%). Not all Latinos speak Spanish; however, the USA has a large Spanish-speaking population and more than 75% of Latinos speak Spanish, many of whom are monolingual Spanish speakers. In 2000, of the 47 million people in the USA who spoke a language other than English, more than half (59.8%) spoke Spanish. Many, but not all, Latinos are Spanish–English bilinguals. Of more than 75% of Latinos who spoke a language other than English, all (99%) spoke Spanish. Thirty-nine percent of Latinos reported speaking English less than very well, much more than the 8.1% of the general US population who reported the same low level of English proficiency.

Immigration

Because the USA is adjacent to Latin America, and because of the unique historical, political, and economic relationships between the USA and Latin American countries, immigration to the USA since 1965 has been primarily from within the hemisphere. 1965 is an important milestone in US immigration policy because it was the year the US government amended the Immigration Act, repealing the national origins quota system and replacing it with a system based on family reunification, and with a focus on attracting immigrants with needed skills to the USA. It was the most extensive revision of US immigration policy since the 1920s.

Immigration to the USA from Latin America, and to a lesser degree Asia, has been driving profound changes in the racial/ethnic composition of the US population in the last 40 years. These changes have been exacerbated by a relative decrease (aging and decreased birth rates) among the majority White non-Latino demographic. In 2007, more than half (53.6%) of the US foreign-born population was from Latin America; 39.8% of Latinos are foreign born compared to 12.6% of the overall US population. However, this indicates the majority of Latinos (60%) are born in the USA and are thus not immigrants. Children of immigrants are the fastest growing subpopulation of US children, the vast majority of whom are Latino. In 2000, more than half (56%) of children living with a foreign-born householder were Latino.

Latino National Origin Groups

Although Latinos have origins in many diverse countries, people of Mexican, Puerto Rican, Cuban, Salvadoran, and Dominican origin comprise close to two-thirds of the US Latino population.

People of Mexican origin constitute the largest share (64%) of the Latino population. The majority of Mexican immigrants (62.6%) came to the USA in 1990 or later. Puerto Ricans are the second largest group of Latinos, comprising 9% of the mainland Latino population. In 2007, the 4.1 million persons of Puerto Rican origin living on the US mainland exceeded Puerto Rico's population of 3.9 million. Because Puerto Rico is a US territory, all Puerto Ricans are US born, have US citizenship, and are entitled to a US passport at birth. Thus, Puerto Ricans who move from the island to the US mainland are considered migrants, not immigrants. Cubans are 3.5% of the Latino population and are the third largest Latino national origin group, concentrated in Florida. Sixty-one percent of Latinos of Cuban origin are foreign born. People of Salvadoran origin account for 3.2% of the Latino population and Dominicans represent 2.6%.

Although Mexicans are the largest Latino national group, they are overwhelmingly concentrated in the southwest. This largely reflects the population characteristics of a large swath of land that once was part of Mexico. Because of the historic immigration and migration patterns of Latinos from the Caribbean to the mainland USA, Dominicans and Puerto Ricans are primarily concentrated in the northeast and south Florida, particularly in urban areas such as New York City, New York, Boston, Massachusetts, Providence, Rhode Island, and Hartford, Connecticut. In the northeast, Puerto Ricans are the largest Latino ethnic group and Dominicans are the third largest immigrant group. Between 1990 and 2000, the northeast Dominican population doubled, illustrating the high rate of immigration from the island to the mainland.

The Historical Incorporation of Latinos of Mexican, Puerto Rican, and Cuban Origin

Not all Latinos are of immigrant backgrounds, as Latinos have lived within the modern-day political borders of the USA since before the inception of the country. That the Latino demographic is so large and growing is in no small part the result of US intervention in Latin America since the 1800s, and in considerable part reflects lengthy political and economic ties to three countries in particular, Mexico, Puerto Rico, and Cuba, representing the three largest Latino national groups.

That the Latino demographic is concentrated in the southwest is a function of historical events that in significant ways have come to characterize the demographic composition of the USA. As the USA expanded westward to the Pacific Ocean during the 1840s, *Mexicanos* (Mexicans), *Tejanos* (Texans), and *Californios* (Californians) in what today is the US southwest – but which then was the territory of the sovereign state of Mexico – were squeezed by US settlers and eventually incorporated into the USA when their land was annexed by the US government when Mexico lost the Mexican-American War (1846–1848). US westward expansion was in part driven by the belief in *Manifest Destiny*, which also prompted the Mexican-American War. *Manifest Destiny*, meaning obvious or undeniable fate, was the nineteenth-century belief that America was created to be expanded, and that the USA had a divine mission to expand across the continent of North America. The Mexican-American War ended with the Treaty of Guadalupe Hidalgo. This entailed that Mexico sell almost half its land to the USA, including what is today Texas, New Mexico, Arizona, California, Nevada, Utah, most of Colorado, and some small parts of Kansas, Oklahoma, and Wyoming. Mexicans living in the newly acquired land that became the US southwest were involuntarily incorporated into the USA. The profound impact of Mexican culture on US culture is evident in the southwest today, as the region was infused with and, to some degree, culturally determined by Mexican culture. Many people of Mexican origin in the USA, particularly the southwest Texas and California, are not immigrants, but rather US citizens by birth who are the descendants of people who have lived within the borders of the USA since before such borders formed the political boundaries of what is now the USA.

The unique relationship between the USA and Latin American countries, and that Latinos comprise a key demographic group in the USA today, in part reflects US military, political, and economic intervention in the region from the 1800s through the present day, as enshrined in the Monroe Doctrine. The Monroe Doctrine was issued in 1823 by President James Monroe. It declared that sovereign states in the Americas should be free from European interference, and that furthermore the Americas should be closed to future colonization by Europeans. It also proclaimed that the USA would view European interference with sovereign states in the Americas as a hostile act toward the USA. Although the Monroe Doctrine was intended to declare US opposition to colonialism, the USA assumed colonial rule over Puerto Rico, as it continues to have to this day.

Like much of Mexico, the island of Puerto Rico became a US territory after military conflict. The Spanish-American War of 1898 ended with a peace treaty between the USA and Spain, under which Puerto Rico was ceded to the USA after its victory. The Foraker Act of 1901 formally established the territorial relationship between Puerto Rico and the USA and the Olmstead Act of 1909 gave the US president a direct role in Puerto Rican affairs. The Jones Act of 1917 made Puerto Rico an unincorporated US territory and granted Puerto Ricans US citizenship. Because of their citizenship, Puerto Ricans were included in the World War I draft as well as future military conflicts in which the draft was in effect. Puerto Rico became a self-governing commonwealth in 1952. Puerto Rico has no voting representative in the US Congress; however, US federal laws apply to Puerto Rico. Although Puerto Ricans are US citizens by birth, Puerto Ricans living on the island may not vote in federal elections and thus may not vote to elect the President. Only Puerto Ricans living on the mainland USA can vote in federal elections. Puerto Ricans living on the island periodically vote in nonbinding plebiscites. Puerto Ricans not living on the island may not participate in plebiscites, which present a choice between independence, becoming the 51st US state, or remaining a US territory. The last plebiscite was held in 1998.

Like Puerto Rico, Spain ceded control of Cuba to the USA at the end of the Spanish-American War in 1898. US military rule of Cuba continued until 1902 when the island was granted independence. US troops were withdrawn from the island after adopting the Platt Amendment, which gave the USA the right to intervene in the political, economic, and military affairs of Cuba. The Cuban economy was dominated by the USA through the mid-twentieth century. When General Batista became President of Cuba in 1940, a period of cooperation between the USA and Cuba was ushered in. However, the Batista government was overthrown by the Cuban Revolution, led by Fidel Castro, in 1959, after which Cuban–US relations deteriorated. Trade restrictions on Cuba were imposed by the US President Nixon in 1959. Diplomatic relations with Cuba ended in 1961, the year of the Bay of Pigs, a failed, armed invasion of Cuba by Cuban exiles launched by the US government. Tensions escalated in 1962 with the Cuban Missile Crisis, which led to a complete US ban on all trade with Cuba and prohibition of US travel and financial transactions. The US embargo against Cuba continues to this day. It is in large part viewed by the international community as a key factor sustaining the profound poverty and lack of opportunity in Cuba, which, along with resistance and opposition to communism in Cuba, have been the primary forces driving Cuban emigration.

Cuban immigration to the USA is the result of a complex mix of political and economic factors, and can be summarized in four waves. The first wave followed the Cuban Revolution from 1959 to 1962, and consisted of upper and upper-middle class professionals, such as lawyers and doctors (those who, simply, had the most to lose after the Revolution with the establishment of a socialist/communist economic and political system). The second wave between 1965 and 1974 consisted of “freedom flights” organized by the USA and Cuba, and primarily brought middle- and working-class Cubans to the USA. The third wave began with the Mariel boatlift in 1980, which brought approximately 125,000 Cubans from every class and segment of Cuban society to the USA. People who came during this wave of Cuban immigration became known as the *Marielitos*. The fourth wave began in 1989 with the fall of communism in Europe and continues to this day. Cuban emigrants headed to the USA during this wave include people known as *balseros* (rafters) who take to the sea and head for Florida (which at its closest point is only ninety miles from Cuba) in boats, rafts, and various other forms of vessels. Immigrants today also come through a visa lottery system implemented by the Cuban and US governments in 1994. US policy toward Cuban immigrants has been much friendlier compared to immigrants from any other Latin American country. Unlike other immigrants from Latin America, Cubans are admitted under a unique parole power of the US Attorney General that puts Cubans on a path to citizenship and grants them full legal status. Under the so-called wet-foot/dry-foot policy, all Cubans who manage to land on US soil are permitted to stay in the USA, but Cuban immigrants seized at sea are returned to Cuba.

Conclusion

Latinos are a diverse pan-ethnic group, and their growth is driving dramatic population changes in the USA. As with population changes earlier in the country's history, such as those driven by the influx of Irish, Italian, German, and Jewish immigrants, Latinos today, whether US or foreign born, will be decisive in shaping the political and economic future of the country as they come to define a significant portion of the US social fabric.

Related Topics

- ► Central America
- ► Colonialism
- ► Foreign-born
- ► Hispanic health paradox
- ► Hispanics
- ► Immigration and Nationality Act Amendments of 1965 (U.S.)
- ► Mexico
- ► Puerto Rico
- ► U.S.–Mexico border

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Lead Poisoning

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Lead is a naturally occurring metallic element found throughout the environment in all parts of the world. High levels of environmental lead have resulted from human activities such as mining, industrial processes, and burning fuels. A variety of commonly used products – including gasoline (in countries where leaded fuel is still permitted), batteries, paints, solder for food cans, ceramic glazes, ammunition, cosmetics, traditional medicines, mini blinds, and even toys and trinkets for children – may contain lead as a component. Drinking water delivered through lead or lead-soldered pipes may also become contaminated with the metal.

Despite its usefulness in multiple processes and products, lead is toxic to humans. Children are particularly susceptible to lead's toxic effects, and lead poisoning is a serious child health concern worldwide. Numerous physiologic and behavioral characteristics place young children – especially those between 12 and 36 months old – at higher risk. Children's bodies absorb greater proportions of lead than adults' bodies, and their developing brains and other organ systems are more permeable and sensitive to the metal's detrimental effects. Young children typically explore their environments through behaviors such as crawling, playing on the floor or ground, and placing their hands and other objects in their mouths; while these behaviors are developmentally normal, they magnify environmental lead exposure.

Upon entering the body, lead is distributed to organs including the kidneys, brain, liver, and bones. The body does excrete some lead, but it also stores the metal in the bones and teeth, where it may accumulate over time. Effects of lead exposure vary widely among individuals and are influenced by factors including the level and timing of exposure, age of the exposed individual, and the person's underlying nutritional and health status. Individuals with significantly elevated blood lead levels may display no symptoms in some cases, while seizures, coma, and even death may occur in the most severe cases of acute lead poisoning. Potential symptoms of lead poisoning are diverse and nonspecific, including impaired thinking, delayed language development, hearing loss, behavioral problems, decreased IQ, vomiting, abdominal pain, decrease in kidney function, poor growth, and decreased red blood cell production. Exposure of pregnant women to environmental lead may negatively impact fetal brain development and has been associated with miscarriage, premature birth, and low birth weight.

Lead exposure occurs mainly through breathing in dust and air contaminated by lead particles, as well as through ingestion of lead in dust, soil, and paint chips (a major route of exposure in children). Although lead exposure occurs worldwide, there is significantly less environmental lead exposure (and therefore a lower prevalence of lead poisoning) in countries which have mandated the removal of lead from gasoline, paints, and soldered cans, and that have focused on reducing other sources of lead exposure, such as in drinking water and children's products. In the United States, for example, the prevalence of blood lead levels greater than 10 micrograms per deciliter in children aged 1–5 years fell from 88 % to 1.6 % between 1976 and 2002. This dramatic decrease resulted from the mandated removal of lead from gasoline and paints, preschool screening programs, and increased public awareness.

Because automobile fumes containing lead particles are such an important source of lead poisoning in children, many countries worldwide have implemented fuel policy changes, eliminating the use of leaded gasoline. In 2002, the World Summit on Sustainable Development called for the removal of lead from gasoline globally, and the World Bank has worked with countries to help achieve this objective. Despite these global calls, numerous countries, primarily in African and Eastern Mediterranean regions, continue to use lead to boost octane levels in gasoline.

Average blood lead levels in many developed countries have fallen drastically over the past three to four decades due to implementation of public policies designed to reduce environmental lead, lead poisoning screening programs, and increased public awareness of the disease. Despite these successes, lead poisoning continues to be a major global health concern. Poor children in developing countries are at especially high risk for lead poisoning. Approximately 20% of the world's disease burden from lead poisoning occurs in the Western Pacific nations, while another 20% occurs in Southeast Asia.

In developed nations, non-White individuals with low educational levels and those living in poorer areas are at the highest risk for lead poisoning. In the United States, the prevalence of elevated lead levels is highest among African-American children living in the inner city, especially among those living in housing structures built prior to the 1970s when lead-based paint was still used. In addition, recently arrived refugee children and those children entering the foster care system are groups with a high prevalence of lead poisoning in the United States.

Related Topics

- ► Adolescent health
- ► Child health and mortality
- ► Maternal dietary intake
- ► Pediatrics

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United States Environmental Protection Agency. http://www.epa.gov/lead

United States National Library or Medicine and the National Institutes of Health. http://www.nlm.nih.gov/medlineplus/leadpoisoning.htm

World Health Organization/Healthy Environments for Children Alliance. http://www.who.int/heca/infomaterials/lead.pdf

Legal Services

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The history of American civil legal services began with the German Legal Aid Society in New York founded in 1876 to provide legal assistance to German immigrants. Chicago became the second city to establish a legal aid office in 1890, followed by Boston in 1900. It was Reginald Heber Smith, a young lawyer at the Boston Legal Aid Program, who brought forth the concept of free legal aid for the poor and put the responsibility of providing such service squarely in the private bar. In his seminal work on legal services published in 1919, Smith stated that without equal access to the law, the system gave the most ruthless and powerful weapons that the oppressors of the poor could ever invented. By mid-twentieth century, almost all major U.S. cities had legal aid offices. But many of these offices were tiny with barely one paid staff, often operated in conjunction with local charities, and mostly relied on private attorneys who donated their time to provide legal assistance to the indigent population. When the Ford Foundation began funding the National Legal Aid and Defendant Association (NLADA) in 1959 to launch law school clinical programs, there were barely 400 full-time lawyers scattered among 157 legal aid organizations operating in isolation from one another. Access to justice for many poor people remained elusive.

The Civil Rights Movement ushered to the forefront the plight of the poor and minorities. In 1964, President Lyndon B. Johnson unveiled his Great Society ideal in which he envisioned “abundance and liberty for all. It demands an end to poverty and racial injustice.” He created a new federal agency, the Office of Economic Opportunity (“OEO”) and appointed Sargent Shriver to wage War on Poverty. The OEO administered most of the antipoverty programs such as food stamps, Medicaid, Medicare, Head Start, Community Action Programs, Work Study, VISTA, and Job Corps. However, local politicians did not welcome the new antipoverty forces and fought to block their progress. When Shriver found his programs politically blocked, he turned to the law and created the legal services programs to make law an ally to the poor to challenge obstinate and uncaring government entities and institutions.

The OEO created a legal services system that utilized staff attorneys working in private, nonprofit entities that were full-service legal assistance providers each serving a specific geographic area. The legal services programs were required to take a broad range of cases except fee-generating cases and criminal matters. They were also charged with advocating for law reform and making preventive law and client education high priorities. The OEO also created an infrastructure of national and state support centers, training programs, and a national clearinghouse for research and information in support of the field offices. Despite vehement opposition from all quarters, the first storefront neighborhood legal services began operation in January of 1966. The OEO-funded programs marked the beginning of modern day legal services in the United States.

During the early years, OEO-funded legal services programs brought landmark cases to challenge school boards for discrimination, sued employers for engaging in unfair labor practices, and took government agencies to court for violating the rights of poor people. Notable cases include *Shapiro v. Thompson*, 394 U.S. 638 (1969), which prohibited welfare agencies from arbitrarily denying benefits to poor people; *Goldberg v. Kelley*, 397 U.S. 254 (1970) in which the U.S. Supreme Court held that due process required welfare agencies to give recipients the right to pretermination hearings; and *Javins v. First National Realty*, 428 F.2d 1071 (D.C. Cir. 1970) that established warranty of habitability for renters. Legal services lawyers also advocated behind the scenes in enacting or modifying local, state, and federal legislation. Legal services' success in challenging powerful business and government interests to advance the rights of the poor earned them many enemies, among them powerful political figures.

In 1973, President Nixon proposed the dismantling of the OEO and the creation of a private, nonprofit legal services entity that would receive an annual appropriation from Congress which then distributes the funds to the field. In summer of 1974, President Nixon signed into law the Legal Services Corporation Act of 1974 (LSC Act), creating the Legal Services Corporation (LSC) overseen by eleven board members appointed by the President and confirmed by the Senate. The LSC Act placed new restrictions on legal services programs and staff, such as restricting staff from engaging in the outside practice of law and political activities, and prohibiting programs from engaging in certain kinds of advocacy and lobbying. The new LSC developed a "minimum access" goal, aggressively increased funding, and expanded programs to reach as many poor people as possible. The goal was to fund two lawyers for every 10,000 poor people, defined as someone whose household income was at or below 125% of federal poverty set annually in February. By 1981, the "minimum access" goal was almost a reality with LSC funding 325 programs across 50 states and the territories, with a budget that increased from $71.5 million in 1975 to $321.3 million by 1981.

The 1970s and 1980s marked the heyday of growth for legal services: there were field programs established in every county in the country; a network of migrant and Native American programs; a system of state support centers and national support centers; LSC began a national training program for lawyers; paralegals, including some who were former legal services clients, community activists, or social workers, became full-fledged advocates. On the advocacy side, law reform work that used to reside in specialized programs became more integrated with basic service work; programs expanded into new fields of poverty law, such as advocacy for persons with disabilities, veterans, nursing home residents, and other groups with special problems accessing legal services. The significant legal victories of the 1960s that established constitutional, statutory, and common law rights for the poor finally became a reality with the new legal services system.

The election of Ronald Reagan in 1980 as President of the United States marks the beginning of almost three decades of restrictions and defunding of federally funded legal services programs. President Reagan initially sought to eliminate LSC and to replace it with law student clinical program and a judicare system using private attorneys funded through block grants. Although Congress did not pass the law calling to eliminate LSC, it cut LSC funding by 25% for FY 1981, leading programs to close offices and lay off staff. The following year, the House of Representative passed a LSC Reauthorization Bill that would provide the blueprint for restrictions that Congress in subsequent sessions sought to impose on LSC. Though the Senate did not adopt the House Bill, in 1982, Congress passed new laws and restricted the use of LSC funds for lobbying and rulemaking; it also added new procedural requirements for class action and restricted LSC-funded programs' ability to represent certain classes of immigrants. At the same time, new LSC board members mostly appointed through recess appointments and new LSC staff were openly hostile to the legal services programs they were charged with overseeing. For example, LSC began a highly intrusive and exhaustively detailed monitoring program that sought access to client files and confidential client information. Instead of focusing on the quality of client representation or program performance, the monitoring process focused on the technicalities such as board vacancies and the like. These monitoring processes caused programs to spend inordinate amount of time and resources that could have been used to assure equal justice for the poor.

In the face of reduced federal funding, programs sought funding from foundations, the bar associations, the private bar, the United Way, private donations, and non-LSC federal grants. By the mid-1980s, a new source of funding called the Interest on the Lawyer Trust Account (IOLTA) emerged through new cooperation with the banking industry. By capturing pooled interest on small amounts or short-term deposits of client trust funds used for court fees, settlement proceeds, or similar client needs that were previously held in non-interest-bearing accounts, IOLTA became a significant source of funding for legal services. By 2000, all 50 states, plus Washington, D.C., and Puerto Rico had an IOLTA program.

A temporary respite to legal services came with the election of President William Clinton in 1992: LSC funding reached $400 for FY 1995. The midterm election of 1994 changed the political landscape for the USA and the short-lived fortune of legal services. While the new Congress did not succeed in eliminating LSC and federally funded legal services, it succeeded in imposing significant restrictions on LSC-funded programs. In addition to more stringent restrictions on what kind of work legal services could engage in, the new law prohibited LSC-funded programs from using other sources of funding to engage in restricted activities. The new law directs LSC to distribute funding based on a strict Census formula, which led many programs to close shop or merge. It also requires attorneys and paralegals in LSC-funded programs to follow a time-keeping system and allows LSC expanded access to recipient and client records. These restrictions prohibit LSC-funded programs from representing prisoners, specific groups of immigrants, or public housing tenants being evicted on drug-related charges. The new law also restricts programs from participating in class actions, welfare reform advocacy, and most affirmative lobbying and rule-making activities. In addition, until its repeal in January of 2010, programs were prohibited from claiming or collecting attorney's fees, thus removing a potentially significant source of funding for programs and an effective strategic tool in litigation. To further handicap programs from engaging in law reform work, Congress eliminated funding for national and state support centers and all other entities that had provided support, technical assistance, and training to LSC-funded programs.

In essence, Congress redefined the role of federally funded programs from one that engages in law reform advocacy seeking to address systemic problems to ameliorate poverty to one that provides access to justice only on a case-by-case basis through individual representation. Between 1980 and 2010, LSC funding has hovered between the low of $241 million in 1982 to a proposed high of $400 million for FY 2010. Even at the highest level of funding of $400 million reached in 1995, it still represented a 28% actual reduction in funding compared to the base year of 1980.

During the period when Congress passed law to severely restrict the activities of federally funded legal services, LSC, the American Bar Association (ABA), NLADA, the Center on Law and Social Policy (CLASP), and State Justice Commissions engaged in state planning efforts to focus on developing a state justice community that can provide access to justice to all eligible clients across entire states. Although the number of LSC-funded legal services programs decreased from 325 in 1995 to 138 in 2006, new, non-LSC-funded entities emerged to work alongside the LSC-funded counterparts, including centralized intake programs that provide single points of entry to legal services. During the same period, funding for the new state justice system has increased significantly. New sources of funding include those from the Department of Justice under the Violence Against Women Act (VAWA), the Department of Housing and Urban Development, the Internal Revenue Service, and other federal agencies. Local initiatives such as court filing fees surcharge, attorney registration fees, state bar dues, *cy pres* awards (funds held in trust accounts that are redirected per court order to substitute agencies that can most closely fulfill the original intent of the trust whose initial purpose has become impracticable or infeasible) and attorney fees awards pursuant to fee-shifting statutes also supplemented funding for legal services.

Despite the draconian restrictions imposed on LSC-funded programs, new generations of lawyers continued to enter legal services seeking to fulfill the original intent of legal services by making the law and lawyers allies to low-income people in their struggle for equal justice by engaging in community lawyering practice. Teaming up with other professionals, these legal services lawyers use the law as a powerful tool to support community-initiated advocacy for environmental justice, equitable land use policies, preservation of affordable housing, containment of institutional expansion, access to equitable education, fair labor practices, and enforcement of voting rights. In addition, legal services programs have engaged in developing a comprehensive and integrated system that enhances collaboration across programs on community legal education, client outreach, and statewide advocacy through email listservs, task forces, and cocounseling arrangements to address clients' needs across the state. At the same time, courts have also taken significant steps to make access easier by simplifying court forms, instructions and procedural information, and translating documents into languages other than English to address the needs of pro se litigants (individuals who appear before the court without a lawyer) who have limited English proficiency.

More than four decades since the modern legal services system was created, it has grown significantly in numbers and funding and has evolved continuously to fulfill its overarching goal of equal justice for all. Depending on the local priorities, most legal services programs provide legal assistance in the following areas: abuse prevention, disability, elder law, employment, family, housing, immigration, Medicaid/Medicare advocacy, and public assistance. Clusters of programs also provide legal representation in care and protection, education, bankruptcy, and, recently, foreclosure prevention. However, because there is no law in the USA that guarantees the poor's right to court-appointed counsel in civil matters per a U.S. Supreme Court decision in *Lassiter v. Department of Social Services*, 452 U.S. 18, (1981), civil legal assistance will continue to be challenged by the ebb and flow of resources and the political whim of those that control funding decisions.

Unlike the American legal assistance system, most other countries where such assistance is available adopt the judicare model, where individuals seeking legal assistance apply to a government or quasi-governmental entity for legal assistance. Once approved, these individuals will be represented by private attorneys either for free or for an established fee. In most cases, civil and criminal legal assistance are administered by the same agency. In Europe, the right of the indigent to access legal assistance is provided under the European Convention on Human Rights that makes "equality of arms" between the state and the individual or between parties in the case a guiding principle for legal aid. Cases interpreting the right to free legal assistance under Article 6 of the Convention instruct the courts to weigh three factors: (1) the potential consequences faced by the applicant, (2) the complexity of the case or the procedure, and (3) the capacity of the applicant to effectively exercise his or her right to access to court.

Various international treaties provide considerable guidance on the government's obligation to provide legal assistance to those who cannot afford it. For example, comments adopted by the Human Rights Committee in association with Article 11 of the International Covenant on Civil and Political Rights concerning the right to adequate housing and protection against forced eviction recommends the provision of legal aid to persons seeking redress from the court. Article 37(d) of the Convention on the Right of the Child requires State Parties to ensure "[e]very child deprived of his or her liberty . . . to have the right to prompt access to legal and other appropriate assistance." Principle 3.3 of the United Nations Basic Principles on the Role of Lawyers asks government to ensure the provision of sufficient funding and other resources for legal services to the poor. The treaty establishing the European Community instructs The Council of Europe "to adopt measures in the field of judicial cooperation in civil matters." (Article 61). The Council proceeded to adopt a Directive on January 27, 2003, "to improve access to justice in cross-border disputes by establishing minimum common rules relating to legal aid for such disputes" (Council Directive 2002/8/EC of 27 January 2003). These international treaties affirm the core belief that the provision of civil legal assistance is crucial for the progressive establishment of freedom, security, and justice for the member states and beyond.

Related Topics

- ▶ Barriers to care
- ▶ Bureau of Immigration and Customs Enforcement
- ▶ Citizenship
- ▶ Civil Rights Act of 1964 (U.S.)
- ▶ Discrimination
- ▶ Housing
- ▶ Human rights
- ▶ Immigration Act of 1990 (U.S.)
- ▶ Poverty
- ▶ Social service needs
- ▶ Support services

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Leisure-Time Physical Activity

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The US Department of Health and Human Services reports that regular physical activity, fitness, and exercise are critically important for the health and well-being of people of all ages. Physical inactivity is associated with premature mortality, obesity, and increased risk for chronic diseases such as cardiovascular disease, certain cancers, and diabetes mellitus. In the USA, women, older adults, and the majority of racial/ethnic minority populations have the greatest prevalence of leisure-time physical inactivity.

Research has demonstrated that all individuals can benefit from regular physical activity. Mobility and functional health can be improved through physical activity – even for those who are very frail. Regular physical activity has been shown to reduce the morbidity and mortality from many chronic diseases. Millions suffer from chronic illnesses that can be prevented or improved through regular physical activity. In the USA, currently 12.6 million people have coronary heart disease; 1.1 million people suffer from a heart attack in a given year; and 17 million people have diabetes – approximately 90–95% of cases are type 2 diabetes. Notably, in a 1993 study, 14% of all deaths in the USA were attributed to inactivity and diet, while another study associated inactivity and diet to 23% of deaths from major chronic diseases.

Physical Activity Guidelines

Published by the US Department of Health and Human Services, their *Physical Activity Guidelines for Americans* provides guidance to help Americans aged 6 and older improve their health through appropriate physical activity. The content of the *Physical Activity Guidelines* complements the *Dietary Guidelines for Americans* – one of the outcomes from a joint effort between the US Department of Health and Human Services and the US Department of Agriculture (USDA). Together, the two documents provide guidance on the importance of being physically active and eating a healthy diet to promote good health and to reduce the risk of chronic diseases.

Children and a Healthy Lifestyle

Physical activity is essential to a healthy lifestyle. In combination with healthy eating, it can help prevent a range of chronic diseases, including the three leading causes of death: heart disease, cancer, and stroke. Physical activity helps control weight; builds lean muscle; reduces fat; promotes strong bone, muscle, and joint development; and decreases the risk of obesity. Children need 60 min of vigorous physical activity every day to grow up to a healthy weight.

Over the past 30 years, childhood obesity rates in America have tripled. Today, nearly one in three children in America are overweight or obese. It is estimated that one-third of all children born in 2000 or later will suffer from diabetes at some point in their lives; many others will face chronic obesity-related health problems like heart disease, high blood pressure, cancer, and asthma. The *Let's Move* Campaign is a nationwide initiative to solve the challenge of childhood obesity within one generation so that children born today will reach a healthy weight at adulthood. The four pillars of the campaign are empowering parents and caregivers, providing healthy food in schools, improving access to healthy and affordable foods, and increasing physical activity.

Immigrants and Physical Activity

Researchers have recently begun to examine the association between acculturation and physical activity among first-generation immigrants. Researchers found that immigrants are faced with four unique barriers to leisure-time physical activity. They call for the following barriers to be addressed.

There is a needed focus on the overall health benefits of physical activity, not just weight loss. Cultural differences exist related to weight and body image. Emphasis should be placed on the benefits of physical activity as it relates to overall well-being, disease prevention, increased vitality, and mood enhancement.

Cultural influences and the impact of acculturation should be examined. For example, the Hispanic culture may place more value on rest and relaxation. Therefore, they may view leisure as a sedentary activity. In the acculturation process, it is important to value the importance of both.

Stressing the importance of physical activity in the aging process is essential to the education of immigrants. Osteoporosis, arthritis, and other bone and joint problems are sometimes viewed as synonymous with aging. It is well documented that regular physical activity is especially important for people with joint and bone problems and that weight-bearing exercise and walking help to strengthen bones.

It is critical to promote the value of life-long physical activity for immigrant girls. Cultural influences may deter girls from leisure-time physical activity. This issue needs to be addressed so that girls learn skills related to physical activity that can be carried over into adulthood and old age.

Related Topics

- ► Blood glucose
- ► Body mass index
- ► Cancer
- ► Cancer prevention
- ► Cardiovascular disease
- ► Cardiovascular risk factors
- ► Diabetes mellitus
- ► Disease prevention

Suggested Readings

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Jones, W. K. (2003). Understanding barriers to physical activity is a first step in removing them. *American Journal of Preventive Medicine, 25*(3Si), 2–4.

Solomon, C. G., & Manson, J. E. (1997). Obesity and mortality: A review of the epidemiologic data. *American Journal of Clinical Nuturition, 66*, 1044S–1050S.

Suggested Resources

For information on the Centers for Disease Control and Prevention. http://www.cdc.gov/

For information on the *Let's Move!* campaign. http://www.letsmove.gov

For information on the U.S. Department of Agriculture. http://www.usda.gov/wps/portal/usda/usdahome

For information on the U.S. Department of Health and Human Services. http://www.hhs.gov/

LEP

► Limited English proficiency

Leprosy

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History of the Disease

Leprosy, or Hansen's disease, is an infectious disease caused by the bacterium *Mycobacterium leprae*, closely related to *M. tuberculosis*, the microbe responsible for tuberculosis. The microbe was discovered by Armauer Hansen in 1873, before Koch's discovery of *M. tuberculosis*, but the inability to grow the microbe in the laboratory allowed for Koch to be credited with the discovery and for the germ theory of disease, one of the backbones of modern medicine. Leprosy is one of the most dreaded diseases because it is contagious, deforming, and was untreatable previously. Its history dates to biblical times; it was recognized by the oldest civilizations of China, Egypt, and India. Historically, persons who contracted leprosy were quarantined in Leprosaria, or leper colonies, which were widespread during the Middle Ages. A nongovernmental organization (NGO) (IDEA – International Association for Integration, Dignity, and Economical Advancement) is interested in conserving leprosy heritage sites such as leprosara and leprosy hospitals. Remnants of these sites of quarantine can be found on every continent; already some have been turned into museums.

Disease Status: Twenty-First Century

Despite efforts by the World Health Organization (WHO) to eliminate the disease by the start of the twenty-first century, it continues to be a global health threat. However, the number of cases worldwide is declining steadily, with approximately 212,802 cases reported to the WHO at the beginning of 2008. In that year, three countries with a population greater than 1,000,000, Brazil, Nepal, and Timor-Leste, had not achieved the goal of elimination – considered accomplished when at any given time the disease is present in fewer than 1 out of 10,000. Areas of high disease occurrence remain in regions of the Amazon forest in Brazil, the Central African Republic, Angola, the Democratic Republic of Congo, parts of central and west India, Madagascar, Mozambique, Nepal, and the United Republic of Tanzania.

Leprosy in the United States

In the United States, the disease persists mainly through immigrants, although it is reported occasionally in native-born Americans. There is an endemic focus in Texas, around the western Gulf Coast. Armadillos, which have a low body temperature that serves to facilitate the growth of the microbe, can harbor the disease. Infected armadillos have been identified in parts of the United States, such as Louisiana and Texas, and, to a much lesser extent, in Arkansas and Mississippi. It remains controversial, however, whether they transmit the disease to humans. Autochthonous, or local, transmission of the disease was recognized also in Hawaii; Puerto Rico; and, possibly, California.

Effects of the Disease

Leprosy affects the skin and peripheral nerves; it can cause irreversible impairment of nerve function and chronic disabilities. It is suspected that only a small percentage of persons is susceptible to the infection and will develop the disease after contact. While the degree to which one is prone to the disease is determined by the individual's genetic background, at present, there is no publicly available method to determine if a specific individual is at risk. Furthermore, onset can be latent, with many years passing between exposure and the arrival of disease symptoms.

Leprosy can affect children and adults of any age. Although the manifestations are variable depending on the disease subtype, usually a skin lesion presents with or without nerve involvement. Skin lesions can be flat or raised, reddish-brown or pale colored, with raised, well-defined edges and loss of hair. Usually, there is local absence of sensation to pain, temperature, and touch. The lesions can be found anywhere on the body, but they involve rarely the scalp, axillae, or perineum. The specific number of lesions appearing can range from one to many, reflects the number of infecting germs, is key in determining the disease type, is related to other manifestations of the disease, and is a determinant in selecting the most appropriate treatment.

Forms of Leprosy

The disease can take on a variety of forms, in mild forms manifesting as simple, painless, red bumps on the anterior legs. In more severe forms of leprosy, those affected may experience abnormal sensations in their limbs, called peripheral neuropathy, which can lead to deformities and ulcers that will not heal. In advanced disease states, patients may suffer from involvement of the eyes (blindness), nose (septal perforation and nose deformity), larynx, liver, kidneys, testicles (infertility), and bone, leading to disfiguration, disability, and death.

Leprosy Diagnosis

Doctors suspect the presence of leprosy based on the appearance of the skin lesions, the associated complaints and findings, and, most importantly, the patient's exposure history, which makes of utmost importance places and dates of travel, special activities, and contact with sick people or with certain animals. While other methods are still under development and testing, the most reliable means to determine the presence of the disease are examining skin samples under the microscope and looking for the culprit bug.

Treatment

A combination of specific antibiotics is used to treat leprosy. Rarely, one dose of an antibiotic combination is sufficient; in most cases, a prolonged course is necessary, frequently up to 2 years and rarely as long as 10 years, to assure cure and to prevent the emergence of mutant resistant germs. Adequate response to treatment is determined by the disappearance of skin lesions and the reversal of nerve disease. Resolution is slow, and some manifestations are irreversible and can be ongoing; reoccurrence is possible also after ceasing treatment.

Precautions

To inhibit progression of the disease, a physician who is knowledgeable of leprosy and the disease process should examine all household contacts and first-degree and second-degree relatives to detect and treat leprosy cases. Awareness is necessary of the modes of transmission to avoid exposure, occurring mostly through respiration but with the potential for transmission via contact with the skin. Although tuberculosis vaccine is active partially, still there is no reliable way to prevent transmission of leprosy.

Progress of Medicine and Disease Resilience

Leprosy is an ancient disease of which worldwide occurrences have been reduced substantially by the efforts of international organizations, local authorities, local community involvement, and active health care workers. This illustrates the progress of medicine, which has transformed this long-lived dreaded disease surrounded by a nebula of myths into an object of science, with well-defined diagnostic and treatment procedures. It demonstrates also the resilience of certain diseases and the difficulty to control them despite international effort. Finally, it exemplifies the necessity of international cooperation in order to control global health threats.

Related Topics

- ► Disease prevention
- ► Health beliefs
- ► Infectious diseases
- ► Quarantine

Suggested Readings

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Suggested Resources

For information on Gerhard Armauer Hansen. http://www.medlibrary.org/medwiki/Gerhard_Armauer_Hansen

For information on the US Department of Health and Human Services' National Hansen's Disease (Leprosy) Program. http://www.hrsa.gov/hansens/

For information on the World Health Organization. http://www.who.int/lep/en/

Liberia

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Located on the west coast of Africa, Liberia has a population of 3,441,790 and is surrounded by the Atlantic Ocean on the southwest, Sierra Leone on the northwest, Guinea on the east, and Côte d'Ivoire on the southeast. Guinea, Sierra Leone, and Liberia are known as the three Mano River Union countries of West Africa.

Liberia was named using the Latin word, liber, meaning "free." In 1820, the first groups of repatriated slaves from the United States, referred to as Americo-Liberians, and a second group of former slaves from the West Indies and Africa, the Congoes, were sent to this West African country, inhabited already by a variety of indigenous Africans. These newcomers did not govern themselves initially; the country was run by wealthy, White administrators from the American Colonization Society. In 1839, Liberia was declared the Commonwealth of Liberia, and in 1841, Joseph Jenkins Roberts was elected the first black governor. Liberia received independence in 1847, becoming the Republic of Liberia. In 1870, the True Whig political party was created, and governance was controlled by the Americo-Liberians. With the True Whig party in power, the Americo-Liberians continued to be heads of state until 1980, when Samuel Doe, a Krahn tribesman, became the first indigenous ruler of the country. Of the Liberian population, 3% is Americo-Liberian and 97% is indigenous.

Liberia's indigenous population is comprised of 18 ethnolinguistic groups. These groups, or official tribes, include: Kpelle, Bassa, Gio, Kru, Grebo, Mano, Krahn, Gola, Gbandi, Loma, Kissi, Vai, Bella, Dei, Gbe, Mende, Sapo, and Mandingo – with the Kpelle and Bassa comprising the largest ethnic groups. Although the official language of Liberia is English, many Liberians speak their tribal languages and/or Liberian Pidgin English. The linguistic groups are subdivided into four ethnic cluster groups: the Kwa, the Mande-Fu, the Mande-Tan, and the Mel (or West Atlantic), and each cluster group is comprised of multiple tribal affiliations. Many of these tribal groups have ethnic ties to other West African countries. The Mandingo, Krahn, and Gio are affiliated with tribal groups in Côte d'Ivoire; the Mende and Vai with Sierra Leone; and the Kissi, Kpelle, and Loma with Guinea.

Liberia has experienced years of strife and civil war. Examples include: Rice Riots in 1979, the Doe's coup d'etat in 1980, and a bloody civil war from 1989–2003 when President Charles Taylor's rule ended. Taylor is being tried for war crimes and crimes against humanity due to his brutal rule of the country. Currently, Liberia experiences peace under the rule of the first woman president of an African country, Madame Ellen Johnson-Sirleaf. Despite a period of peace, Liberia is experiencing severe hardship as it struggles to recover from the devastating civil war.

The fighting within Liberia killed more than 250,000 Liberians and caused almost 1,000,000 more of its people to flee their homes and become internally displaced persons (IDPs) or refugees in the neighboring African countries of Sierra Leone, Guinea, Côte d'Ivoire, Ghana, and Nigeria. Population statistics remain fluid and unpredictable as there is significant movement in West African countries due to economic and governmental instability. The United Nations High Commissioners for Refugees (UNHCR) statistics report over 75,000 refugees originating from Liberia during 2009 who are living outside of their homeland. Many Liberians began the process of repatriation to their homeland from neighboring countries in the mid-2000s as the UNHCR's goal was to provide reintegration. Due to conflicts that have spilled over from neighboring West African countries, Liberia hosts over 15,000 refugees from Côte d'Ivoire and 1,500 from Sierra Leone.

Currently in a state of peace, Liberia continues to struggle with the effects of war and abject poverty. An approximately 14-year civil war has produced economic instability, a lack of infrastructure, and significant unemployment. Government programs, humanitarian support, and peace building initiatives are partnering to rebuild social service and educational programs, as well as to develop safeguards against future outbreaks of violence. The declining health and well-being of Liberians is reflected in significantly high rates of infant mortality, shortened life expectancies, a high death rate for adults, low literacy rates, and high infectious disease rates.

Nearly all Liberians have experienced some level of trauma, and many have been victims of torture and rape because of wartime atrocities in their own country or in their country of asylum. Also, it is important to recognize the high incidence of personal, physical, and sexual violence, especially in the lives of Liberian women and children. Often the perpetrators of this violence were rebel fighters, soldiers, or others who had the responsibility to protect vulnerable refugees and IDPs. Some Liberian children were drugged, forcibly recruited to be child soldiers, and forced to commit violent acts and murder against their own family or community. Fears, anxiety, depression, and familial conflict/abuse are a frequent result of the individual and collective suffering of the Liberian war victims. Physicians and mental health practitioners should be alert to stress symptoms and psychosomatic disorders in their Liberian clients. Professionals should utilize culturally relevant support systems such as the Liberian reliance on deep religious faith and their community/familial support systems that may be crucial to assisting these traumatized victims of war. Programs promoting literacy and education should be high priority interventions that will promote self-sufficiency and increase self-esteem.

Related Topics

- ▶ Africa
- ▶ Child abuse
- ▶ Child health and mortality
- ▶ Civil war
- ▶ Genocide
- ▶ Posttraumatic stress disorder
- ▶ Refugee resettlement
- ▶ Trauma

Suggested Readings

Ellis, S. (1999). *The mask of anarchy: The destruction of Liberia and the religious dimension of an African civil war.* New York: New York University Press.

Fraenkel, M. (1964). *Tribe and class in Monrovia.* London: University Oxford Press.

Gifford, P. (1993). *Christianity and politics in Doe's Liberia.* Cambridge: Cambridge University Press.

Gifford, P. (1998). *African Christianity: Its public role.* Bloomington: Indiana University Press.

Potocky-Tripodi, M. (2002). *Best practices for social work with refugees and immigrants.* New York: Columbia University Press.

Suggested Resources

For information on the Central Intelligence Agency. Retrieved May 13, 2011, from http://www.cia.gov/library/publications/the-world-factbook/index.html

For information on the United Nations High Commissioners for Refugees statistics. Retrieved May 13, 2011, from http://www.unhcr.org/pages/49c3646c4d6.html

Life Expectancy

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Life expectancy is affected by many factors. The common causes of death vary as a function of age. For example, in data from Canada, that may be representative of many regions globally, the most common cause of death from birth to approximately 44 years of age is injuries and the second most common cause in this age group is malignancies. In the 14-year-old-and-less age group, the third most common cause of death is congenital abnormalities, while in the 15–19 year age group, cardiovascular disease is the most common cause of death. From 20 to age 24, the third greatest cause of death was neurological disease and, in the 25–44 year age group, it was cardiovasculator diseases. In the age group of 45–64, the three leading causes of death are malignancies, cardiovascular illness, and injuries. In age groups from 65 and older and across all age groups, the three leading causes of death are cardiovascular illness, malignancies, and pulmonary disorders.

In addition to age, the number of comorbid illnesses and functional limitations are important predictors of life expectancy. Congestive heart failure, advanced renal disease, severe chronic obstructive pulmonary disease, and significant functional dependencies in ordinary activities of life lower life expectancy. Reduction in functional status and mobility are associated with decreased life expectancy. Life expectancy is negatively correlated with diabetes and the resulting increase in cardiovascular illness. Smoking, hypertension, poor blood glucose control and increased body fat contribute to increased mortality and decreased life expectancy from cardiovascular diseases and malignancies. Cognitive decline and neurodegenerative disorders have a negative correlation with life expectancy. Now 50% of individuals over 85 years of age have Alzheimer's disorder. Additionally, in the age group of 65 years of age and older, suicide is a significant risk to life expectancy. Higher suicide rates have been reported in this group for both men and women.

In men, life expectancy has been lower attributable to higher risk behaviors and using health services less. Further, in older men, it has been reported that work plays a key role in their health and life expectancy as does work-related exposures that may cause ill health and adversely affect the health of men. It has been reported that there is a strongly positive correlation between civic participation and life expectancy. In comparisons between similar populations in the United States and Canada, where health care is more widely accessible compared to the United States, there were findings of greater life expectancy in Canada. Also, measures of quality of health were better in Canada than in the United States for those over 40 years of age and the same for those less than 40 years of age. Health management issues affect life expectancy. Race, ethnic background, and neighborhood socioeconomic status have been found to be associated with life expectancy. In another study, life expectancy and material deprivation were inversely related. Social disparities are widespread and continuing, affecting quality of health and life expectancy.

In the history of life expectancy, the major advance in life expectancy is due to major decline in perinatal, infant, child, and maternal mortality along with increased survival rate for those past 65 years of age. Current trends in life expectancy indicate that in the twenty-first century life expectancy continues to advance although at a slower pace than the rapid increase that occurred in the twentieth century. Men have made gains in life expectancy but continue to lag women. The 80–89 year of age subgroup is the fastest growing age group. As a result of longer life span, major illnesses that affect the increasing aging population are malignancies, cardiopulmonary illnesses, and dementia. The aging process itself is probably related to an accumulation of body and genetic damage. Increasing life expectancy has been associated with decreasing fecundity. Recently, it also has come to light that single genes have extended the life of laboratory animals and that these findings have been found in a wide range of organisms. Life expectancy in the future may involve greater substantial gains.

Regarding immigrants in general, this population tends to be a selected population secondary to multiple screenings that many times occur before arriving at the country of immigration. It has been reported that male and female immigrants to the United States have a 3.4 and 2.5 year longer life expectancy respectively than citizens born in the United States. Most immigrant groups had lower risks of infant mortality. At the same time, the longer the residence of immigrants, the more their pattern of chronic illness and disability approximates, in the case of this report, the United States born. Immigrants continue to be a growing segment of the population of the United States. The disparity in life expectancy advantage of immigrants compared to US-born population has been increasing. From 1979 to 1981, immigrants had a 2.3-year advantage over the US-born population. Explanations put forth for immigrant advantage in life expectancy have been heterogeneity of the immigrant population, selectivity by virtue of the process of immigration, and behavioral characteristics of this population.

An estimation of life expectancy becomes an important component of medical management when a given individual may be nearing the last stage of life. In this case, the physician needs to allocate resources in the best interest of the patient based on weighing the risks and benefits of interventions. Unfortunately, physicians tend to overestimate the remaining survival time of their patients. In addition, the more they know their patient, the more physicians tend to overestimate. As a result a number of tools have been developed to provide better estimation of remaining life span. In estimating life expectancy, the factors that affect life expectancy involve the well-known parameters of age, disease, and functional status. In addition, the physician must weigh the time needed for an intervention to have impact and whether the outcome of that intervention is likely to be effective. A useful construct for thinking about prediction of end stage life expectancy is to consider an algorithm that separates estimated survival time as greater than 6 months, less than 6 months, or a matter of days. A tool to estimate survival in heart failure is the Four-Year Mortality Index for Older Adults. In cases of expected life span of less than 6 months in advanced dementia, a useful tool is FAST, the Functional Assessment Staging Test. In this time span, estimating when to refer for hospice services can be a clinical decision point of significant import as both patient and family may be in significant need of support. Late referrals to hospice have been associated with family perception of reduced quality of care. As determining when a hospice referral is indicated can be difficult, a palliative referral can be a prior step in the process. The PPS (Palliative Performance Scale) is a useful tool for predicting 6-month mortality and was developed for patients with oncological disease. With very low scores on the PPS, this can be an indicator that death is imminent. Cheyenes–Stokes respiration (a pattern of breathing characterized by several rapid breaths followed by a period of no breathing) or protracted apnea are also indicators of impending death.

Life expectancy is determined by many factors. These include age, comorbid illnesses, and psychosocial determinants. Life expectancy has improved drastically over the twentieth century largely thanks to simultaneous advances in public hygiene and medical advances. Life expectancy continues to show gains, but reduced fecundity may occur with an increase in life expectancy in the general population. Recent understanding in aging suggests that life expectancy may experience significant advances as genetic and medical understanding and care progress.

Immigrants are a special select population that have had in the United States and Canada characteristics with advantaged life expectancy to date. However, the longer the immigrant residence, the more chronic illness and disability approaches the US population.

In medical practice, estimating the last stage of life becomes an important process for assessing appropriate interventions in the best interest of patients. Physicians tend to overestimate patient survival time. Several tools have been developed to estimate life expectancy effectively.

Related Topics

- ► Child development
- ► Functional health

Suggested Readings

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Lifestyle

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The evidence is overwhelming for the importance of a healthy lifestyle; there is an unmistakable relationship between lifestyle and health status. A healthy lifestyle includes not smoking, limiting alcohol intake, physical activity, consuming a higher amount of fruits and vegetables, an overall healthy diet, low belly fat, and maintaining a proper weight. Unhealthy lifestyle factors have been linked individually to chronic disease and premature death.

Chronic diseases are long-lasting conditions that can be controlled but not cured; they have generally a slow progression. Chronic illness affects the population worldwide and is the leading cause of death and disability in the USA. It accounts for 70%, or 1.7 million, of all deaths in the USA each year. Data from the World Health Organization show that chronic disease is the major cause also of premature death around the world – even where infectious diseases are rampant. Chronic diseases are among the most common, costly, controllable, and preventable of health problems. Chronic diseases, such as heart disease, stroke, cancer, chronic respiratory diseases, and diabetes, are by far the leading cause of mortality in the world, representing 60% of all deaths. Out of the 35 million people who died from chronic disease in 2005, half were under 70 and half were women.

Four modifiable health risk behaviors – lack of physical activity, poor nutrition, tobacco use, and excessive alcohol consumption – are responsible for much of the illness, suffering, and early death related to chronic diseases. The results of countless recent studies show that overall lifestyle modification, to include a healthy lifestyle, is critical in disease prevention.

Simple lifestyle measures have been shown to be effective in preventing or delaying the onset of type 2 diabetes and other chronic diseases. Health authorities recommend that people should achieve and maintain healthy body weight; be physically active, including at least 30 min of moderately intense activity on most days of the week, with more activity required for weight control; eat a healthy diet of between three and five servings of fruit and vegetables a day, reduce sugar, and reduce saturated fats intake; avoid tobacco use; and limit alcohol consumption.

Related Topics

- ▶ Diabetes mellitus
- ▶ Dietary patterns
- ▶ Disease prevention
- ▶ Fitness
- ▶ Health outcomes
- ▶ Leisure-time physical activity

Suggested Readings

Blaxter, M. (2005). *Health and lifestyles* (2nd ed.). London: Taylor & Francis.

Suggested Resources

Centers for Disease Control and Prevention. (2008). Prevalence of self-reported physically active adults – United States, 2007. *MMWR*, *57*, 1297–1300. http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5748a1.htm

For information on the Centers for Disease Control and Prevention.

For information on the Center for Managing Chronic Diseases. http://cmcd.sph.umich.edu/

For information on the World Health Organization. http://www.who.int/en/

Limited English Proficiency

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Limited English proficiency (LEP) is a term used to describe individuals living in the United States (US) who do not speak English as their primary language and who have a limited ability to read, speak, write, or understand English. The precise number of LEP persons in the US is difficult to estimate because LEP is defined generally, lacking clear qualifying criteria. Furthermore, as in the cases of the decennial US Census and the annual American Community Survey, often respondents are required to self-assess and self-report their English language proficiency in terms of imprecise categories. For example, persons age 5 and older are considered LEP who report speaking English "not at all," "not well," or "well," while persons are considered proficient in English who report speaking only English or speaking English "very well." Although some experts raise concerns over the origin of the data, surveys conducted by the US Census Bureau are accepted as providing the most comprehensive information on the current LEP population and trends.

LEP and Other than English at Home

It is presumed that prior to age 5, language ability is limited for foreign and native-born speakers of all languages; therefore, the figures that follow pertain only to the US population age 5 and older, unless otherwise noted. The US Census Bureau 2000 reports that at home 80.3% of the US population spoke English only. Of the remaining 19.7% who reported speaking a language other than English, Spanish was by far the most commonly spoken (61.9%), followed by Chinese (4.4%), Tagalog (2.7%), French (including Cajun, 2.4%), Vietnamese (2.1%), and German (2.0%). In 2008, slightly over half of the foreign-born population – 19.6 million – was considered LEP; this compares to 15.6 million in 2000. Furthermore, the percentage of persons in the entire US population considered LEP has trended upward in recent years, from 4.8% in 1980 to 6.1% in 1990 to 8.1% in 2000.

English Ability by Language Group and Geography

There are approximately 380 unique languages in the US, each falling within one of four larger language groups: Spanish, other Indo-European, Asian and Pacific Island, and all other languages. According to US Census 2000, the percentage of each group who were identified as LEP included Spanish, 48.9%; other Indo-European, 33.8%; Asian and Pacific Island, 51.6%; and all other, 31.4%. Persons who are LEP are not distributed equally across or within regions of the US. In 2000, while the West had only slightly more than one-fifth of the US population age 5 and over, it was home to more than one-third (37%) of all non-English-language speakers – the highest proportion of any region. Within regions, the proportion who spoke a non-English language at home was 29% in the West, 20% in the Northeast, 15% in the South, and only 9% in the Midwest.

Federal LEP Policy: Brief Timeline

Federal policy relative to LEP has been shaped by three key legislative events: Title VI of The Civil Rights Act (1964), Lau *v.* Nichols (1974), and Executive Order 13166 (2000). The cornerstone is Title VI of The Civil Rights Act, which prohibits discrimination on the ground of race, color, or national origin. Second, in *Lau v. Nichols* (1974), the Supreme Court prohibits national-origin discrimination, denial of equal access to programs or services because of an individual's limited proficiency in English. Most recently, on August 11, 2000, was signed Executive Order 13166 (EO 13166) – *Improving Access to Services for Persons with Limited English Proficiency.* As each federal agency is tasked with taking reasonable steps to provide meaningful access to its own federally conducted activities, EO 13166 was designed to provide persons who are LEP with greater access to federally conducted and federally assisted programs and activities.

Implications for Healthcare Institutions

The evolving federal policy on LEP has specific implications for healthcare, including all non-federal entities that receive federal financial assistance, for example, state agencies, hospitals, physician practices, community clinics, pharmacies, and nursing homes. Federal financial assistance may include training, grants, donations or use of property or equipment, receipt of Medicare or Medicaid funds, and other assistance. The Office of Civil Rights (OCR) within the Department of Health and Human Services is responsible for enforcing Title VI, while the Coordination and Review Section of the Civil Rights Division of the Department of Justice oversees the implementation of EO 13166. According to OCR, in terms of compliance with Title VI, the focus is on whether an institution's policies and procedures support LEP individuals in participating meaningfully in health and social services.

As compared to other US institutions, especially healthcare must be poised to respond quickly to emergent situations and variable environments. In this context, EO 13166 has significant impact, as information frequently must be drafted in multiple languages and disseminated quickly. Of those who speak a language other than English at home, a high percentage of persons in various ethnic groups are LEP. The Centers for Disease Control and Prevention (CDC) reports the following data concerning the portion considered LEP of various groups in the US: Latinos, 39.4%; Hmong, 76%; Cambodians, 70%; Laotians, 68%; Vietnamese, 61%; Koreans, 52%; Chinese, 51%; Tongans, 39%; and Samoans, 22%, while high percentages of LEP individuals exist also among other immigrant communities, such as those from Africa and Eastern Europe.

To assist health centers in providing language services, the Department of Health and Human Services has created access grants. These funds aid health centers so that they can provide translation, interpretation, and other services to assist LEP persons in overcoming language barriers. Studies show that the quality of care increases dramatically when there is clear communication between the healthcare provider and LEP persons. The aim of the access grants is to give those in healthcare the tools necessary to communicate effectively with the LEP populations they serve.

Related Topics

- ► Access to care
- ► Acculturative stress
- ► Barriers to care
- ► Communication barriers
- ► English as a Second Language
- ► Interpreter services
- ► Language
- ► Language acculturation

Suggested Resources

For information from the U.S. Department of Health and Human Services: http://www.hhs.gov/

For information on Immigrant Children in Schools and the Community: http://news.brown.edu/pressreleases/2010/09/immigrants

For information on Immigrants' Access to Insurance and Health Care: http://www.gcir.org/immigration/facts/health

Karliner, L. S., Jacobs, E. A., Chen, A. H., & Mutha, S. (2007). Do professional interpreters improve clinical care for patients with limited English proficiency? A systematic review of the literature. *Health Research and Educational Trust*, *42*, 727–754. Retrieved April 7, 2010, from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1955368/

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U.S. Department of Justice, Civil Rights Division. (2004). *EO 13166 limited English proficiency resource document: Tips and tools from the field*. Retrieved April 7, 2010, from http://www.lep.gov/resources/tips_and_tools-9-21-04.htm

Linguistic Minority Community

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In Canada, there has been an unprecedented increase in the number of immigrants from various countries from all continents and representing different categories of immigration (humanitarian, meaning refugees; economic, meaning the labor market needs; and social, meaning family reunification). These immigrants have to negotiate substantial cultural and, often, linguistic discontinuities. Whether it symbolizes a search for adventure or an escape from a war-torn country, immigration generally represents a drastic change in values, customs, society's expectations, language, much of which often leads to significant tensions, feelings of ambiguity, and sometimes a sense of loss. While the process of immigration is, in itself, often intentional, the circumstances leading to the intention of immigrating can range from an enthusiastic search for new (often well-calculated) challenges to a desperate hope for a refuge away from violence, insecurity and instability.

Additional layers of challenges become visible when immigrants who are members of cultural minorities are also members of linguistic minorities. The process of adaptation is more difficult for immigrants whose cultural and linguistic capital is incongruent with what is declared to be the norm, because the immigrant becomes a visible minority within a linguistic minority. As such, parallel to issues of attachment in the development of a renegotiated cultural identity, issues of language marketability and economic health arise as immigrants attempt to secure a job in a social context that privileges English over any other language, even if this other language is the other official language in the country, as is the case for French in Western Canada.

The process of adaptation to a new country involves a number of steps or, to be more to the point, obstacles, some of which are on a systemic and structural level, while others are on a relational and interpersonal level. While a very small minority of immigrants are actively recruited for a well-established purpose (e.g., a well-known scientist, or a high-performing soccer player), in which case settling is structurally organized for them, the vast majority of immigrants struggle (granted, to various degrees, depending on premigration circumstances) to settle. On a structural level, difficulties may include the recognition (or lack of) of prior professional experiences and diplomas, leading to economic hardship such as unemployment and inability to find adequate lodging, systemic inequities in hiring practices, often leading to a low representation of visible minorities in leadership positions, and language barriers, leading to limited meaningful social and political participation. These difficulties potentially threaten the health and well-being of the family, which may have an impact on the most vulnerable, namely the children, and specifically their education. On a relational and interpersonal level, immigrants may experience tensions related to the differing values between host and home cultures. For example, children may be under pressure to behave in a certain way in order to be accepted by their peers at school while feeling an obligation to conform to parental expectations that might be quite different from mainstream values.

While working through these tensions, immigrants often redefine their own sense of cultural identity through two major stages, namely attachment and detachment. Most immigrants experience an immediate sense of attachment toward the host culture, some because immigration represents an adventure and others because it represents peace. However, as immigrants progress through the many, often difficult, levels of adaptation, a sense of detachment from the host culture often follows. In this phase, immigrants may come to miss their home culture, including family members left behind, language, and ways of interaction, and may find it particularly difficult to find a sense of belonging. Feelings of split loyalties may follow until the immigrant is able to emotionally reattach to communities (church, cultural centers, school, etc.) can give him or her a new sense of home comprised of elements of both (or more) worlds.

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Related Topics

- ► Culture shock
- ► Education
- ► Ethnic identity
- ► Ethnic minority group
- ► Identity
- ► Language
- ► Language acculturation
- ► Linguistic minority community
- ► Translation services
- ► Vulnerable populations

Suggested Readings

Daniels, R. (1990). *Coming to America: A history of immigration and ethnicity in American life.* Princeton: Harper Collins.

Fantino, A. M., & Colak, A. (2001). Refugee children in Canada: Searching for identity. *Child Welfare, 80*(5), 2–8.

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Madibbo, A. (2008). The integration of black Francophone immigrant youth in Ontario: Challenges and possibilities. *Canadian Issues*: 45–49.

Padilla, A. M., & Perez, W. (2003). Acculturation, social identity, and social cognition: A new perspective. *Hispanic Journal of Behavioral Science, 25*(1), 35–55.

Piquemal, N., & Bolivar, B. (2009). Discontinuités culturelles et linguistiques: Portraits d'immigrants francophones en milieu minoritaire. *Revue d'Intégration et de Migration Internationale, 10*, 245–264.

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Literacy

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Literacy is certainly the ability to read and write, a definition that emphasizes print. The various academic disciplines that have claimed literacy define it more broadly, and conceptualizations of literacy differ across, and even within, disciplines. The variability of definitions is both in terms of the skills included as well as the extent to which literacy is determined by the context in which it is practiced. As a result of the variety of ways literacy has been defined and studied, there are no universal definitions of literacy or standards for determining what it means to be literate. In addition, literacy is rarely considered as a dichotomy, literate versus illiterate, but rather is thought to exist on a continuum.

In the United States, the National Institute for Literacy defines literacy as "an individual's ability to read, write, and speak in English, compute, and solve problems, at levels of proficiency necessary to function on the job, in the family of the individual, and in society." The definition comes from the Workforce Investment Act of 1998, Section 203. Depending on time and context, the reading, writing, and speaking skills required to be considered functionally literate can vary. The literacy skills of a theologian may not be up to the task of reading an article in a physics journal, and the physicist likewise might struggle with an exegesis. Time has also changed our views of what constitutes literacy. During the Civil War, military recruits were judged to be literate if they could sign their name, whereas today's GI is expected to have attained a high-school diploma or GED. When interpreting statistics related to literacy rates, it is important to know how literacy was defined and what criteria were used to assess it.

The United States conducted the National Assessment of Adult Literacy (NAAL) in 2003. The literacy skills of US adults aged 16 and older, including prison populations, were assessed. The NAAL used written materials that might be found at home, in the community, or on the job to assess three types of literacy: prose, document, and quantitative. Prose literacy is the knowledge and skills needed to search for and comprehend information in continuous texts such as editorials, news stories, brochures, and instructional materials. Document literacy is the application of the prose literacy skills, but to noncontinuous texts in various formats, such as job applications, payroll forms, transportation schedules, maps, tables, and drug or food labels. Quantitative literacy is knowledge and skills required to identify and perform computations, either alone or sequentially, using numbers embedded in printed materials, such as a checkbook, a restaurant check, an order form, or a tax form. To characterize the English language literacy of American adults, the NAAL reported results in terms of the following performance levels: nonliterate in English, below basic literacy, indicating no more than the most simple and concrete literacy skills, basic literacy, indicating skills necessary to perform simple and everyday literacy activities, intermediate literacy, indicating skills necessary to perform moderately challenging literacy activities, and proficient literacy, indicating skills necessary to perform more complex and challenging literacy activities. The results for prose literacy among US adults 16 and older indicated that 14% were below basic, 29% were basic, 44% intermediate, and 13% proficient. Results for document and quantitative literacy were similar.

The NAAL provided an opportunity to examine the English literacy of foreign-born adults living in households in the United States. The NAAL data showed that on average, foreign-born adults had lower scores on prose, document, and quantitative literacy. The English literacy scores varied across different background characteristics. Hispanics had the lowest scores compared to their foreign-born peers. Foreign-born Blacks scored above Hispanics, but below foreign-born Whites and Asians. Generally adults who had arrived in the United States at age 11 or younger tended to have higher scores than those arriving at older ages, and more years in the United States were also associated with higher scores. Speaking a language other than English before starting school was associated with lower scores, while higher educational attainment was associated with higher scores.

The NAAL provides an overview of English language literacy among foreign-born adults, but given the great variability between and within immigrant populations, understanding the particulars of each immigrant group will allow for greater insight into potential strengths and weaknesses in terms of English language literacy. Immigrants with strong literacy skills in their native language are likely to quickly develop English language literacy skills if they see the need for them, as many of the skills that contribute to literacy in one language are transferable to another. Immigrants lacking literacy skills in their native language can find it more difficult to learn English literacy skills. It is important to keep in mind that any cognitively normal adult can learn to read at any age; however, as with all adult learning, they must see a purpose.

There are a number of sources of information about literacy levels in other countries that can help provide insight into the literacy levels in the country of origin for various immigrant groups. The International Adult Literacy Survey (IALS) was a large-scale cooperative effort by governments, national statistical agencies, research institutions, and the Organisation for Economic Co-operation and Development (OECD). Using a similar definition of literacy and assessment strategy to the NAAL, the IALS has been conducted in Canada, France, Germany, Ireland, the Netherlands, Poland, Sweden, Switzerland, the United States, Australia, the Flemish Community in Belgium, Great Britain, New Zealand, Northern Ireland, Chile, the Czech Republic, Denmark, Finland, Hungary, Italy, Norway, and Slovenia. Because the same methodology was used, the IALS allows for comparisons across participating countries.

For countries that have not participated in the IALS reliable and comparable cross-national data on literacy rates is often lacking. The United Nations Educational, Scientific and Cultural Organization (UNESCO) has programs in place to develop viable systems to define, monitor, and evaluate literacy across the developing world. Potential sources for international literacy statistics include UNESCO, US Agency for International Development (USAID), and the Central Intelligence Agency (CIA). In 2006, UNESCO published a global monitoring report focused on literacy. The MEASURE DHS project, funded by USAID to collect data on health and population trends in developing countries, includes brief measures of literacy practices (such as frequency of reading) as well as level of education. The CIA compiles country-reported literacy rates in its Fact Book.

Related Topics

- ▶ Communication barriers
- ▶ Education
- ▶ Health education
- ▶ Health literacy
- ▶ Low literacy level
- ▶ Vulnerable populations

Suggested Readings

Barton, D. (1994). *Literacy: An introduction to the ecology of written language.* Oxford/Cambridge, MA: Blackwell.

Gee, J. P. (1996). *Social linguistics and literacies: Ideology in discourses* (2nd ed.). Philadelphia: Falmer Press.

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Suggested Resources

Kutner, M., Greenberg, E., Jin, Y., Boyle, B., Hsu, Y.-C., & Dunleavy, E. (2007). *Literacy in everyday life: Results from the 2003 National Assessment of Adult Literacy* (NCES 2007–490). Washington, DC: National Center for Education Statistics. http://nces.ed.gov/naal/. Accessed May 12, 2011.

Statistics Canada, Ottawa (Ontario) & Organisation for Economic Cooperation and Development, Paris (France). (2000). *Literacy in the information age: Final report of the international adult literacy survey.* Washington, DC: The OECD. http://www.oecd.org/dataoecd/48/4/41529765.pdf. Accessed May 12, 2011.

UNESCO. (2005). *EFA global monitoring report 2006. Education for all: Literacy for life.* Paris: UNESCO. http://unesdoc.unesco.org/images/0014/001416/141639e.pdf. Accessed May 12, 2011.

Liver Cancer

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Cancers of the liver, or hepatobiliary malignancies, are a growing health care problem around the world. These cancers include malignancies of the liver cells themselves as well as malignancies arising from the passageways, or tracts, within or just outside the liver. Cancerous tumors of the liver cells are called hepatocellular carcinoma, whereas biliary tract cancers include cancer of the cells lining the biliary ducts, termed cholangiocarcinoma, and gallbladder cancer. All of these types of hepatobiliary cancer are strongly associated with inflammation within the liver, the biliary ducts, and the gallbladder. This inflammation is frequently the result of chronic infections or ingestion of various toxins, especially alcohol.

The most common factors associated with the development of hepatocellular carcinoma are chronic infection with hepatitis B virus or hepatitis C virus and chronic ingestion of excessive quantities of alcohol. This is so because chronic viral hepatitis and chronic alcohol abuse can lead to inflammation of the liver, which can lead to cirrhosis, or scarring of the liver, which, in turn, often precedes hepatocellular carcinoma. In the United States, an estimated 30% of new cases of hepatocellular carcinoma likely are to be related to alcohol abuse. Worldwide, however, new cases of hepatocellular carcinoma vary according to the prevalence of chronic hepatitis B and chronic hepatitis C infections. Currently, Asia and sub-Saharan Africa have the highest rates of infectious hepatitis and the highest incidences of hepatocellular carcinoma in the world. As such, immigrants from Asia and sub-Saharan Africa to other regions of the world frequently have higher rates of chronic hepatitis and hepatocellular carcinoma than those born to these other regions.

Hepatocellular carcinoma is the fifth commonest cancer in men and the eighth commonest in women, with an estimated 560,000 new cases diagnosed annually worldwide. The number of new cases of hepatocellular carcinoma is rising due to the prevalence of chronic hepatitis C infection. Many expect incidence may decline over time, however, with more widespread use of vaccination against the hepatitis B virus. People with hepatocellular carcinoma usually present to physicians late in the course of their disease, and median survival is only 6–12 months. Additionally, the surgical cure rate is estimated at 5%. The most common symptoms of hepatocellular carcinoma include jaundice, generalized itching, significant weight loss, and an increase in abdominal girth.

Diagnosis of hepatocellular carcinoma is usually made by its characteristic appearance on imaging, with ultrasound, CT scanning, or MRI; characteristic blood tests; and, frequently, a liver biopsy. If present, the cancer is staged based in its size, location, number of masses, involvement of lymph nodes, and presence of distant metastasizes. Unfortunately, surgical resection and liver transplantation offer the only hopes for a cure and are appropriate for only a small minority of patients. Other treatments, like local or systemic chemotherapy, or radiation treatments, among others, may be helpful to prolong life and decrease symptoms, but their rates of success are poor.

A far less common cancer of the liver is cholangiocarcinoma, which arise from the cells that line the biliary ducts. In the United States, there are approximately only 2,500 cases of cholangiocarcinoma each year. However, in some areas of the world, this type of cancer is very common and accounts for a great number of deaths annually. For instance, in Northeast Thailand and Southern Laos, cholangiocarcinoma is among the leading causes of death each year. This is because infection with the liver fluke, Opisthorchis viverrini, is endemic in these areas of Southeast Asia and is strongly associated with the development of cholangiocarcinoma. Additionally, in areas of the world where another liver fluke, Clonorchis sinensis, is common, like China, Taiwan, Vietnam, and Korea, rates of cholangiocarcinoma are relatively high. Both of these parasites (Opisthorchis and Clonochis) are acquired through eating raw, undercooked, or fermented fish, which allows passage of the metacercariae (or immature stage) of the parasite into the stomach, intestines, and, ultimately, bile ducts of the human host. Once in the bile ducts, this parasite develops into its adult form and lives out its life within these small ducts of the biliary tree. It is thought that a specific type of immune response is directed against this adult worm, and after many years, this inflammatory response leads the cells that line the biliary ducts to transform into cancer cells.

People with cholangiocarcinoma develop symptoms similar to those of hepatocellular carcinoma. Similarly, surgical cure rates of cholangiocarcinoma are generally low, approximately 10%, and median survival is approximately 6 months from the time of diagnosis. Symptoms can be temporarily relieved with use of biliary stents, photodynamic therapy, and radiation therapy – used alone or in combination with chemotherapy.

Cancerous tumors may occur in the gallbladder, but these are uncommon as well, with only 5,000 new cases per year in the United States. Gallbladder cancer usually is associated with chronic inflammation of the gallbladder. This type of cancer is more common in women, and usually begins after the age of 50. These tumors usually grow into adjacent structures in the abdomen, making surgical cure very difficult. The further the tumor has spread, the worse the prognosis. In patients with gallbladder tumors that have spread beyond the gallbladder itself, only 5–10% will live another 5 years. However, sometimes gallbladder cancer is found incidentally at the time of cholecystectomy or removal of the gallbladder. If this is the case, the prognosis is very good, with only a 5% chance of death in the next 5 years.

Related Topics

- ► Cancer incidence
- ► Cancer mortality
- ► Cancer prevention
- ► Cancer screening
- ► Disease prevention
- ► Five-year bar
- ► Lifestyle

Suggested Resources

For information on primary liver cancer worldwide incidence and trends. http://www.ncbi.nlm.nih.gov/pubmed/15508102

For information on the global burden of cancer. http://www.who.int/mediacentre/factsheets/fs297/en/index.html

Mayo Clinic Staff (1999). *Gallbladder cancer.* Mayo Clinic. Retrieved from http://www.mayoclinic.com/health/gallbladder-cancer/DS00425

Liver Cirrhosis

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Cirrhosis is the replacement of normal liver tissue with fibrosis, scar tissue, and regenerative nodules. It is the final common pathway of many types of liver disease. Complications of cirrhosis can include ascites, peritonitis, esophageal varices, encephalopathy, liver cancer, and liver failure. Hepatitis B, Hepatitis C, and alcoholic liver disease, all common in various immigrant groups, are the three leading causes of cirrhosis and primary (hepatocellular) liver cancer worldwide. Screening, vaccination, and treatment for liver disease are complex issues for physicians, health care researchers, and immigration officials.

Hepatitis B

Hepatitis B (HBV) is the commonest type of viral hepatitis, with an estimated two billion persons exposed and 350–400 million with chronic infection. Of these, 25–40% will eventually develop cirrhosis or liver cancer, causing up to one million deaths annually. Vertical transmission (mother-to-infant) leads to chronic infection in 90%. Consequently, there are high rates of infection in infants and children in endemic areas. Horizontal transmission (via sexual contact, bodily fluids, transfusion of blood products, intravenous drug use) occurs at a 6% rate in adults. HBV is 50–100 times more contagious than HIV. Cirrhosis develops in 15–20% of actively infected HBV patients within 5 years. Endemic areas, with >8% rates of chronic infection, include much of Asia, sub-Saharan Africa, and parts of Central and South America. Between 1997 and 2006, approximately three million Asians and 600,000 Africans emigrated to the United States. Assuming infection rates around 8%, 290,000 new cases of HBV were introduced into the United States over that decade from Asia and Africa alone.

Prevalence studies suggest that this estimate may be low. A study of Chinese immigrants in Chicago's Chinatown showed that 11.1% were hepatitis B surface antigen (HBSAg) positive, indicating chronic hepatitis. A study of Vietnamese immigrants in the 1990s showed a 13.8% prevalence rate. In 2006, the New York Times reported "staggeringly high" rates of chronic HBV infection (around 15%) among recent Chinese and South Asian immigrants to New York City. Recent studies of sub-Saharan African immigrants to Australia showed 19–22% rates of chronic Hepatitis B. In Minnesota, 8% of sub-Saharan African refugees tested in 1999 were HBSAg positive.

Although 40–65% of people with chronic hepatitis B have no symptoms, serious illness is common. In one cohort of Chinese immigrants, severe disease – fibrosis or cirrhosis – was found in 34%. In those who are aware of their illness, cultural taboos and prejudices often make them reluctant to disclose their hepatitis for fear of being rejected and isolated from their families and communities. "Our culture is not to talk about disease," commented a California State Assembly member of Chinese descent with chronic HBV disease. "I was walking around for 20 years not knowing what to do about my own health. I have a one in four probability of developing liver cancer. . .People should not keep this a secret."

The World Health Organization has recommended universal immunization for hepatitis B.

An effective hepatitis B vaccine has been available in the United States since 1982. Vaccination of children and high-risk adults has decreased new cases of hepatitis B by 70%. However, there are still approximately 1.25 million people in the United States with chronic hepatitis B infection, many of whom are immigrants. The US Centers for Disease Control (CDC) recommended in 2008 that people born in either Asia or Africa who currently live in the United States should be tested for HBV. The CDC also recommends testing for refugees, immigrants, and adoptees from countries where HBV infection is endemic. For those who are chronically infected, treatment is expensive ($2,000–$9,000/year), lengthy, often poorly tolerated, and complex because of multiple HBV genotypes and increasing drug resistance. Annual health care costs for the 150,000 US HBV patients with significant liver damage (many of whom are immigrants) have been estimated at $360 million.

Although screening of immigrants is recommended, hepatitis B is not on the US Health and Human Services "List of Communicable Diseases of Public Health Significance" that make a foreign national inadmissible to the United States.

Hepatitis C

Hepatitis C (HCV) has been called "a viral time bomb." It is transmitted chiefly by intravenous drug use, blood transfusions, and infected medical equipment. Unlike hepatitis B, sexual and maternal-fetal transmissions are rare, and adults are far more likely to be infected than children. According to the WHO, 3% of the world's population (170 million people) have been infected with HVC, of whom 80% have chronic hepatitis C. Of these, 20–50% will eventually develop cirrhosis, and about 5–7% may die from complications of the infection. Eighty percent of patients infected with hepatitis C have no symptoms, and most are not aware that they have the disease.

Hepatitis C prevalence is highest in Africa, Latin America, and Central and Southeast Asia (5–10%). The prevalence of HCV is lowest in Northern European countries, including Great Britain, Germany, and France. In the United States, about 1% of the population (3.6 million) are infected. There are pockets of very high prevalence among some immigrant groups. For example, 28.3% of a cohort of immigrants from the former Soviet Union to New York City were found to be seropositive for HCV. This was attributed mainly to inadequate sterilization and reuse of medical equipment. Approximately 20% of Egyptian blood donors test positive for the HCV antibody, probably because of a past practice of mass treatment with parenteral therapy for schistosomiasis. In Italy, the prevalence is >5% in some communities, likely associated with dental therapy and past use of glass syringes. Before HCV screening of blood donors began in 1990, blood transfusion was the leading cause of HCV transmission. Since then, the leading cause of new infections has been high-risk drug behavior (intravenous drug use, intranasal cocaine) and unsafe injection practices. Overall, new cases of HCV in the United States have decreased by 80% since 1990.

Unlike hepatitis B, there is no immunization available to prevent Hepatitis C. Treatment with interferon and ribavirin can induce viral remission, but it is expensive ($10,000), takes 24–48 weeks, and is often poorly tolerated. Response rates vary from about 45% to 80%, depending on the viral genotype. Genotypes 2 and 3, which are more common in Asian, African and European immigrants, generally have better treatment response rates (70–80%) than genotype 1 (<50%), which is most common in US natives. Annual health care costs for the 3.6 million US patients infected with HCV have been estimated at $9 billion.

Hepatitis C is not on the US HHS “List of Communicable Diseases of Public Health Significance;” presence of the HCV antibody does not bar prospective immigrants from admission to the United States.

World Health Organization Recommendations

The WHO has recently published recommendations for prevention and control of viral hepatitis. These include immunization of children and health care workers for hepatitis B, ensuring safety of blood supplies, promoting safe injection practices, supporting development of new vaccines, increasing awareness among communities and health care workers of the opportunities to prevent viral hepatitis, and expanding care and treatment services for people with chronic viral hepatitis.

Alcoholic Cirrhosis

Cirrhosis caused by excessive alcohol consumption is the most common cause of liver cancer in the developed world. Epidemiologic studies show that Europe has the highest per capita alcohol consumption worldwide, and that the highest rates of alcoholic cirrhosis are found in Germany, Italy, Spain, France, and Russia. Immigrants from these countries may be at particularly high risk for cirrhosis and its serious complications. Intermediate rates of alcoholic cirrhosis are seen in the Americas and Australia, and the lowest rates are in Africa, Asia, and the Middle East.

Rates of alcohol use may change as immigrants become acculturated to their new countries. Studies of Asian-American and Mexican-American immigrants, for example, show that their drinking behaviors conform to those of the general US population over time. On the other hand, some ethnic groups and individuals may cling to their pre-immigration drinking habits. In general, rates of alcohol consumption depend on a complex combination of physiologic, cultural, social, religious, and legal factors that are beyond the scope of this article.

Though data on alcoholic cirrhosis in immigrants are limited, the general pattern appears to be that alcoholic cirrhosis is more common in industrialized countries, and hepatitis B is a far more common cause of cirrhosis in less developed countries. For instance, an Australian study of causes of hepatocellular cancer found that excessive alcohol intake was a risk factor for 46% of the Australian-born patients and only 13% of immigrants. Sixty-four percent of the immigrants, however, had markers for hepatitis B infection.

Another factor limiting the significance of alcoholic cirrhosis in immigrants is its higher prevalence in middle-aged and older populations. Immigrants are often somewhat younger than the general US population. About half of new immigrants are 25–44 years old (average age below 37), compared to less than 40% of the overall US population between 25 and 44 (average age above 37). And immigrants may be getting younger: in New York City, the average age of recent Irish immigrants was 24; Mexican immigrants to the United States are now entering at an average age of 21.5. Alcoholic cirrhosis is almost always diagnosed in patients over 35, often substantially older. Therefore, immigrants might be less likely to have alcoholic cirrhosis than natives for two reasons: they are younger on average, and most (with the exception of some European immigrants) come from countries where per capita alcohol consumption is lower and cirrhosis from alcohol less common.

Related Topics

- ► Alcohol use disorders
- ► Drug abuse
- ► Hepatitis
- ► Immunization
- ► Liver cancer

Suggested Readings

Batash, S., et al. (2008). High prevalence of hepatitis C virus infection among immigrants from the former Soviet Union in the New York City metropolitan area: results of a community-based screening program. *The American Journal of Gastroenterology, 103*(4), 922–927.

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Dodoo, M., Phillips, R. L., McCann, J. L., Ruddy, G., Green, L. A., Klein, L. S. (2005). Immigrants may extend the impending aging baby-boomers effect in this country further than anticipated. Abstract Academy Health Meeting. 22, Abstract No. 3055.

Palumbo, E., et al. (2008). Immigration and hepatitis B virus: Epidemiological, clinical, and therapeutic aspects. *Eastern Mediterranean Health Journal, 14*(4), 784–790.

Suggested Resources

Centers for Disease Control and Prevention. Viral hepatitis. http://www.cdc.gov/hepatitis/index.htm

Medical News Today. CDC recommends Asian, African immigrants be tested for hepatitis B. http://www.medicalnewstoday.com/articles/122293.php

Sixty-Second World Health Assembly, provisional agenda item 12.17, 16 April 2009. Viral hepatitis. Report by the secretariat. http://apps.who.int/gb/ebwha/pdf_files/A62/A62_22-en.pdf

Locura

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Locura has been referred to as a culture-bound syndrome; it is a term used by Latinos in the United States and Latin America to describe a severe form of illness. The term describes a concept of deviance from the norm due to mental illness. A person with locura may exhibit a variety of symptoms, including auditory and visual hallucinations, agitation or possible violence, inability to follow rules of social interaction, incoherence, and unpredictability. Locura is not considered a part of normal life. It is sometimes thought to be the result of supernatural maneuvers (*mal puesto*) of another person but may also occur naturally and without reason to the individual due to the effects of life difficulties. La locura is said to be stronger and more severe than a case of *nervios*. Within the culture, immigrants with locura are believed to have some sort of nervous system weakness. Mental health disorders such as schizophrenia are commonly defined as locura in many Latin American countries and by Latino immigrants in the United States. While others do not blame the individual for their physical illness, there is a stigma associated with locura as there is with most mental health issues. It is understood that the individual does not have the power to control his/her actions one-way or the other but indicates a physical problem. Latinos diagnosed with locura, or a severe mental disorder like schizophrenia, most often live with their families. Thus, families should be considered in the treatment and diagnosis of the illness.

Cultural anthropologists who researched the term "locura" have found that there are vast arrays of differences concerning its meaning within the culture. The various subcultures reported that la locura could occur as the result of child abuse, heredity, accidents, and brain tumors. Conditions such as a weakened mind (the result of thinking too much), and having nerves on the edge are thought to be other contributing factors to the syndrome. Locura is said to be weak or strong, in regard to its impact on the individual. Those with strong locura may not be cured and may commit suicide.

As there are various interpretations of locura, there is also a variety of treatment modalities that an individual may seek. Medical attention and psychiatric treatment or commitments are some of the recommended treatment options. However, consultation and treatment by a curandero (traditional healer) may be considered part of the treatment either alone or a combination with one of the above. It is important that factors in the Latino culture, such as the role that family plays in fostering specific values and beliefs, be considered in order to treat and assess locura. In treatment and diagnosis, culturally informed health care providers must recognize the role and influence of cultural factors, including patient beliefs, values, behaviors, and complementary health practices.

Related Topics

- ► Culture-specific diagnoses
- ► Hispanics
- ► Latinos
- ► Mental illness
- ► Schizophrenia

Suggested Readings

American Psychiatric Association (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text revision). Washington, DC: Author.

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Loneliness

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Loneliness means much more than merely a state of being alone. Environment alone does not define loneliness. Loneliness includes unwanted feelings of solitude; it may occur in the presence of others. It may include feeling forsaken, lack of identification with others, or feeling abandoned by others.

Loneliness is based on the person's subjective view, rather than necessarily being related to the objective view of others. Some feel lonely for psychological reasons, some for sociological reasons, and some for biological reasons. A review of over 8,000 people in twin and sibling studies found that genetics accounts for approximately half the difference in loneliness. The rather large research on the importance of attachment and bonding in early childhood has potential implications for loneliness later on in life.

Those who are experiencing true loneliness may experience an overwhelming feeling of separateness from others. They may experience anxious symptoms, depressive symptoms, and feel hopeless, meaningless, or resentful. These feelings, left unchecked, could progress to full-blown syndromes of depression and anxiety. Scales to measure loneliness have been developed. For example, the UCLA Loneliness Scale includes questions about having no one to talk to, feeling a lack of understanding, and feeling shut off from others.

Loneliness represents a public health problem and may be a particular problem for immigrants. One study evaluated the experience of loneliness among hundreds of immigrants from the former Soviet Union to Israel. They compared "distress-related loneliness" and "distress-free loneliness." They noted that while loneliness without distress was considered a normal reaction to a lack of satisfaction with the level of support they were receiving from others, distress-related loneliness was a more general negative experience in which the immigrant experienced other symptoms as well.

Another study followed almost 200 recent immigrants from the former Soviet Union to Israel for a 1-year time period. While 44% of the people demonstrated a normal pattern of permanent low-level distress, 33% had a positive pattern (showing decreasing distress or persisting moderate distress), and the final 23% had a negative pattern with persisting high distress or actually increasing distress. Those with a negative pattern had less social support, and increased stressors related to personality factors and lack of acceptance of the new host culture.

Many people have few close friends or relatives to confide in. Some may need to immigrate due to religious persecution or problems in their homeland. They may need to leave their support system and may become lonely in their new homeland.

Loneliness does not just occur in underpopulated areas. Indeed, those immigrating to large cities may feel cut off from others, and rather feel anonymous in a crowd. In industrialized large cities, there may be many rather temporary residents of various groups.

In the long term, loneliness has been correlated with mental health issues such as anxiety, depression, and alcoholism, as well as physical problems such as cardiac disease, cancer, stroke, elevated blood pressure, and sleep problems. Treatment when a person is lonely or socially isolated may include psychotherapy, which would explore negative feelings, and help the person to reach out and feel connection with others. Establishment of a support system in one's new area is also of importance. Additionally, the social aspects of various religions may be helpful for people experiencing loneliness.

Related Topics

- ► Acculturation
- ► Addiction and substance abuse
- ► Anxiety
- ► Depression

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Loss

- ► Ambiguous loss
- ► Culture shock

Low Income

- ► Poverty

Low Literacy Level

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Low literacy refers to limited ability to read, write, and comprehend. Low-literacy adults may be able to read and understand signs, box labels, and simple texts, but they lack the reading, writing, and inferential skills that are necessary for educational advancement, which promotes access to health care, economic improvement, and civic contributions. Furthermore, low-literacy adults cannot provide literacy experiences in the home environment that lead to reading and academic achievement.

Approximately half of adults who are of Limited English Proficiency (LEP) have low levels of literacy skills in English. These adults may have low literacy skills (1) because English is not their primary language, (2) due to limited educational opportunities in their primary language, or (3) because of unidentified language learning disabilities. Important predictors of a child's reading and academic success are the literacy levels of the parents or guardians and the quantity and quality of literacy activities in the home environment (e.g., books read by adults and to child or language interactions between adult and child). Hence, children in LEP immigrant home environments are at risk for reading and academic failure.

The challenges of providing intensive language education were highlighted by an elementary school in a rural agricultural community in northern California. With 48% of its students from LEP immigrant families, the school prepared a plan to improve the literacy skills of all students. In accordance with California Proposition 227, the school was an English-only school. English was not the home language for 98% of the children from the immigrant families. In a district with eight elementary schools, the school ranked eighth in reading achievement on state- and district-mandated measures. Previously, the school had employed literature-based reading curricula that had little emphasis on the teaching of sound-symbol correspondences and other language patterns (e.g., syllable division rules, spelling rules). Moreover, the critical role of oral language in developing comprehension and higher-order thinking skills was not completely understood by all the teachers. A major part of the school's improvement plan was to provide an intensive 30-hour professional development session to all teachers on research-based reading instruction as delineated by the National Institute of Child Health and Human Development. A master reading specialist observed the teachers to ensure fidelity of implementation.

In third grade, two teachers were rated as having high levels of implementation, and two teachers were rated as having low levels of implementation. The achievement of 46 third-graders was measured on a standardized reading test. Seventy-one percent of these students were from immigrant families. On the pretest, no statistically significant difference between classroom groups was found. All classroom groups demonstrated statistically significant gains on total reading scores on the posttest. Furthermore, a statistically significant difference between the reading achievement of students whose teachers demonstrated fidelity of instruction and the reading achievement of students whose teachers taught with less fidelity was found. Students, including those from immigrant families, made greater gains with teachers who had high levels of implementation. Although the sample sizes of teachers and students were small, preliminary data from an ongoing longitudinal study suggest that teachers who deliver explicit reading instruction with fidelity can help to close gaps created by low home-literacy environments.

Certainly, improving home-literacy environments would further enhance the results of the explicit reading instruction. Recent reviews of family literacy programs have advocated the development of programs that increase parents' literacy skills and provide parents with skills to support the literacy of their children. For example, parents in the aforementioned school could participate in literacy classes aimed at providing the most appropriate instruction to help them become more proficient readers and writers. In additional sessions with parents and children, teachers could model literacy strategies for parents, and parents could practice the strategies with their children and then use them at home. Thus, both parents and children would gain the literacy skills necessary for educational and economic advancement and full participation in society.

Related Topics

- ► Barriers to care
- ► Education
- ► Language
- ► Linguistic minority community
- ► Literacy

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www.barbarabushfoundation.com

www.nifl.gov

www.readingrockets.org

Machismo/Macho

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The Spanish term *machismo* is a common reference to Latino masculinity, in particular, the gender construction of extreme traditional masculinity or of the characteristic of the "true" man ("macho") in Latin American and Caribbean societies. The term is commonly employed within Latina/o communities inside and outside of the USA to refer to such males or the behaviors associated with those males. It has been theorized as a form of masculinity derived from the Spanish conquistadores. The complementary gender construct for Latin American women is referred to as *marianismo*.

While the term machismo has become part of the lexicon of lay people and social scientists, the exact definition, associated decontextualized characteristics, and applicability to most Latino men, is a matter of debate. Some researchers have noted that the initial social science descriptions and focus on machismo were obtained from particular populations of Latin American men and then simplified and generalized through an ethnocentric lens. Several scholars have studied the use of the term in the social sciences and have found that machismo as a concept is not well defined or consistently defined in the literature with various characteristics being attributed to the concept without a systematic approach to understanding the larger social context and the diversity among Latino masculinities.

In some of the earliest research, machismo is represented as a constellation of characteristics (referred to as the "machismo complex") while in more recent works it may simply refer to any form of sexism or attitudes that place males in a dominant position over females and other males. The various characteristics attributed to machismo in the social science literature include: male domination and female subordination; the control of female behavior and sexuality; the use of physical and verbal aggression; drunkenness; the refusal to do anything perceived to be feminine; a strong sexual drive with little social constraints; and a desire to father many children, in and out of legal unions, as a sign of virility and conquest of women. Machismo has also been linked to concepts such as invulnerability, courage, honor, respect, and dignity, in particular, around issues of the family, veneration of their mothers, and a sense of obligation to protect and provide for their family. While these characterizations have been seen by some researchers and programs as positive attributes of Latino masculinity, some feminist scholars have cautioned about the underlying power and gender inequality issues also related to these attitudes and behaviors.

Machismo does not prevent men from engaging in sexual intercourse with other men as long as the man takes on the active ("activo") or inserter role in sexual intercourse. The male who is sexually receptive ("pasivo") is placed in the role of the woman and is therefore, the homosexual. This conceptualization of Latin American same-sex sexualities and behaviors is also beginning to be questioned in terms of the rigidity of these roles.

The lack of a clear and consistent definition of machismo as well as the simplistic use of the term leads to its application in research and programs in contradictory ways. For example, research findings that show Latino men do not use condoms can be attributed to machismo. Yet, when Latino men use condoms to protect their partners, it can also be attributed to machismo. Therefore, machismo can

Sana Loue & Martha Sajatovic (eds.), *Encyclopedia of Immigrant Health*, DOI 10.1007/978-1-4419-5659-0,

be seen as both the problem and the solution. Yet, both sets of findings are attributed to a concept that is not directly being studied within the research. Another issue associated with US research utilizing the concept of machismo is the assumption that those behaviors are more likely to be found among immigrants, and that through acculturation males shed machismo and become more egalitarian. This assumption does not take into account the various forms of masculinities in Latin America, the Caribbean, and the USA as well as the social structural factors contributing to particular forms of masculinity. Characteristics similar to machismo are described among Puerto Rican youth born and raised in urban centers in the USA. These characteristics (referred to as Coolin) have been linked to inner-city masculinity, which developed as a response to social inequities within the USA.

In any given population of Latino males, the elements described as *machista* may vary in magnitude or be absent. Latino males may subscribe to different male roles, standards, and types of masculinities. The social science literature shows that the behaviors and beliefs associated with machismo vary across Latin American regions, ethnic groups, age cohorts, socioeconomic status, sexual orientation, geographical locations, and historical periods. Although machismo commonly is presented as a unique phenomenon of Latina/o culture, researchers also have used this term to describe masculinity in a variety of non-Latino cultures. It is a product of the relationship between masculinity and power and framed by the larger socioeconomic and political terrain. The colloquial and frequent usage of the term macho by the media and the general population to describe any form of sexism or hypermasculinity by any individual from a variety of cultural or social groups implicates Latinos as the reference point for such behaviors. Thus, it can create the danger of reducing all Latino men to a decontextualized stereotype.

Related Topics

- ► Family
- ► Homosexuality
- ► Latinos
- ► Women

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Mal de Ojo

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Mal de ojo is a Spanish term meaning "evil eye," which is frequently used to refer to a culturally specific illness common in Latin Americans and Latino immigrants in the United States. The origin of mal de ojo has been traced to the Eastern Mediterranean and Greco-Roman traditions, although many variations of this syndrome have existed for thousands of years. The widespread belief of the evil eye in Latin America is credited to the Spanish colonizers who brought it to the continent, amid combinations that resulted from indigenous and folk-healing systems. In Brazil, the equivalent for the evil eye is called "olho gordo" or "mau olhado," that is translated as "fat eye." Among Latin American popular cultures mal de ojo is generally believed to be caused by a strong stare full of jealousy, envy, or admiration directed at either vulnerable or perceived weaker individuals such as women or children. Certainly, babies and infants are considered at special risk for the evil eye, given the fact that childless parents and women may admire and want them. Mal de ojo typically occurs when the child is the object of a strong stare without being touched by the person. Smiling or paying too much attention to a child can also result in mal de ojo. Therefore, protective measures include allowing, and even encouraging, strangers to touch children.

Different symptoms, preventive measures, and methods of treatment have been associated with this syndrome. Symptoms of mal de ojo often consist of fatigue, headache, weight loss, exhaustion, and malaise. Gastrointestinal symptoms may also include desiccation and dehydration, as well as crying and irritability. Wrapping children's wrists with red laces and ribbons are considered as affective talismans against mal de ojo. In addition, it is widely accepted that some people can unintentionally cast a curse on others. The mere act of *ojear* is actually understood as giving someone the evil eye as an involuntary act that is rooted in deep envy or jealousy. In fact, individuals with "mirada fuerte" (heavy look) are considered as potential doers of mal the ojo. They may *ojear* babies, animals, or inanimate objects just by staring and wanting them.

The evil eye may result in diseases, and even death, among the living and in failure of working inanimate objects, such as cars. The figure of the *curandero* is sought to prevent and cure the evil eye among other folk illnesses. A curandero is an important community-based folk healer held in high regard by Latin American transnational communities and Latino immigrants. Curanderos usually treat this illness through a series of rituals aimed at ridding the victim from the strong power caused by the stare. "Cleansing" is one of the preferred healing methods that involves saying prayers while passing a raw chicken egg over the body, in order to absorb the evil power of the person who casted the spell. In Southwestern United States and some regions in Mexico, the egg is then broken and left in a bowl of water under the victim's bed overnight. Finally, the egg is examined the following morning to assess success – the shape of the yolk will tell the curandero if the aggressor was a man or a woman. Other treatments involve a *barrida*, or ritual sweeping of the individual with medicinal herbs.

While mal de ojo has historically been dismissed by conventional medicine as a benign folk disease, research has shown that individuals suffering from this condition have very real physical symptoms that often need immediate medical treatment. In some cases, this syndrome can be life threatening if not addressed. Researchers are currently investigating mal de ojo in relation to diseases readily diagnosed in conventional medicine. In this vein, several studies have found that the evil eye is thought to be the cause of several medical conditions including upper respiratory infections, the flu, and viruses.

Related Topics

- ► Access to care
- ► Alternative and complementary medicine
- ► Communication barriers
- ► Cultural competence
- ► Cultural humility
- ► Culture-specific diagnoses
- ► Curandero
- ► Transnational community

Suggested Readings

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Malaria

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Immigrants are also distinguishable from other mobile populations by several characteristics that determine health and disease outcomes. One of these characteristics is directly related to the process of migration and the source and transition countries through which they have moved prior to arrival at their destination. For diseases like malaria that have a defined geophysical limit to the areas of endemic transmission and biological limitations on their incubation periods, the impact of this disease on incoming immigrants is both predictable and inevitable. There are four species of human malaria: *Plasmodium falciparum*, *Plasmodium vivax*, *Plasmodium ovale*, and *Plasmodium malariae* all of which are transmitted by the bite of a mosquito. Blood transfusion, shared equipment during intravenous drug use, and maternal-to-child transmission of malaria occur very rarely.

Of the 108 countries with endemic malaria, only 31 are considered "high impact" countries, most of which are in sub-Saharan Africa. The adverse impact of endemic malaria is almost completely due to *P. falciparum* and its associated morbidity and mortality particularly in children and pregnant women.

In low-transmission but malaria endemic countries, adults may not develop semi-immune or immune status due to frequent exposure to *P. falciparum* and as a consequence may also experience severe illness and death due to this infection. This includes many urban dwellers particularly in sub-Saharan Africa and those who use personal protective measures against mosquito bites and malaria; they may have a similar risk as nonimmune travelers for serious or fatal malarial infections.

Public health epidemiological reports from low to middle income immigrant recipient countries may be challenging to interpret for several reasons. The immigrant-receiving country may also be a malaria endemic area and differentiating where the infection was acquired may be difficult. Epidemiological reporting requirements may not include either malaria or the administrative classification of the affected person. Several epidemiological reporting systems exist in high income countries where malaria generally is not transmitted so that virtually all cases of this disease must be imported. In the USA, approximately half of all reported cases of malaria occurred in immigrant travelers. Immigrant travelers, often also called "visiting relatives or friends" (VFR) travelers, are foreign-born nationals, and sometimes their spouses and locally born children, who return to ancestral homes. Their travel characteristics differ from other travelers such as businesspersons or tourists in location (more often rural), accommodation (non-hotels), duration (longer), and the intent (to visit friends or relatives), as well as other characteristics. In the US report, 70% of VFR-associated malaria was acquired in West Africa, reflecting the immigration source region and risk for return travel to a hyperendemic malaria transmission zone.

Management Considerations

Fever in a migrant (of any nature) to any malaria transmission area should be considered a medical urgency. Appropriate clinical assessment, diagnostic testing, and treatment are essential. Incoming immigrants rarely arrive *in bulk* as occasionally occurs with planned refugee movements that provide a window of opportunity for mass treatment of incubating diseases like malaria. For many reasons, immigrant or VFR travelers do not access, do not have available, or cannot afford pretravel advisory services for the prevention of malaria.

Prevention of malaria in immigrants and the prompt and professional management of malarial illness will reduce personal morbidity and mortality, and also minimize adverse impacts on health care service and delivery systems.

Disclaimer

The opinions expressed in this entry are the author's alone and do not necessarily represent the position of any institution, agency, or society that the author is associated with, currently or in the past.

Related Topics

- ► Africa
- ► Border health
- ► Chronic disease
- ► Health disparities
- ► Immunization

Suggested Readings

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Malnutrition

► Food
► Food insecurity
► Nutrition

Mammography

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Breast cancer is the most common cancer diagnosed in women worldwide. In low- and middle-income countries (LMC), also referred to as underdeveloped and developing countries, the incidence of breast cancer has increased in the past few decades. This has been associated with risk factors linked to the Westernization of dietary patterns as well as changes in physical activity. Also, infectious disease, which was responsible for a large portion of deaths in lower resource countries, has declined. People who would have died from infectious disease are growing older and age is a well-documented risk for breast cancer. Recent global efforts to promote breast cancer detection identify more cases; newer data collection systems, such as cancer registries and atlases, are better equipped to record breast cancer events. Thus, the coupling of reduced death from competing risk with improved screening and recording systems has contributed to increased breast cancer rates globally.

Mammography screening is the best method of breast cancer detection. Implementing breast cancer detection programs in LMC as well as in resource-poor areas of developed countries is difficult. In recent decades, policy makers and providers have made notable inroads to changing this. Still, even when poor, immigrant and minority women do have mammograms, they continue to be diagnosed for breast cancer at later stages when treatment is either more complex and sometimes near impossible. Consequently, the 5-year survival of breast cancer varies widely from 81% for the general population in the United States to 32% in sub-Saharan Africa.

Well-intended efforts seeking to promote mammography screening face substantial barriers beyond structural and access issues. Cultural barriers are particularly difficult to overcome. The target population may perceive mammography screening as the beginning of a process leading to disfigurement, disability, and death. Cultural barriers are especially apparent where mammogram screening is widely available. In Europe, Israel, and North America, for example, researchers have documented screening disparities in immigrant and minority women.

Remennick details structural and organizational barriers to mammography screening with an emphasis of immigrant women to Israel but cites similar barriers in the United States. She describes qualitative research demonstrating poor women are socialized to be caregivers. Therefore, any behaviors that would potentially cause them to become burdens to their families are typically avoided. This reiterates the need for efforts to promote and increase mammography screening to address sociocultural issues. She provides a concise table enumerating barriers to mammography screening; these barriers include structural, e.g., lack of transportation; organizational, such as language; psychological, such as a fear of cancer; and sociocultural, which includes women's subservience in the household and family. Many of these same barriers have been recently documented as being pertinent to Asian immigrants in the United States.

The focus of this paper will be Latin American women and women of Latin American origin residing in the United States and henceforth referred to as Latinas who face both structural and cultural barriers to mammography screening. The United States Census designation for this population is "Hispanic" and the terms may be used interchangeably depending on the original source cited. These women, for the purposes of health services research, are classified as minority in the United States; a subset of these women is immigrant with diverse levels of acculturation. This distinction is made as much of the available literature cites acculturation as affecting adherence to mammography screening even though the relationship is modified or confounded by other variables such as English language proficiency. English language proficiency helps navigate the health care system but more importantly allows women to be employed in the primary labor market where they are more likely to have access to health insurance. Moreover, there is evidence that only a third of Latina immigrant women residing in the United States less than 10 years have had a mammogram in the past year. Further examination reveals that Latina immigrant disparity differs by country of origin and is attenuated by higher socioeconomic status.

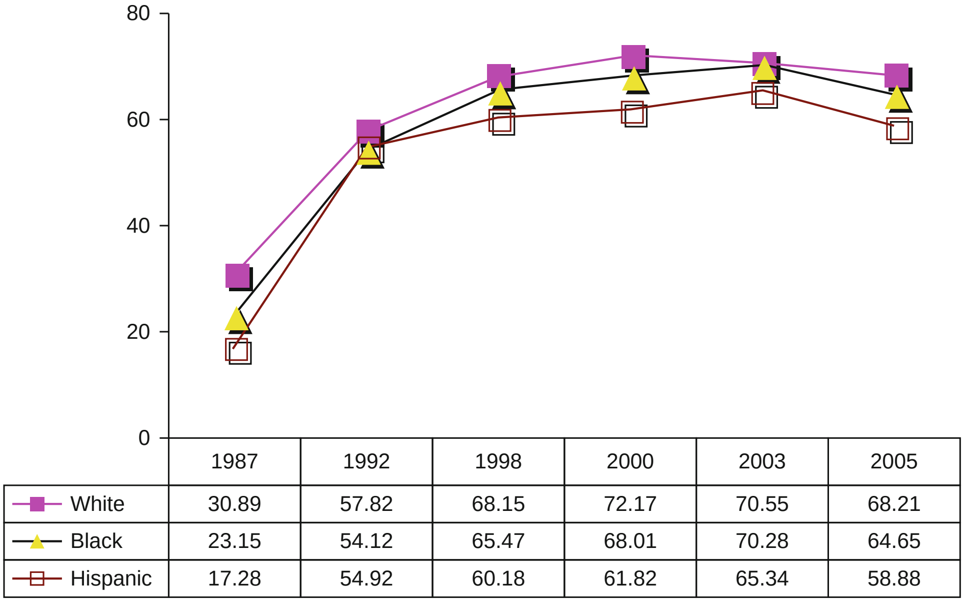
According to the American Cancer Society and the National Cancer Institute, breast cancer is the most common cancer diagnosed in women in the United States. It is the second cause of cancer death in White women and the primary cause of cancer death among Latinas. In other words, Latin American origin women living in the United States have cancer mortality rates that mirror those of women living in low- and middle-income countries. Although mammography rates, which affect incidence and mortality, have been repeatedly shown to be slightly lower in Asian immigrant women, breast cancer mortality is currently higher among Latinas.

Previous to 1989, in the United States, national mammogram rates were lower than 50% and not available by Latin American ethnicity. Since 1989, expanded media coverage coupled with public, private, national, and local efforts have championed the use of mammography to reduce breast cancer morbidity and mortality. Despite the resulting increases in mammogram screening rates, Latinas continue to be diagnosed at later stages, when breast cancer treatment options are more limited.

Data from 2002 to 2006 indicate 55% of breast cancers among Latinas in the United States were diagnosed at the local stage, compared to 63% of cases among White women. They are also more likely to be diagnosed with larger breast tumors and approximately 20% more likely to die of breast cancer than White women diagnosed at a similar age. Many reasons have been suggested for this difference in breast cancer outcomes. Historically, Latinas in the United States have had lower mammogram rates than their White and African American counterparts. The screening and treatment differences have been attributed to various causes and parallel results from studies done with other immigrant and minority groups both in the United States and in other Western countries. These range from cultural belief systems, health care access issues, and insurance status. More recent research has focused on immigration status and citizenship.

PubMed, a service of the United States National Library of Medicine, as of this writing, registers 237 articles found using search terms "Latinas and mammogram" and 312 using search terms "Hispanic women and mammogram." These go back to the 1980s and cover diverse subtopics. Most studies rely on self-reported data from surveys. A large number of studies involve secondary data analysis from national surveys. These include the National Health Interview Survey (NHIS). Screening data from the NHIS are depicted in Fig. 1.

The NHIS is the principal source of information on the health of the civilian noninstitutionalized population of the United States. It is a household survey. A subcomponent of the NHIS, the The Medical Expenditure Panel Survey (MEPS) collects additional data on respondent health care expenditures. This includes data collected from the respondents' medical insurance providers, as well as employers. Other self-reported mammogram data are compiled from the Center for Disease Control (CDC)'s Behavioral Risk Factor



	1987	1992	1998	2000	2003	2005
■ White	30.89	57.82	68.15	72.17	70.55	68.21
▲ Black	23.15	54.12	65.47	68.01	70.28	64.65
□ Hispanic	17.28	54.92	60.18	61.82	65.34	58.88

Mammography. Fig. 1 Mammogram data from the NHIS (modified from Reyes-Ortiz et al. 2006)

Surveillance System (BRFSS). The BRFSS is the world's largest ongoing telephone health survey system, tracking health conditions and risk behaviors in the United States yearly since 1984.

Smaller surveys have been conducted and analyzed as primary data sources. Focus groups have helped gather qualitative data not easily available from surveys. Finally, a very small portion of published studies are derived from insurance claims. When claims data have been evaluated compared to self-reported data, the latter have been consistently higher. These diverse data sources contribute to our knowledge base and might best be evaluated as pieces of information that may be helpful in better understanding this health care gap, thereby allowing us to design more appropriate interventions. They should also, however, be evaluated with caution and a clear understanding of potential biases including, but not limited to, recall and selection bias. Recall bias is not relevant to insurance claims data but Latina women are less likely to be insured than their African American or White counterparts.

The United States federal government supports two initiatives to help improve access to mammography services. The Breast and Cervical Cancer Mortality Prevention Act of 1990 established the Centers for Disease Control and Prevention (CDC)'s National Breast and Cervical Cancer Early Detection Program. Under this program, the CDC makes grants to states to provide mammography services to medically underserved women, especially those with low incomes and without health insurance coverage. Although the program has historically covered only about 20% of eligible women, the goal is to cover all eligible women. Program availability, however, has been hampered following the new United States Preventive Services Task Force guidelines recommending screening start at age 50. The second national public initiative relates to coverage for screening mammography under Medicare, the federal government's health insurance program for people age 65 and older and certain disabled people. Additionally, in 2000, the United States Congress passed the Breast and Cervical Cancer Treatment and Prevention Act to facilitate follow-up services, through individual state-managed Medicaid programs, to medically underserved women who are found to have breast or cervical cancer or a related precancerous condition.

Eliminating mammogram disparities became a national Healthy People 2010 goal. Healthy People 2010 provides a framework for prevention for the United States. Additionally, compliance with mammography screening became a quality metric (in the private sector under HEDIS or the Health Employer

Data Information Set) used to compare health plans. The Healthy People 2010 goal of screening 70% of eligible women was not met and disparities continue even among privately insured women.

Before further summarizing the literature on mammogram compliance and Latin American origin women in the United States, it may be useful to acknowledge the diversity of the population. Latin American individuals originate from one of more than 40 countries and may speak a language other than Spanish, such as Portuguese, French, English Patois, and Dutch, as well as an indigenous language. Since the largest and first immigrant group is Mexican origin, much of the available research has focused on this group. Generalizing to other groups should be done with caution. Within-group variation, due to variables ranging from longer residency in the United States to civil status (e.g., refugee, documented, citizen), also affects subgroup heterogeneity.

The second point worth discussing before exploring more research on Latinas and mammography utilization relates to a technological divide between the United States and Latin America. Mammogram technology was introduced in the United States in 1960, but modern mammography has been available only since 1969 when the first x-ray units dedicated to breast imaging were available. By 1976, mammography as a screening device became standard practice and a guideline of the American Cancer Society. Mammogram technology continues to improve as lower doses of radiation now detect even smaller potential problems earlier.

Mammogram facilities and licensed radiologists are common in the United States. This is largely due to the Mammography Quality Standards Act (MQSA) – a Federal law passed in 1992 intended to guarantee mammograms be safe and reliable. Through the MQSA, all mammogram facilities in the United States must meet stringent quality standards, be accredited by the Food and Drug Administration (FDA), and be inspected annually. The FDA ensures that mammography facilities across the country (and Puerto Rico) meet MQSA standards. These standards apply not only to the facility but also to (1) the technologist who takes the mammogram, (2) the radiologist who interprets the mammogram, and (3) the medical physicist who tests the mammography equipment.

In 1997, Mexico's public health department documented that there were 330 mammogram facilities in all of Mexico and 43 radiologists who were certified to read a mammogram. To put this in perspective, California has 729 FDA-approved mammogram facilities; New York, Texas, and Florida, where a large part of the Latino population reside, have 561, 520, and 508, respectively. The United States General Accounting Office (GAO) reports that from October 1, 2001, to October 1, 2004, the number of mammography facilities nationwide decreased from 9,306 to 8,768 but is still adequate, albeit not in all areas.

According to 2005 mid-decade United States Census across ethnic subgroup, 40% of all Latinos in the United States were foreign born and most were of Mexican origin. Among Central American and South Americans approximately 67% and 72%, respectively, are foreign born. Recent immigrant women may not have had access to mammogram technology or may not have had a relative in their countries of origin that had a mammogram. More information on this has become available as a result of the Pan American Health Organization's Salud, Bienestar y Envejecimiento (Health, Well-Being, and Aging) also known as the "SABE" survey.

The SABE study population was 6,207 women aged 60 years or older living in various Latin American and Caribbean cities. Older age, higher education, and health insurance status were strong predictors of mammography use. Women without insurance and with public insurance had 70% and 46%, respectively, lower odds for having a mammogram than women with private insurance. Table 1 presents the survey variables associated with mammogram utilization. An odds ratio greater than one means a woman was more likely to have a mammogram. An interesting finding is that being married, which tends to be associated with having a mammography, had the inverse effect on women in Mexico, where married women were less likely to have had a mammogram. Much has been written on the topic of male Mexican machismo and, in this situation, because spouses would have been older, machismo may have played a role. Moreover, this is consistent with Remennick's qualitative research documenting that women in male-dominated societies are less likely to have mammograms. Across all Latin American sites, medical conditions increased the

Mammography. Table 1 Odds ratios (95% confidence intervals) for mammography use in the prior 2 years for women aged 60 years or older, by city, 1999–2000 (source: Reyes-Ortiz et al. 2006)

	Buenos Aires *n*=603	Bridgetown *n*=993	Sao Paulo *n*=1167	Santiago *n*=777	Havana *n*=1,143	Mexico City *n*=690	Montevideo *n*=834
Age (years)	0.92 (0.89–0.95)	0.95 (0.93–0.97)	0.95 (0.93–0.97)	0.93 (0.90–0.96)	0.94 (0.91–0.97)	1.01 (0.98–1.04)	0.97 (0.94–0.98)
Married	1.41 (0.92–2.14)	1.51 (1.07–2.13)	1.28 (0.98–1.68)	2.19 (1.48–3.23)	1.13 (0.72–1.78)	0.58 (0.35–0.97)	2.40 (1.72–3.35)
Education (years)	1.14 (1.08–1.20)	1.05 (0.99–1.10)	1.04 (0.99–1.09)	1.06 (1.03–1.10)	1.01 (0.96–1.07)	1.10 (1.05–1.16)	1.05 (1.01–1.09)
Public/military insurance[a]	0.40 (0.21–0.76)	0.40 (0.16–0.99)	0.47 (0.36–0.61)	0.49 (0.23–1.06)	–	0.28 (0.11–0.76)	0.96 (0.66–1.40)
No Insurance	0.22 (0.09–0.51)	0.31 (0.19–0.50)	0.08 (0.02–0.34)	0.16 (0.06–0.45)	–	0.30 (0.10–0.85)	0.26 (0.03–2.10)
Number of medical conditions	1.13 (0.92–1.39)	0.93 (0.79–1.09)	1.11 (0.98–1.25)	1.11 (0.93–1.33)	1.35 (1.13–1.60)	1.08 (0.86–1.37)	1.00 (0.86–1.17)
Number of IADL difficulties	0.90 (0.72–1.12)	0.87 (0.69–1.09)	0.88 (0.80–0.96)	1.00 (0.89–1.13)	0.90 (0.76–1.07)	0.91 (0.76–1.07)	0.98 (0.81–1.19)

Odds ratios were adjusted for all variables in the table using logistic regression; medical conditions include arthritis, diabetes, hypertension, heart attack, and stroke

IADL instrumental activities of daily living

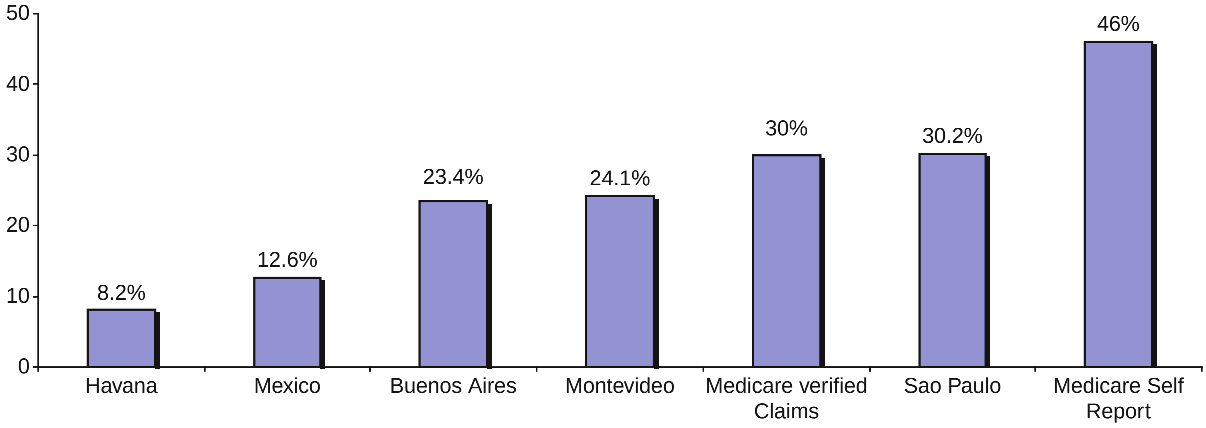
[a] The comparison group is private insurance

likelihood of having a mammogram probably because the woman had a usual source of care. Across studies, having a usual source of care whether that is a private physician or a clinic has been overwhelmingly associated with mammogram compliance. Alternatively, women with functional disabilities were less likely to have mammograms probably due to competing priorities.

Predictors of mammogram in the first SABE survey parallel those in the United States where women with higher levels of education and private insurance have higher screening rates. Two more issues related to the SABE study merit attention. These involve geography and knowledge. The SABE study sampled cities. Women from smaller cities or rural areas are not likely to have easy access to mammogram facilities. Also, the data were self-reported and still very low. This suggests that most women did not see value in (falsely) reporting something they may not have recognized as important. The mean age of the SABE study participants was 70 across study sites. This is comparable to the United States Medicare population. Figure 2 depicts the proportion of SABE survey participants who reported having a mammogram in the past 2 years and compares them to a Latina Medicare population where self-reported data were verified with claims data. The graph underscores the risk of recall bias and demonstrates that Medicare claims data mirror self-reported data from at least one SABE site, Sao Paulo.

A notable finding from the SABE survey is that privately insured women are more likely to have had a mammogram. Most women in Latin America have public insurance. However, in the United States, Latinos are less likely to have any insurance coverage compared to their White or African American counterparts. Still, much of the research published on the Latino population points to the protective effects of having insurance. That protective effect may be linked to the fact that, since the early 1990s, United States health plans have reported quality metrics to the National Committee for Quality Assurance (NCQA) and mammogram compliance for women ages 50 and older is a quality metric.

A Harvard study analyzing NCQA quality metrics across ten health plans discovered that sociodemographic characteristics associated with individual member's area of residence were related to performance measures such as mammogram screening.



Mammography. Fig. 2 Mammogram prevalence within the last 2 years SABE survey participants and medicare Latinas (source: Pelaez et al. 2000)

Sociodemographic data were not specific to each enrollee but rather were estimated from Census data. The findings, however, do reiterate that minorities, low-income and poorly educated individuals, immigrants, are less likely to have recommended medical services. These findings are especially salient because screening differences were found among commercially insured members within the same health plans and therefore were not attributable to differences in insurance coverage.

A number of possible factors may be associated with these detrimental neighborhood effects. Low-income, recent immigrant, and minority populations are concentrated in geographic areas that may have difficulties in recruiting and retaining physicians; poor transportation to health facilities may affect screening rates. Additionally, lower-income, less-educated health plan members may be less aware of the importance of mammogram screening. This finding does not undermine the importance of insurance coverage but does suggest the need to better understand other potential screening barriers.

The research on acculturation and sociodemographic variables has recently taken a new angle. Historically, English language usage was used as a proxy for acculturation. More recent studies have operationalized the concept of acculturation by using citizenship as a proxy. Citizenship requires legal residency in the United States for 5 years and a basic level of English proficiency. This is not only a cultural variable but affects a woman's ability to find work and, therefore, improves her chances of securing health insurance. Women with greater English proficiency are more likely to be eligible for employment that allows them to take time during their work day to have medical care. These are jobs where employees are salaried and not paid in hourly wages. Finally, English proficiency helps a woman better navigate the health care delivery system.

Citizenship is associated with higher mammogram rates. However, the American Cancer Society reports that Central and South American women, who according to census data are more likely to be recent immigrants than Mexicans, have higher mammogram rates than Mexican women. Foreign born women are more likely not to have had a mammogram but this is reversed when socioeconomic status and insurance coverage are evaluated. Recent analyses of National Health Interview survey data reiterate the role of acculturation in mammogram screening compliance.

The older literature on Latino health issues espoused cultural models that described a fatalistic world view that could be equated with an external locus of control. For example, Hazuda, Stern, and Haffner characterized Hispanics as prone to use unconventional medicine and being fatalistic: “Mexican Americans as a whole had a certain ‘cultural tenacity’ about maintaining a religious orientation which places a high value on doing God's will, an outlook about factors influencing one's state in life which emphasizes luck and living for the present, and an attitude toward health and death which is largely fatalistic.” The older research placed more emphasis on belief systems, which in the absence of access to medical care, would have been protective and may have made sense to a low-income, low-literacy immigrant population. Recent research involving focus groups and Latino scholars has examined fatalistic beliefs and found that, in light of other variables, these are less related to noncompliance with health issues than was once believed. Given the elapsed time between the fatalistic studies and more “modern” beliefs, this may be a sign of later generational acculturation.

Mammography data has been available by Latin American ethnicity for approximately two decades. In that time period, mammogram rates have improved but the gap between Latina and White women persist. The more recent literature has examined structural variables affecting access to care and once these are examined, differences in screening are significantly reduced. Having health insurance has been widely cited as being a predictor variable as has having a usual source of care. These are important because they are characteristics that policy and decision makers can affect. But as many researchers have discussed, less acculturated women into the host society require culturally relevant interventions. Table 2 provides a summary of recommendations made elsewhere by Remennick that may help improve breast cancer screening among minority and immigrant women.

Mammography. Table 2 Approaches to improving use of breast-screening services among immigrant and minority women in multicultural societies (source: Remennick, 2006)

Macrolevel approaches
Conduct community needs assessments
Ensure women’s access to breast-screening services
Motivate health care providers to perform screening and to ensure follow-up
Train providers in culturally competent care for immigrant and minority women
Include more immigrant and minority providers in screening activities
Train community outreach workers
Increase the involvement of men in breast cancer and early detection
Involve alternate and traditional healers in breast cancer advocacy
Engage breast cancer survivors in educational and screening efforts
Microlevel approaches
Empower women and improve their self-efficacy and self-care
Educate women about navigating complex health systems
Dispel popular myths about cancer and breast cancer
Encourage a proactive approach in cancer detection
Educate women about contemporary cancer therapies
Elevate the ranking of breast health on the list of women’s health concerns

Related Topics

- ► Access to care
- ► Acculturation
- ► Barriers to care
- ► Gender role
- ► Health determinants
- ► Machismo/Macho

Suggested Readings

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Managed Care

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Just how managed care impacts immigrant health or how the facts regarding immigrant health have implications for managed care practices are not issues easily analyzed. One challenge comes from neglect by researchers of the conjunction of the two. Managed care has been extensively studied, and excellent reviews exist. While far from comprehensive, an empirical basis also exists for profiling health-related characteristics of immigrant populations, including modest attention to issues potentially related to managed care, such as access, costs, and quality of care. Nevertheless, investigations reporting on both immigrant status and managed care remain very much the exception. A second, more far-reaching challenge comes from the complexity, variety, and constantly changing character of the social phenomena falling under the "managed care" and "immigrant" labels which, we discuss in what follows.

Managed Care

The term "managed care" describes a motley and controversial collection of administrative practices designed to eliminate wasteful health care spending while promoting practices that save money and/or improve health outcomes. It is motley because, historically, the term has been applied to a variety of business and organizational strategies that typically share little more than an intention to alter behavior to promote efficiency. It is controversial because, although most observers would agree that some cost-saving strategies come from superior health care such as better preventive care, patient education, or monitoring of chronic conditions, critics charge that some cost-containment measures deny payment and limit liability even for needed care through tactics sometimes referred to as "rationing by hassles."

In most respects, managed care is a development of the US health care system. While health care systems outside the USA confront many of the same challenges that motivate managed care – the need to use limited resources efficiently, integrate and rationalize care, and organize incentives to promote system priorities – the most characteristic features of managed care reflect the distinctively American reliance on widespread high-cost technologies, an insurance system whose tight connection to employment is supported by tax policy, a fee-for-service delivery system that produces higher revenues for providers who deliver more services, and a historical aversion to direct government influence on costs of care (outside public insurance programs).

Several types of organizational arrangement have been described as managed care. The name Health Maintenance Organization (HMO) dates from the 1970s and refers to an organized care delivery system supported by premiums, either for profit or nonprofit. An HMO may own hospitals, lab services, and the like and employ MDs to treat members (a "staff model"); contract with hospitals and a physician group that pays MDs (a "group model"); or contract with multiple physician groups (a "network model"). A combination of federal incentives and regulation initially encouraged the creation of HMOs, but further evolution in managed care was driven by corporations' efforts to respond to the impact of rising costs, which forced them to devote more and more of their labor costs to health insurance. The resulting demand for cost-containing organizational innovations was more often met by for-profit firms supplying administrative oversight than by HMOs supplying health care. (An example is the decision by individual medical practices to form Independent Practice Associations (IPAs) to contract as an organization for per capita fees.)

Over the past decade, managed care organizations have come to resemble distinct types less than various ways of bundling an assortment of strategies and techniques. A review of these illustrates how the logic of efficiency has developed under managed care.

One set of strategies uses oversight to stop provision of more, or more expensive, care than is really needed. While the problem of excessive care (by some definition) may partly reflect patient demand, the assumption of managed care is that it reflects the incentives of a fee-for-service system in which providers make more money when they provide more procedures (including some that may not be strictly necessary). "Utilization review" requires examination of medical procedures by a third party who can challenge or authorize payment. Specialty care is a particular target. It is expensive, and most efficiently used when reserved for cases that require additional levels of training and technology. Cases that can be effectively treated by a primary care physician should be. When care is managed, a payer may require patients to get a referral from their primary care physician, whose job it is to determine whether the more expensive service is warranted, a function called "gatekeeping."

"Capitation" combines organizational and financial strategies to reverse the incentive structure by contracting with a physician or provider group to supply needed care to anyone in a designated group in exchange for a set amount for each person in the group. With this arrangement, unnecessary procedures reduce the providers' income, making them both more likely to provide no more care than is needed and to keep patients healthy. In practice, capitation may require providers to assume more financial risk than can be efficiently managed, since the costs of a given provider's patients may be hard to predict and prone to fluctuate significantly from year to year based on the very high costs of a small number of patients. A consequence is that providers may use part of the capitated fee they receive to purchase insurance to limit their liability for these very high cost patients.

Other strategies focus on increasing patient engagement in care by promoting prevention, fostering self-care, and trying to make sure patients do not "fall through the cracks" of an often fragmented and poorly coordinated delivery system. A "case manager" is someone who tries to make sure a patient gets the services they might need from a number of different sources. For example, a patient just discharged from the hospital may need to keep a range of appointments, arrange for transport, get complex prescriptions, arrange for consultations, and the like. A case manager's job is to make sure these things get done. Sometimes primary care doctors are expected to provide a medical home that coordinates care among many providers. (This coordination function is not always sharply distinguished from the resource management "gatekeeping" function mentioned earlier.)

Disease management interventions and groups may be provided to educate patients about their illness, medications, and desired behavioral changes – particularly for chronic illnesses. These range from simple, low-cost innovations such as reminders for medication refills, vaccinations, and check-ups, to more extensive investments, such as nutritional consulting or subsidies for exercise programs. Financial disincentives for preventive care may also be reduced by lowering or eliminating co-payments or reducing deductibles.

Immigrant Health

According to Larsen (2004), approximately 12% of the US population is foreign born, and this group is quite heterogeneous. Immigrants differ considerably in characteristics likely to exert direct or indirect influence on health and health care utilization, including country of origin, race/ethnicity, religion, family structure, language, educational attainment, and occupational and socioeconomic status. Differences in legal status are also important, with estimates suggesting the 12% figure is approximately equally distributed among naturalized citizens, legal permanent residents, and undocumented immigrants.

Insofar as managed care strategies represent efforts to control payer costs through oversight, care integration, and health promotion, the first questions to be answered concern how health care for immigrants is financed and how much it costs. The most important generalization in this discussion – that most evidence indicates immigrant health care costs are lower, not higher, than native born – is doubly significant because it is often unrecognized, and is poorly understood. Indications that, overall, immigrants are less costly users of health care services than are US natives are particularly striking, since figures include low frequency, high-cost utilization, such as in emergency room settings, which sometimes are used as a first point of contact for those with no usual source of medical services. Despite concerns over costs of caring for undocumented immigrants sometimes voiced in political disputes, a study by Goldman and colleagues found that figures based on the Los Angeles County Family and Neighborhood Survey suggested per capita costs for undocumented patients were 39% of their native-born counterparts for men and 54% for women. Extrapolating from these data, these researchers estimated a national health care price tag of $6.4 billion for undocumented individuals, 17% of which is funded by public sources.

There is little disagreement that health care spending by immigrants is likely influenced by multiple factors, although the contribution of each is difficult to determine. One influence is dubbed the “healthy immigrant” phenomenon. Most studied among Latino groups, data suggest immigrants arrive in the USA in better health than US natives as measured by indices such as mortality rates, despite exposure to a variety of risk factors for poorer health (e.g., higher rates of poverty, lower education, lower insurance, and less access to care). Hypotheses for this effect include selective migration, in which those who chose to emigrate are particularly healthy; additionally, there may be home-country protective factors that are lost with acculturation in the USA. A second influence that depresses spending may be high rates of uninsurance, with especially sizable rates among low-income and nonnaturalized citizens. These rates reflect, in part, the US linkage of the health insurance system to employment; again, with the caveat of considerable heterogeneity, immigrants are less likely to work in employment settings where insurance coverage is offered through the workplace. For example, they may be more likely to work in smaller or family-run businesses, which cannot afford to provide coverage, and are also disproportionately represented in agricultural and migrant farm work. Legal status determines federal eligibility for public insurance programs, including Medicaid-managed health care plans, although essentially all are eligible for Emergency Medicaid. Low-income legal immigrants who do not receive insurance through employment qualify for Medicaid, but only after 5 years of residence in the USA (in accordance with the 1996 Personal Responsibility and Work Opportunity Reconciliation Act).

A third influence may be culture-specific factors, such as reliance on care delivered outside the formal health care system from traditional healers, combined with a US health care system that can fall short in cultural sensitivity. Costs associated with care received from traditional healers are almost always out of pocket, and utilization is difficult to estimate. (Problems can sometimes arise when patients, concerned about disapproval or a lack of cultural understanding, prefer not to make providers in the formal care system aware of their use.)

If the prototypical target of managed care is the excessive service use of costly insured populations, the profile of immigrant health and utilization might seem singularly unpromising as a focus of concern. A closer examination of the facts suggests otherwise, at least to some degree. First, “healthy immigrant” status is not a stable trait. With increasing time in the USA, immigrants increasingly resemble native-born counterparts across a range of health indicators. For example, among Latinos, more group members smoke, use alcohol and other substances more, and become overweight or obese with adoption of a US diet. This trend co-occurs with increasing service utilization as time in the USA increases. Second, studies suggest rates of recommended vaccinations are lower among foreign-born children and adults. Third, if scrutiny of service use patterns is combined with independent evidence for the existence of access barriers, it is apparent that lower utilization and costs likely coexist with considerable unmet need and fragmented care.

In principle, managed care strategies tailored to promote health and integrate care have the potential to have a positive impact on immigrant health outcomes. Correlations between duration in the USA and increases in certain unhealthy behaviors are an obvious target for prevention and harm reduction strategies, as are low immunization rates. Immigrants are more likely than native born to lack a "medical home" or usual source of care, suggesting managed care's emphasis on primary care could benefit health status and utilization outcomes. Superior rates of preventive care have been found for Latinos in managed care compared to those in fee-for-service. Improved primary care and disease management could offset a perverse incentive to utilize high-cost emergency care. Recent or undocumented immigrants ineligible for Medicaid may have services financed by Emergency Medicaid. Spending for this may be increasing, particularly among elderly and disabled patients, with a significant contribution to their need from chronic illness complications. A potentially significant barrier to care is posed by a cluster of social psychological effects indicative of the social distance between providers and immigrant patients, including communicative style, language barriers, and cultural mismatch. While the construct of "acculturation" has correctly been criticized for collapsing the complexities of identity management into a single dimension, studies find even after controlling for a range of demographic and clinical variables, foreign-born patients who are less "acculturated" often receive inferior care. A patient-centered approach advocated by proponents and defenders of managed care would seem well-positioned to improve health outcomes by stressing cultural competence for providers, provision of skilled translators, and other strategies. Development of these may also create tensions with managed care's cost-containment strategies.

The future relevance of managed care for the delivery of health care to foreign-born populations can be anticipated only in the most general terms. Under any imaginable policy scenario, cost containment will be a pressing priority for the delivery system as a whole. More and more care is likely to be managed toward this end. While the 1990s saw some patient-driven pushback against managed care economies, the prospects for this seem poor today. Economic insecurity provides employers with leverage over employees who prefer to accept limitations on their medical care to unemployment. Uncertainties about immigration policy and how various immigrant groups will fare in the economy only compound the difficulty of predicting how the impact of managed care may be distinctive for the foreign born.

Related Topics

- ► Health barriers
- ► Health beliefs
- ► Health care
- ► Health insurance

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Maquiladora

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Maquiladoras are factories or export assembly plants, usually foreign-owned. They are generally contracted by transnational corporations (TNCs) to conduct the final stage of a production process, often assembling and packaging products for export. TNCs provide maquiladoras with materials, including preassembled cloth, electronic components, and chemicals. Maquiladora employees finish or semi-finish products. One hundred percent of maquiladora products are then exported back to TNCs. TNCs import machinery and materials duty-free and export finished products around the world.

In the past 40 years, maquiladoras have taken root on the northern and southern sides of the USA–Mexico border and throughout Latin America, although they also exist in other parts of the world where cheap labor is plentiful. As centers of production in what is referred to as the global factory system, maquiladora workers now provide a significant share of the world's industrial labor. Some 60–80% of maquiladora workers are thought to be women and are subject to low wages and extreme forms of discipline inside of factories.

Maquiladoras were first established along the USA–Mexico border in 1965 as part of the Mexican government's Border Industrialization Program. This program was meant to address wide-scale unemployment prevalent following the end of the Bracero Program, which allowed Mexicans to work under short-term contract in the USA. The growth of maquiladoras skyrocketed following the implementation of the North America Free Trade Agreement (NAFTA) in 1993. By 2003, there were close to 3,000 maquiladoras along the US–Mexican border employing well over 1,000,000 workers. Maquiladoras functioned as a source of employment for people living in the region as well as tens of thousands of Mexicans migrating from other parts of the country and from Central America and Latin America. More recently, they have become temporary sources of employment for migrants who encounter difficulties crossing an increasingly militarized border.

Environmental, Health, and Immigration Issues

According to environmental watchdog organizations, this high concentration of maquiladoras together with loosened enforcement of environmental regulations has led to what the Council on Scientific Affairs of the American Medical Association has called a "cesspool" that breeds infectious disease. The high cost of removing hazardous waste contributes to illegal dumping and the pollution of surrounding water, air, and land. Meanwhile, inside of these factories, workplace safety and exposure to toxic chemicals have alarming health implications for workers. Skin and respiratory protection are not provided, and workers report that drinking water and toilet facilities are inadequate to serve all employees. In one maquiladora, employees reported that there was no lunchroom and they were forced to eat on the floor where their food was at risk of contamination. In another, one employee reported that the workers were yelled at, were not permitted to use the bathroom, and were provided with food that made them sick. These occupational and workplace hazards are have been a linchpin for action and advocacy on the part of many border and labor solidarity activists, particularly the Maquiladora Health and Safety Support Network, a volunteer network of 400 occupational health and safety professionals.

Related Topics

- ► Labor migration
- ► Mexico
- ► Occupational and environmental health

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Marginalization

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A dynamic range of practices, shaped by an aggregate of factors, most important of which are government migration laws and policy, labor market conditions and the politics of otherness in the host society. The marginalization sustained by migrant workers potentially embraces all aspects of their lives. Marginalization is enacted by classifying, sorting, and regrouping migrant workers through two simultaneous and interrelated practices of bureaucratic categorization and socio-geographic segregation.

Bureaucratic Categorization

Migrant or foreign workers are divided into sharply defined bureaucratic categories of legal workers and illegal aliens. These categories are constructed and reified by host government migration laws and policies. Legality and illegality are juridical statuses in relation to the host state. The boundaries of these statuses determine the ease with which the migrant worker moves between the two, as well as limit his/her socioeconomic mobility. Foreign workers become illegal in one of two ways: if they are found working for an unauthorized employer or without a valid work visa. Those who become illegal may be deported to their countries of origin. Bureaucratic categories produce the marginalization of foreign workers by locating them as noncitizens within the state, with restricted opportunities for socioeconomic mobility, cultural acknowledgment, family reunification, and social security benefits. Additionally, they are often exposing them to civil rights violations.

For the common migrant worker, legal status is often a fragile state and almost inevitably gives way to periods of illegality, due to limited access to legal sources of income. Described as "the servants of globalization," most foreign workers are mainly employed in transient low-wage, low-status positions in secondary sector manufacturing and construction and tertiary sector nonprofessional services, regardless of their education, skills, or qualifications. The nature of their low-skill jobs renders them disposable in the fluid work market, making them vulnerable to exploitation by their employers, who may threaten to withhold payment or fire them if they do not comply with illegal demands. The bodies of migrant workers become their instruments of work. For example, Filipina work migrants worldwide are employed in mothering and care-giving roles such as household servants and geriatric and child care workers. The globalization of care and domestic services from the Philippines illustrates the feminization of the system of care which is based on the stereotypic notion of feminine empathy. Thus it is the Filipina's gendered body which keeps her employed. Often the confluence of gender, race, and ethnicity with migration serves to deepen and intensify the marginalization of migrant workers. This contrasts with the foreign professionals employed in specialized fields such as international business, academia, sports, or the arts who benefit from high-wage and high-status labor even though they are noncitizens within the host state.

Socio-Geographic Segregation

Most foreign workers are segregated into somewhat self-contained sociocultural and geographical enclaves. These enclaves are generally located near state borders or on the periphery of large cities, made invisible to the host country's citizens, in neighborhoods designated specifically and exclusively for the foreign worker, the literal outsider, and proverbial "other." Such neighborhoods are typically low-cost, overcrowded, underdeveloped, and neglected. As a result, they develop into threatening sites for the host society. Sub-enclaves often emerge within these neighborhoods, along ethnic and racial or legal and illegal lines. Marginalization becomes an inherent and practically inescapable state of existence characterized by invisibility, exclusion, discrimination, and exploitation. Therefore, even in countries which grant citizenship on the grounds of *jus soli* (right of soil, i.e., automatic citizenship to those born in the country), as opposed to *jus sanguinis* (right of blood), systematic marginalization may still be inherited by second-generation migrant workers.

Access to health care is an issue which highlights the all-encompassing nature of migrant worker marginalization, and the connection between bureaucratic categorization and socio-geographic segregation. The significance of health care is paramount, because as a low or unskilled laborer, the foreign worker's body becomes his/her primary work instrument. However when this body breaks down due to illness or injury, it can be easily replaced by younger, stronger, healthier bodies from the tireless flow of migrant workers. From the perspective of the migrant subject, falling ill becomes a cost-prohibitive luxury. In addition, most foreign workers as noncitizens do not receive national medical insurance. At best, legal migrants are covered by a private policy purchased by their employers. Even then several issues arise: Does the private health insurance cover only emergency treatment or also pregnancy, well-care, and chronic sicknesses? Does the policy ensure reasonable access to quality care? Does the migrant worker lose his or her medical immunity if the employer is the owner of the health insurance policy? Thus, migrant vulnerability and marginalization, which are consequences of migration laws and policies, become taken for granted as natural exigencies of the social order. Hence, the marginalization of the migrant worker becomes a potentially endless, self-propagating cycle of practices, performed and patterned along two axes: an *external* axis between the host society citizens and the foreign worker noncitizens, and an *inner* axis between the foreign workers themselves (in their work sites, neighborhoods, or even within their families), delineating professional and nonprofessional, legal and illegal.

The marginalization practices emerge along both axes from complex connections between migration laws and policies, economic conditions, and social relations which shape the daily reality of the migrant worker. For the host state, the marginalization process is a double bind. In order to maintain their high standards of living, developed countries demand cheap and plentiful labor, while keeping the laborers themselves at arm's length. At the same time the host countries feel threatened by the growing number of foreign, marginalized people within their borders.

Related Topics

- ► Discrimination
- ► Exclusion
- ► Loneliness
- ► Segregation

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Marianismo

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Marianismo is a Spanish term used as a reference for the prototypical woman among Latin American and Caribbean people. It is also the complementary gender construct to machismo. Marianismo is an obsolete concept used to explain Latinas' gender norms and sexuality. The term is much less frequently used in the social science literature as a gender construct than machismo. Yet, the characterization associated with this term frames the discussions on Latinas, culture, and gender.

Marianismo (or Mariolatry) is linked with the deep worship of the Virgin Mary. Marianismo ("the cult of the Virgin Mary") has been thought to influence the female ideal in many cultures (including non-Latina/o cultures) where Catholicism has been dominant. The characteristics associated with the Virgin Mary are assumed to provide the example for women to emulate. As such, marianismo confers on females a spiritual superiority over men which can provide them with a place of power in their personal relationships.

Marianismo includes the expectation for women to be virgins, asexual, submissive, humble, tolerant, faithful, and devoted to the male partner and assume the sole responsibility for childrearing and caregiving to the family. Motherhood in particular is exalted. A female's love for a male is demonstrated through complete trust and martyrdom. Although the honor of the family is connected to the sexual purity of females, virginity in perpetuity is not supported unless women enter a religious order. As with many societies, women who never marry or have children may be perceived as strange, problematic, or objects to be pitied. Marianismo also frames the madonna/whore dichotomy of womanhood. It represents the madonna (Virgin Mary) and therefore, it distinguishes itself from the whore category (which in Catholicism is a reference to Mary Magdalene). The characterization of Latina womanhood (as a well as in other societies) is predicated upon expectations of female sexual behavior. Most commonly, a female who is sexual or has sexual intercourse outside of marriage is labeled "a bad woman" (*mujer mala*) or "a whore" (*puta*). The madonna (virgin) is supposedly protected under machismo, but the whore can be a target for male lust and abuse. This creates the necessity to have a relationship with a man, in particular through marriage or a committed recognized union, for a woman to be perceived as "respectable" to the larger society. There is a societal expectation that women do not talk about sex with men since this may not only be seen as vulgar behavior in women but as a sign of sexual promiscuity. The label puta (whore) is also used as a way to silence women.

Another gender construct associated with marianismo is "hembrismo" (femaleness). Although some scholars have used it synonymously with marianismo, others have characterized it as a different gender construct altogether. In the latter case, hembrismo is a reference to a Latina woman who is of strong character, perseveres, and is a survivor. She is neither submissive nor passive as with marianismo. This gender construct, unlike marianismo that privileges the colonial influences in Latin America, derives from depictions of strong indigenous women of pre-Columbian times and represents a matriarchal figure whose actions are geared to benefit family and community. This gender construct explains female's agency in negotiating oppressive sociopolitical environments, such as the Latina who provides financially for her family or fights against social injustices. A more recent usage of the term hembrismo defines it as being the female version of machismo. As such, it has been connected to beliefs of female superiority and dominance over males, discrimination against males, or devaluing males. In some popular writings, it has been equated with the Latina feminist. Hembrismo, regardless of its varying conceptualizations of Latinas, is even less prevalent in the social science literature than marianismo. In the portrayals of Latina womanhood, what seems to remain consistent is the centrality of motherhood.

Marianismo (*and hembrismo*) are often broadly defined with multiple characterizations and based on limited research with Latina populations. To characterize all Latinas as marianas diminishes the range of femininities ascribed to by Latinas and makes invisible the larger socioeconomic and political environment that frame their attitudes and behaviors. Modernity, urbanization, and other economic and political changes have influenced the expectations and characteristics of womanhood for Latinas in the USA, Latin America, and the Caribbean. There has been a long history of women's rights movements across Latin American and Caribbean nations. Age, socioeconomic status, ethnicity, geographical status, generational status, and region have been shown to play important roles in how gender is enacted by Latinas. Moreover, some of the same marianista characteristics associated with Latinas are also found among women in non-Latina/o societies and non-Catholic societies including non-Latina White women in the USA.

While the actual term marianismo is less frequently used in the literature, the associated characteristics such as passivity, lack of agency or voice, lack of employment or career focus, sexual naïveté, and the bearing of (many) children are present in popular images of and research references to cultural values, in particular those of immigrant Latinas. The term and accompanying characteristics rely on a narrow and uncritical perspective of culture and gender, including the idea that there is such a thing as a Latina/o culture rather than Latina/o nationalities and cultures. As such, it creates a stereotype of all Latinas that feeds into ethnocentric beliefs about Latin American and Caribbean societies. It also reinforces the beliefs that Latinas are embedded in tradition-bound systems that are impervious to change and less evolved than other Western societies, in particular that of the USA and Europe. As such, when a Latina in the USA shows agency or more egalitarian beliefs, she is a product of acculturation rather than representing the diversity of gender perspectives found among Latinas and Latin American women. In addition, ethnocentric images of Latinas as highly fertile and passive also support concerns about them being a drain on the welfare system and an immigration "threat."

Related Topics

- ► Hispanics
- ► Latinos
- ► Machismo/Macho
- ► Women

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Marijuana

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Marijuana is a psychoactive substance derived from the cannabis plant. Its documented use dates back several thousand years, and it is currently considered the most commonly used illicit substance in the world. It can be ingested in several ways, most commonly being smoked as a cigarette or in a pipe. It can also be smoked as a "blunt" (i.e., a cigar that has been emptied of tobacco and repacked with marijuana and sometimes other drugs), mixed with food, or brewed into a tea. Acute effects of marijuana use may include impaired motor coordination and balance, increased heart rate, short-term memory loss, and other impairments to cognitive functioning. Chronic use may lead to several long-term effects, including respiratory problems such as chronic cough, bronchitis, and emphysema, a weakened immune system, heart problems, and increased risk for some cancers. Marijuana is considered to be addictive and it may also be associated with several mental health conditions, including anxiety, depression, suicidal ideation, and schizophrenia, although causality has not been established. There is currently ongoing debate in some nations as to whether marijuana also has medical applications, primarily for alleviating the symptoms associated with a variety of chronic medical conditions such as AIDS, cancer, and multiple sclerosis.

There is a growing body of evidence linking international migration with the risk of marijuana use initiation and increased frequency of use. Numerous empirical studies conducted in the USA have documented increased use of marijuana within US-born and English-speaking minority populations, relative to members of the same groups born elsewhere and having immigrated to the USA. The longer the immigrants reside in the USA, however, the greater their patterns of marijuana use come to resemble those of the native-born population. Similar associations between immigration status and marijuana use have been found in Western Europe. There are several potential explanations for these findings.

One commonly cited explanation is the assimilation, or acculturation, hypothesis, which suggests that immigrants will over time adopt the social values and norms of the dominant national culture as their exposure to it increases and they acquire new language skills. To the extent that immigrants' transition from more traditional and conservative societies to more modern and liberal ones, the risk of initiation of marijuana and other illicit substance will also increase.

A contrasting view, known as the acculturative stress hypothesis, holds that the multiple psychological, social, cultural, and economic stresses associated with migration, along with feelings of marginalization, experiences of discrimination, and pressure to rapidly adapt to a new cultural environment, may encourage maladaptive coping among immigrants via marijuana and other substance use behaviors. The increased stress characteristic of neighborhoods with high levels of social disorganization, poverty, and crime into which many immigrants are consigned further contributes to this process.

A third hypothesis, known as the segmented assimilation theory, posits that there are multiple pathways by which immigrant populations adapt to new social environments, and that these pathways may mediate the risks confronting immigrants. According to this model, some immigrants are able to successfully acculturate to the values of the host society and, consistent with the acculturation hypothesis, become more vulnerable to illicit drug use as they do so. In contrast, other immigrants fail to successfully acculturate, possibly due to the stresses and pressures central to the acculturative stress theory, and become permanently marginalized on the fringes of society, where substance use may be a more normative coping strategy. A third group consists of immigrants able to successfully preserve their traditional cultural values and relationships while navigating the new host society. The traditional values and strong family and ethnic social ties available to these individuals may provide important buffers that offer protection from the stresses and pressures confronting immigrants, thereby decreasing the risk of marijuana and other substance use initiation. Supporting this hypothesis, empirical research has identified protective effects of living in neighborhoods with high concentrations of recent immigrant populations by documenting the association between residence in these "immigrant enclaves" and reduced risk of marijuana use.

The risks associated with increased marijuana use among immigrant populations may thus be best understood as a consequence of multiple, reinforcing social processes taking place concurrently at individual, family, and social structural levels. Within Western nations, immigrants largely gain access to marijuana via the same illicit market channels as do nonimmigrants.

Marijuana and other substance use norms in nations of origin may also be influenced by immigration, as some evidence exists that returning immigrants, and families reporting having members who have immigrated to nations with more permissive substance use cultures, are at increased risk for marijuana use initiation.

Finally, in addition to the known health risks and domestic legal penalties associated with marijuana use, there are many nations in which the possession, marketing, and/or smuggling of marijuana may lead to deportation for immigrants and other noncitizens. In the USA and some other nations, anti-immigration politicians often accuse immigrants, among other things, with the smuggling of marijuana and other substances into the country.

Related Topics

- ► Acculturation
- ► Acculturative stress
- ► Addiction and substance abuse
- ► Assimilation
- ► Cocaine
- ► Drug abuse
- ► Drug use
- ► Marginalization
- ► Peyote

Suggested Readings

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Marriage

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There are far more international immigrants in the world today than ever previously recorded, and their number has increased rapidly in the last few decades. There were an estimated 214 million international immigrants in the world in 2010, representing an increase of almost 40 million in the first decade of the twenty-first century, and over double the number of international immigrants in 1980. Europe hosts the largest number of immigrants, followed by North America and Asia, which host nearly 25.3 million. Most of today's immigrant workers come from Asia. Migration marriages remain an intriguing phenomenon in many parts of the world. Since 1974, family migration has become the most popular way of settling in Western Europe. Many immigrants from South Asia (i.e., India, Pakistan, Bangladesh, and Sri Lanka) form today one of the fastest growing immigrant groups in Canada and USA.

A vast majority of immigrants enter the host country on the basis of family migration, more specifically, on the basis of marriage migration. The popularity of marriage migration is often explained by its instrumental role in making migration possible. The tendency within immigrant communities is to marry someone who grew up in the country of origin.

Macroeconomic factors, such as globalization, unequal economic development between countries, and feminization of poverty are the driving forces in most of the international marriages. According to economic migration theories, it is assumed that people leave their country in order to improve their socioeconomic situation. However, there is also a lot of evidence that the socioeconomic situation of such immigrant communities is many times problematic compared with that of mainstream society. Men are particularly motivated to immigrate in order to improve their socioeconomic situation. They are quite sure that earning a living will be much easier in Western countries. While women also share this view, they often stress the broader advantages of living in a democratic, prosperous country with a sound social security system: access to health care; more social rights for women; better financial provisions in case of sickness, unemployment, and retirement; and also more sociocultural opportunities. Women also share a lot of admiration for the Western health system. Not only young people from poor countries perceive immigration as a relevant project, but parents also dream of having their children immigrate to Europe. The socioeconomic security for their children in combination with easier access to the West for them are the most appealing elements that apparently seem to counterbalance the potential settlement challenges due to systemic, informational, cultural, and linguistic barriers. One can thus notice that there are totally different values that are supposed to be shared between the two partners within an immigrant marriage.

However, once they arrive in the host country, immigrant women may experience multiple oppressions not only from their own community (e.g., gender and class-based norms) but from the dominant society as well, based on their immigrant and ethnic minority status.

Once arrived in their host country, many women often become financially dependent on their husbands and stay at home, thereby limiting their opportunities to socialize, learn the second language, and develop skills to access available jobs. Moreover, the loss of an extended family system after migration increases their social isolation along with a greater burden of housekeeping tasks, which used to be shared in the extended family.

South Asian immigrant women commonly endure culturally prescribed rigid gender roles and patriarchal norms. If they secure employment, those women who work outside the home report triple workloads of paid work, unshared household everyday jobs, and care giving, unlike their male counterparts. Due to a small circle of family and friends, the magnitude of their multiple work responsibilities is also higher than among native born women. This new reality is likely to limit their opportunities to integrate in the host country.

Migration opportunities have a major impact on changing the concept of "family" and "marriage" not only in countries of origin, but also in the host country communities. Especially in Islamic communities, marriage plays a crucial role. Islamic tradition legitimizes the existing gender roles and family values. The spouses are expected to fulfill the tasks related to their gender role and to assure the continuity of the family. Marriage is primarily an alliance between two families. Traditionally, it is the family and not the future spouses who negotiate the marriage arrangement. This conception of marriage which is foremost a negotiated contract between two families fits well within the context of migration where spouses-to-be have far fewer chances of being acquainted with each other than if they lived within the same country, let alone the same community. From a traditional perspective, this is not considered problematic. It is assumed that parents know best whom their children should marry. However, parents have no direct information about the personality and behavior of the future son/daughter-in-law when they live in another country. In the case of migration marriages, it is not unusual for there to be no more than a few days between the decision to marry and the wedding. The parents sometimes take advantage of this situation to hide negative aspects about their children from the future family-in-law, such as disease, drug addiction, "shameful" behavior, or delinquency.

Another issue that may affect the married immigrants' health more than non-immigrants is domestic violence. Although the "battered spouse protection" under the immigration laws is worded in gender-neutral language, it is aimed clearly at women who suffer abuse. The prevalence of physical abuse among South Asian immigrant women varies from 35% to 41% and for sexual abuse is around 19%. The reality of partner abuse is sociohistorically built, women's oppression arising out of the social structures, such as women's gendered inferior roles through societal norms of men's superiority. There is a long delay in seeking help from professionals among abused women of all backgrounds and generally low rates of help-seeking from medical, social, and legal professionals. Many Asian women, like women from many parts of the world, are taught to keep a tight lid on things that might bring dishonor to the family, either her birth family or her family by marriage. The reasons for such a prolonged delay include: social stigma, women's gender roles (silence, marriage obligations, subordination), children's well-being, and lack of social support. Disclosing facts about domestic violence is perceived to bring suffering and loss of respect especially for their family and parents. On the one hand, they may use silence as a strategy to divert attention away from themselves, and view this practice as an indicator of their own strength, as opposed to their weakness. On the other hand, women may feel that the social prescription of "silence" enhances their vulnerability to abuse because their husbands take advantage and the situation worsenes. In the context of an arranged marriage and a desire for harmony, women may feel obliged to maintain the bond and, hence, be able to identify themselves as a "real woman."

Women in an arranged marriage may be hesitant to apply for "battered spouse" protection under the US immigration laws, for fear that it will bring her shame. Quite often, such women are told (and believe) that the INS (Immigration and Naturalization Service) will order them deported if they complain about their spouses or that the conduct of the abusive spouse is somehow their fault or their responsibility. While these beliefs are not limited to women from Asia, quite often the conservative religious and cultural values in Asia contribute to them. It is often difficult to prove the mental or physical cruelty necessary to establish a battered spouse petition.

When the time comes to file the application with the INS, there is little or no proof evidence supporting wife's testimony. If the husband is especially vindictive, he can claim that a traditional marriage dowry was actually a payment for him to immigrate the wife – something that appears to be marriage fraud. A woman unfamiliar with US immigration laws or US culture can accidentally make things worse if she agrees that money was paid for her husband to marry her. Unless it is immediately clarified that she is talking about a traditional dowry or bride price, the INS can assume that the wife married the husband solely for the purposes of evading the immigration laws. This conclusion on the part of the INS results in the wife becoming ineligible to immigrate to the USA for life.

Related Topics

- ► Family
- ► Family violence
- ► Illegal immigration
- ► Violence Against Women Act

Suggested Readings

Ahmad, F., Driver, N., Mc Nally, M. J., & Stewart, D. E. (2009). Why doesn't she seek help for partner abuse? An exploratory study with South Asian immigrant women. *Social Science & Medicine, 69*, 613–622.

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Maternal Dietary Intake

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Maternal dietary health is the corner stone for predicting the survival of mothers and their newborns. The mother's pre-pregnancy weight is a key factor in predicting the survival of the mother and her newborn. Immigrant women are usually underweight and therefore are at increased risk for producing newborns that are at low birth weight and more vulnerable to infectious disease. Subsequent weight gain or loss during pregnancy may result if health choices are unavailable or if there are limited food sources.

The recommended dietary allowance for pregnant women consists of 3 servings of milk, 3 servings of fruit, 4 servings of vegetables, 6–12 servings from the bread group, and 3 protein portions. Folate supplementation is often needed to equal 600 micrograms (1,362 nanomoles) in addition to foods to reach the recommended intake of folate. Several small meals per day and a minimum of eight glasses of water are recommended.

Diets that lack dairy products or a variety of vegetables have placed many women at risk for vitamin D, folate, and iron deficiencies. In one study, Pakistani women in Oslo were found to have the poorest vitamin D intake but all women from Turkey, Iran, India, Sri Lanka, and Vietnam had significant deficits as well. African-American women in the United States who experience the highest rates of low birth weight newborns have also been found to have a diet that lacked dairy products. This is a significant concern for immigrant women who find themselves in communities where traditional foods and ingredients are not readily available. The early pregnancy hormonal challenges that cause nausea and vomiting may be accentuated when new foods are attempted.

Pica, the disorder of intentionally ingesting nonfood substances, is another dietary challenge in many ethnic groups; pica may result in lead poisoning. Geophagia, the consumption of clay dirt, remains a common practice in African-Americans in the United

States. The consumption of pottery ingredients by some Hispanics groups, “tierra,” is believed to add supplemental iron and calcium resulting in healthier babies. As a result of pica, many newborns suffer long-term cognitive and social development disorders resulting in difficulty in later life when they attempt to enter into the mainstream workforce. Impaired growth of female neonates often results in short statured adult females who encounter complications during the delivery of their own children such as obstructed labor, damage to bowels and bladder, and neonatal death.

Prenatal health care facilities that are sensitive to the challenges of immigrant population have developed programs that attempt to eliminate barriers to care, such as language and transportation. Grants and monetary support of such programs have increased the opportunity for immigrants to receive early prenatal care and nutritional counseling. Early prenatal care that includes dietary counseling may dispel myths, reduce harmful practices, and result in improved neonatal outcomes and maternal well-being.

Related Topics

- ▶ Birth defects
- ▶ Midwife
- ▶ Nutrition
- ▶ Pregnancy
- ▶ Prenatal health promotion
- ▶ Reproductive health
- ▶ Vitamins
- ▶ Women

Suggested Readings

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Suggested Resources

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Maternal Employment

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Employment of expectant mothers who have uncomplicated pregnancies is a reasonable expectation especially if she has other children that must be cared for. Many immigrants find themselves in economically challenged positions and work is necessary for day to day survival. Women who are not expecting a child fare better when attempting to find employment but may often have to settle for low-paying domestic jobs.

Legal challenges are the limiting factors in the United States, but these challenges may not exist in other countries. US employers are bound by the Immigration and Naturalization Act of 1990 to employ qualified workers in a safe environment. They may also be penalized for hiring undocumented workers and may be subjected to fines and/or incarceration.

Immigrants must meet legal requirements to work and/or receive medical care. For example, in the United States individuals who enter as nonimmigrants, meaning that they are not going to remain in the United States permanently and are entering for a specified purpose, must hold specified visas to be able to work legally. Individuals who are asylees or refugees can request permission to work. Specific documents that support the right of employment and proper identification must be kept current to avoid the risk of deportation. In some countries displaced persons have no legal restrictions and may seek employment that is consistent with their skill level.

The workforce for immigrants with a low skill level is often limited to housekeeping, janitorial, and child-care opportunities. The pregnancy state itself does not limit the mother's ability to work but some jobs may be difficult as long standing, heavy lifting and body habitus prohibit some job opportunities. Jobs that place the pregnancy at risk, such as those that involve chemical exposure and heavy machinery work, should be avoided.

Women who work and enjoy healthy lifestyles during their pregnancy have fewer complications and outcome data show reduced labor stressors and improved neonatal outcomes. Postpartum recovery periods are shortened and postdelivery depression is minimized.

Related Topics

- ► Breastfeeding
- ► Child rearing
- ► Employment
- ► Immigrant visa status
- ► Marriage
- ► Pregnancy
- ► Women

Suggested Resources

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Matrifocal Family

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Usually this term is used to refer to a residential kinship group with no male in the role of husband/father being regularly present, and where women constitute the focus of the family. Comparative anthropological research has shown that matrifocality can be a culturally preferred or accepted feature, often but not exclusively in connection with matrilineal descent, as among the Minangkabau in Indonesia, the Na in China, or in some societies of the Afro-Caribbean region (e.g., Barbados). Presently, however, there are many other societies that display a tendency toward the emergence of matrifocal families, though officially such a family structure is still deemed as a social anomaly. Examples include the Middle East where men are expected to wield authority over the female family members, or in parts of China where fathers are the uncontested head of the family, or Cuba with its idea of machismo. Despite the overall value of male domination, these and other regions are witnessing an increasing number of matrifocal families bringing about new challenges with regard to long-established gender roles and intra-familial authority.

The reasons for the emergence of matrifocality in traditionally male-dominated societies are to be found in social transformations, which lead to different forms of social instability, such as diasporas and armed conflicts (married women living alone while their husbands are fighting or being imprisoned), or economic pressures entailing the large-scale work migration of men who usually leave their wives and children behind "at home." This "home" can either be situated in the country of origin or in the immigration context, as the Chinese case indicates. In China, during the second quarter of the twentieth century, matrifocal families increasingly came into being as a corollary of the US Immigration Act of 1924, under which the wives of Chinese labor migrants were forbidden to follow their husbands to the USA. As a consequence, while working and living in the USA, the men had to marry in China and leave their children to be raised there. Later, this pattern was reversed, so that Chinese wives and their children now live in the USA while their husbands seek employment in other countries and only come back once or twice a year to see their wives and children.

Health problems evolving as a direct consequence of matrifocality are most likely to emerge in those cases in which matrifocal families are situated in male-dominated societies where such a type of family structure is usually devalued compared to the socially acknowledged ideal of the two-parent family, or among immigrants from male-dominated societies (i.e., Middle Eastern immigrants). Under such circumstances, women not only have to cope with the sole upbringing of their children, but they are also frequently struggling with an “inappropriate” gender role and suffering from exclusion from the major social and/or religious activities, be it in the home or in the host society. This exclusion has been emphasized by psychologists and sociologists as constituting the major factor for the emergence of mental health problems among single-parent immigrants. Clearly, this applies less to those immigrants originating from societies where matrifocality is a culturally accepted feature. Nevertheless, it is highly relevant for female immigrants who live matrifocally in a male-dominated host society or among male-centered social immigrant networks in the USA or in Europe.

In terms of potential health problems, the matrifocal family to a certain extent is comparable to the phenomenon of single mothers. In 2006, 10.4 million single mother families were estimated to live in the USA, including both native-born Americans and immigrants. In the case of both single mothers and mothers in matrifocal families – if the latter are not situated in a three-generation household (grandmother, mother, children) but are living alone with their children – the major health problems suffered by these women are usually attributed to exposure to higher stress levels than those experienced by women who live together with their husband or partner. Many of these women are at risk of becoming economically marginalized; one half of the single mothers in the USA end up in low-wage income and poverty. The higher stress level, as psychologists have maintained, results from the twofold burden of raising the children and earning money as well as from anxieties about the overall financial situation. Statistically, as surveys have shown, immigrant women are less likely to live in single-parent households; however, immigrant women living under such conditions, together with native-born and women of color, are most likely to belong to the low income-level groups. In the USA, single mothers with children may be eligible to participate in government-funded assistance programs such as Medicaid, Food Stamps, and the State Children’s Health Insurance Program (SCHIP). However, the US welfare and immigration reform laws promulgated in 1996 and later severely restricted immigrants’ access to cash assistance and Food Stamps. Undocumented immigrants are ineligible for most government-funded assistance programs. Additionally, eligibility of legal immigrants to participate in several such programs is restricted in most cases to those who have been permanent residents for not less than 5 years and can meet several additional eligibility criteria, and to those who have been granted asylum or refugee status.

Older psychological surveys often attributed children’s retardation to the matrifocal family. Recent psychological reports continue to maintain that children from single-mother families evidence more mental or psychosomatic disorders (such as enuresis, neurosis, stuttering, and various conduct disorders) than other children. This is particularly evident where single-parent families are considered anomalous by the wider social environment or if an immigrant mother has been expelled from her social group. These reports also emphasize that the precarious economic situation appears to have no significant impact on the children’s mental health.

Additional health problems may arise for immigrant single mothers if language barriers impede their understanding of medical staff’s treatment recommendations, potentially resulting in less effective health care for their children (and for themselves). Moreover, language barriers may also complicate their communication with social welfare institutions. However, recent surveys undertaken in the USA and Europe indicate that children from matrifocal families or single-parent families, regardless of their origin, do not display a higher risk of suffering from physical health problems than children from two-parent families.

However, significant differences have been found in the occurrence of physical diseases among women living alone or as part of a couple. Contemporary research in Europe revealed that single mothers of any origin have statistically fewer preliminary checkups compared to women living with a partner. This is even more striking for immigrant women who, due to the above-mentioned language barriers, are often excluded from the health care system. A German survey found that single mothers compared to those living with a partner suffer three times more often from bronchitis; two times more often from renal infections, hepatitis, or liver diseases, 10% more frequently from migraine; 15% more frequently from mental health problems such as neuroses, anxieties, and depression; and 8% more often from diseases affecting the reproductive system. Moreover, single mothers tend to refrain from seeking the help of physicians to a much greater extent than other women, even when they experience a need for care.

An amelioration of the general health condition of single mothers/women in matrifocal families has been recently achieved in the framework of various US and Canadian state-financed test programs. Many of these programs support the establishment of organizations to assist these women with child care responsibilities and their reintegration into social activities as a means of raising their awareness of health care issues. Additionally, the greater availability of interpreters within health care systems could help immigrant women to communicate and negotiate with medical staffs and social welfare institutions, particularly during the period immediately following their immigration to their new host country.

Related Topics

- ► Health care utilization
- ► Illegal Immigration Reform and Immigrant Responsibility Act of 1996 (U.S.)
- ► Immigrant visa status
- ► Mental health
- ► Women

Suggested Readings

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Médecins sans Frontières

► Doctors Without Borders

Media

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Media communication involves messages that are transmitted from one message source to many. One source of communication, often institutional, sends either written/print or oral/broadcast messages to many at one time. This communication results in minimal or zero feedback from the recipients. Radio, television, magazines, newspapers and numerous web sites are examples of media. For example, television and radio provide the *medium* (singular) for large institutions/organizations such as NBC National Broadcasting Corporation), ABC (American Broadcasting Corporation), CBS (Columbia Broadcasting Corporation), BBC (British Broadcasting Corporation), Fox News, and CNN to reach the general public.

This one-to-many form of communication also occurs in social networking where one person may via Facebook, Twitter, Linked-In or MySpace, or some other computer applications reach a large network of friends through combinations of communication loops. Such applications are also useful for persons in the job market as they are venues for recruiting and marketing. Persons may post credentials, resumes, endorsements, and recommendations on some of the sites. As news media and private corporations use these social networks to get feedback, they attempt to establish a two-way communication with the viewers or listeners. Many people reported networks of friends or special interest groups that reach hundreds for the average person and thousands or millions for celebrities. Individuals are responsible for the management of their own spaces and these may or may not be managed. Major networks, for example, employ gatekeepers who control the flow of information in an intermediary role, much like the floodgates at a dam control the amount of water that passes through the floodgates and moves on. These gatekeepers may also function as opinion leaders commenting on particular information and news. Whether in print or broadcast journalism, editors prioritize the vast amount of information submitted by reporters and citizens. Editors who serve as gatekeepers determine which information will be shared. Other editors serve as the agenda-setters who prioritize the news that flows from the gatekeepers. The amount of airtime indicates the significance and priority of the news as do the size of headlines and story location in print journalism (front page, bold headline or small story on page 32, etc.). Is this the lead story or the final human interest story of the evening on the broadcast news? An oil platform explosion in the Gulf of Mexico receives major coverage compared to an area traffic accident and so on. Because of these reporters, gatekeepers, and agenda-setters, we are able to stay informed about an earthquake in Haiti or Chili, tsunamis, war events, or the destruction of the World Trade Centers on 9/11. This information is communicated and disseminated by the media.

Computers and webcasts and live streaming of videos provide alternative means for accessing these broadcasts. IPods and smart telephones provide further recent extensions of personal access to media. Reading devices such as Kindle and Nook provide access to millions of books and access to blogging sites. Message posting and blogging of one's personal thoughts provide a recent extension to electronic print journalism. The public is able to view and listen to current events through multiple mechanisms. Political candidates may now reach voters through social networks. Advertisers have extended beyond print and television/radio broadcast, especially to social networking sites.

To some I-Phones and I-Pads may seem merely toys or gadgets but they have further facilitated news gathering and social networking along with many other activities (games, downloading music, etc.). George Gerbner's cultivation theory addresses how media effects build up over time. Marshall McLuhan recognized in the late 1960s that technology has key effects on its user from extensions of the senses (glasses/eye, cars and planes/feet, computer/brain, etc.) and as such remolds societies from agrarian to industrial to electronic. The world became a "global village" through television, then split into "cultural islands" via Cable (cooking channel, weather channel, sports channels, sitcom reruns, NCIS reruns, etc.). Social networking has reduced some social stratification and linked people separated by thousands of geographical miles.

Conclusion

Media can have positive effects by providing information about storms or hurricanes that are approaching, by providing information about health and nutrition, cultural events, entertainment opportunities, keeping a person connected to one's homeland, and so on. However, it can also have negative effects through advertising or behavior modeling in comedies or dramas that encourage bad eating habits, poor money management, or other irresponsible behaviors. Media is often more influential in times of stress.

Under normal, day-to-day condition, the media may be taken for granted. In times of stress, the media connect us to homelands, provide information from points around the world so that we can be up-to-date on natural disasters and other events that affect us, loved ones, friends, and homeland. The media coverage is often very specific to immigrant interests – new immigration laws in Arizona, related court rulings, immigrant protest about laws, profiling, or working and housing conditions. Internationally, media coverage of disasters and political events, for example, directly affects the health and safety of immigrants. Culturally specific talk shows from Hispanic to Chinese report specific news, provide social networking, provide talk, cooking, shopping, or game shows, and other venues of special interest. These reveal ways that they might participate in special language news and social networking. All of these increase opportunities for native language communication and provide critical health and social information to immigrant populations.

Related Topics

- ► Communication barriers
- ► Health literacy
- ► Linguistic minority community
- ► Low literacy level

Suggested Readings

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Suggested Resources

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http://www.fcc.gov/mb/
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Medicaid

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Established in 1965 through Title XIX of the Social Security Act, Medicaid was developed to help finance health care for low-income persons; this federal-state program helps individuals with little or no medical insurance by paying for part or all of their health care. In 2009, approximately 47 million people received services through this program. People who are eligible for Medicaid fall into one of two groups: the "categorically" and "medically" needy. Categorically needy individuals are those receiving aid because they are aged, blind, or disabled. Those who are medically needy have enough money to live on, but cannot afford to pay for medical care. In general, eligibility requirements include US citizens or permanent residents, people 65 years old or older, low-income children under the age of 19, all children under 6 years of age, and pregnant women with incomes up to 133% of the federal poverty level.

Medicaid is a joint program between the states and federal government, in which each state operates its own system but must follow certain government guidelines to receive matching funds. The program's funding, which is generated through tax revenues, varies according to each state's poverty level. Additionally, patients' eligibility and benefits are determined by each state. For example, each state defines the scope and cost of services but must comply with services for mandatory eligible groups.

State Medicaid programs must provide services for mandatory eligible groups. These groups include: (a) limited income families with children as described in Section 1931 of the Social Security Act who meet certain eligibility requirements in the state's Aid to Families with Dependent Children plan in effect July 1996, (b) Supplemental Security Income recipients (or in states using more restrictive criteria – aged, blind, and disabled individuals who meet the criteria which are more restrictive than the SSI program), (c) infants born to Medicaid eligible pregnant women through the first year as long as she remains eligible, (d) children under the age of 6 and pregnant women whose family income is at or below 133% of the federal poverty level, (e) recipients of adoption assistance and foster care under Title IV-E of the Social Security Act, (f) certain people with Medicare, and (g) special protected groups who may keep Medicaid for a period of time such as families who may have lost eligibility for specified reasons.

At a minimum, a state's Medicaid programs must provide the following services: (a) inpatient and outpatient hospital services; (b) skilled nursing facilities; (c) physician services; (d) home health care; and (e) early and periodic screening, diagnosis, and treatment for children under 21 who are eligible. Medicaid also provides coverage for mental health and substance abuse services, expensive drugs for treatment of AIDS, and rehabilitation services not covered by private insurance. Dental services, prescription drugs, eye glasses, intermediate care facilities, and other services are considered optional services and states may offer any or all of these. These services must be provided to children and pregnant women at no cost. Deductibles (a set amount the patient must pay before Medicaid pays) are not permitted and co-payments (a percentage of the total charges paid by the patient) generally do not apply.

States do have discretion in some program eligibility. The option to have a "medically needy" program, for example, allows states to extend Medicaid eligibility to additional qualified persons who may have too much income to qualify under the mandatory or optional categorically needy groups. This option allows them to “spend down” to Medicaid eligibility by incurring medical or remedial care expenses to offset their excessive income and reducing it to below the maximum allowed by the state’s Medicaid plan. They may also elect to include the medically needy under their plans for certain children under 18 and pregnant women or other groups, for example.

Categorically needy groups can also be given extended benefits under state programs. Such groups may include: (a) infants up to 1 year of age and pregnant women not covered under mandatory rules whose family income is below 185% of the Federal poverty level; (b) low-income children; (c) certain aged, blind, or disabled adults who have incomes requiring mandatory coverage but above the Federal poverty level; (d) children under 21 who meet the income requirements for AFDC but are otherwise not eligible for AFDC; (e) institutionalized individuals; (f) persons who would be eligible if institutionalized but are receiving home or community-based care under services waivers; (g) tuberculosis-infected individuals who would be financially eligible at the SSI level; (h) recipients of SSI; (i) low-income, uninsured women screened and diagnosed through a Centers for Disease Control Breast and Cervical Cancer Early Detection Program and in need of treatment. States may always provide more services than required. In 2005, without Medicaid there were 28 million low-income children, 15 million parents, as well as 9 million people with disabilities without health care coverage.

Children and their parents constitute the majority of the program’s beneficiaries. Enrolled children comprise 48% of enrollees and 19% of the expenditures. Adults comprise 27% of enrollees and 43% of the expenditures. Individuals with disabilities and older people who are poor incur the highest per capita expenditures and consume disproportionate amounts of Medicaid dollars. Sixteen percent of Medicaid enrollees were disabled expending 43% of the total expenditures. The elderly comprise 9% of enrollees and generated 26% of expenditures. Forty percent of Medicaid’s costs are associated with “dual eligibles,” people who are covered by Medicare and Medicaid. More than 90% of elderly are dual eligible as are about one third of Medicaid enrollees with disabilities. Medicaid’s role as a primary source of long-term care, gap coverage for Medicare, and coverage for the disabled is likely to continue with the increasing growth of the elderly population.

Funding Medicaid has become a critical issue for many states because of increasing expenditures as a result of higher program enrollment and medical inflation. There were nearly 3.3 million more people enrolled in Medicaid in June 2009 than in the previous June, the largest ever 1 year increase in absolute numbers. As economic conditions have declined, enrollments have increased with Medicaid’s costs growing faster than state and federal revenue. On average, the federal government pays 57% of all Medicare expenses. The federal government spends more than $300 billion annually on Medicaid services. States fund their 43% from state revenues and while states may expand coverage under Medicaid, many states are seeking to reduce program expenditures. Forty four states report higher than expected enrollment and expenses due to the large demand for services and the limited resources. Enhanced federal matching money for Medicaid through the federal stimulus law is set to expire December 31, 2010, further stressing state budgets.

Governmental actions to address these concerns have influenced the benefits available to Medicaid beneficiaries. In the 1990s, in reaction to the growing number of uninsured people and increasing medical costs, states submitted applications for waivers through the Social Security Act. This waiver allowed states flexibility in modifying eligibility requirements, payment methods, and other program characteristics. For example, it allowed beneficiary enrollment into managed care plans. Another outcome was the extension of health coverage to the working poor and their families who were not previously eligible for Medicaid. As a result of this change, the State Child Health Insurance Programs expanded to provide coverage to children whose family income is too high for Medicaid support and the Personal Responsibility and Work Opportunity Act (1996) redefined the scope of welfare benefits, which set the stage for the work requirements linked to these benefits. More recently, the federal government has used its 42 year experience with Medicare and Medicare to assess the benefits and challenges of the intersection of multiple programs at the federal and state level to assess the role of these programs in health care reform.

The Medicaid program, actually many programs in one, is the largest health care program for low-income families, elders, and people with disabilities. Medicaid has enabled low-income populations to have access to quality health care. In particular, pregnant women and children have received enhanced or special services as part of their enrollment. One study notes that 75% of the children in the Medicaid or State Children's Health Insurance Program had a preventive or well-child visit within the past year, compared to 46% of uninsured children. Further, Medicaid has acted as "gap" insurance for society's sickest and frailest. Medicaid provides mental health and substance abuse services and expensive drugs for treatment of AIDS. Approximately 44% of nursing home care is paid for by Medicaid. Despite this progress, with increased funding issues, Medicaid is a topic of public policy debate now and will be in the foreseeable future.

Since 1996, federal law has generally excluded from Medicaid undocumented immigrants as well as most legal immigrants who have been present in the USA less than 5 years. These groups may receive Emergency Medicaid, however. Immigrants continue to have high rates of uninsured compared to citizens, with 44% of legal Mexican immigrants and 77% of undocumented immigrants lacking health insurance with the notable consequences of lack of access to needed services. While immigrant populations are increasing, relatively little is known about their health status and health services utilization except in local circumstances. Data from North Carolina highlight the utilization of Emergency Medicaid, noting that 94% of eligible individuals were pregnant and 93% were Hispanic. Outside of pregnancy, one-fifth of hospitalizations and one-third of all Emergency Medicaid spending were for injuries. Emergency Medicaid provides critical services for childbirth but fall short of providing the necessary preventive and chronic disease management care required to maintain the health of immigrants and their families.

Immigrants receive limited public benefits. For example, a child born here is a citizen and eligible for coverage, although noncitizen parents may not generally receive benefits or be eligible for Medicaid. In 2007, 23 states chose to use state funds to provide additional services for recent legal immigrants or for undocumented women and children. Passage of the landmark Patient Protection and Affordable Care Act of 2009 has only minimally impacted access to public or private employment-based insurance for immigrants and continues to leave the enrollment of legal and undocumented immigrants into expanded programs like Medicaid at the discretion of states. High growth immigrant states with strained state budgets and anti-immigrant sentiment are unlikely to allocate funds for this population through programs like Medicaid. Further, immigrants, especially those who are undocumented, are reluctant to inquire about public programs and leery of program benefits that might disclose their status. Thus, children born in this country of immigrant parents may be primary beneficiaries while many immigrants will remain without coverage and in many cases without care.

Related Topics

- ► Access to care
- ► Health insurance
- ► Health services utilization
- ► Health status
- ► Medicare

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Medical Examination (for Immigration)

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Medical examinations for migrants, asylum seekers, and other entrants are currently high on political and public health agendas in many countries around the world. In the USA, for example, the Secretary of Health and Human Services frames regulations under the Immigration and Nationality Act, and the Public Health Service Act, for the medical examination of migrants seeking admission to the USA. The Division of Global Migration and Quarantine provides the Department of State and the US Citizenship and Immigration Services with medical screening guidelines for all examining doctors. A medical examination is compulsory for all refugees going to the USA, all applicants applying for an immigrant visa, and for aliens applying to become permanent residents. Outside the USA, medical examinations are performed by around 400 selected doctors. Health-related grounds for ineligibility for visas or admission include communicable diseases, absence of documentation of vaccination, physical or mental disorders, and drug abuse and addiction. Technical instructions are provided to these doctors by the Centers for Disease Control and Prevention, and for immigrants and refugees these examinations (which consist of a physical examination, skin test or chest X-ray examination for tuberculosis, and blood test for syphilis) are done overseas. The purpose of the examination is to identify those applicants with health-related conditions that render them inadmissible.

Similarly in the UK, the British Thoracic Society's Code of Practice recommends that all immigrants or other entrants from all countries other than the European Union, Canada, the USA, Australia, and New Zealand, and all refugees, be screened for specified illnesses or conditions. The ten Port Health Units based at major ports and airports see themselves as having a dual responsibility – to provide immediate health care for asylum seekers and migrants, and to protect the wider community from any risks to public health. Infectious disease and migration remain important political issues, with the Conservative Party arguing that infection should not be imported into the UK, and the Australian experience demonstrating the value of medical examinations in controlling the incidence of tuberculosis. Thus, screening continues to have a symbolic and metaphorical value, over and above any claims to clinical effectiveness.

Nevertheless, despite guidelines, studies have highlighted widespread variations in policies for screening of migrants. There is no national policy on screening migrants to the UK for tuberculosis. The Port of Arrival system operates only at international ports with Port Health Units attached, and relies upon Immigration Officers identifying certain categories of travelers and referring them for screening by Port Health Officers. Details are then forwarded to Consultants in Communicable Disease Control and Primary Care Trusts within which the destination address lies. However, many Trusts do not arrange screening for the new entrants referred to them on the grounds that they do not have the resources or have other priorities. Many migrants do not present for screening due to changes of address, language difficulties, and mistrust of authorities. It has been argued that compulsory screening of migrants for tuberculosis and HIV is not based on adequate evidence, and has practical and ethical problems.

It has been suggested that the specific immigration history of Australia in the twentieth century has strong links with public health policy and practice. The theme of the "immigrant menace" has been similarly influential in histories of migration and public health in the USA. In his important early history, *Silent Travelers*, Alan Kraut identified four key themes: the relationship between health, disease, and nativism; the advances and perceived limitations of scientific medicine; the institutional response of national, state, and local governments to immigration and public health; and migrant responses to differences between their own conceptions of therapy, health care, disease prevention, and hygiene, and those of native-born Americans. In the case of the UK, the theme of "port health" has again been the most influential concept on earlier (mainly sociological) writing on the history of migration and health. Yet against this, Amy Fairchild has argued that the procedure that migrants endured at Ellis Island was part of a process of inclusion. Only when groups of migrants failed to conform to social expectations about the fit industrial worker did the migrant medical examination exclude those groups at the nation's borders. She argues that officials placed little emphasis on racial distinctions between people, with the goal of exclusion; rather, the impulse was to absorb migrants into the laboring body.

In the UK, after the Second World War, it was partly epidemiological evidence, but more importantly professional bodies, notably the British Medical Association (BMA), and political actors (Conservative and Labour MPs and Ministers), that sought compulsory medical examinations at the Ports of Entry. The 1962 Commonwealth Immigrants Act gave powers to Port Health Authorities and Immigration Officers to refer certain categories of people to Medical Inspectors for examination. Furthermore, from February 1965, chest X-rays were introduced on an experimental basis at London's Heathrow Airport. Nevertheless, the emphasis on screening at the Port of Entry was gradually subverted in favor of a policy whereby the addresses of arriving migrants were forwarded to Medical Officers of Health in the district of intended residence. Evidence indicates that neither the experimental X-ray scheme at Heathrow Airport nor the Port of Arrival system were effective as mechanisms for detecting early cases.

Many of the same factors seem uppermost in the debate on medical examinations and immigration today. These include the close association in the popular mind between migration and infectious disease, the emphasis on the importance of "protecting" public health, the stress on the costs of care for patients, the importance to the economy of migration, and the interest in the experience of other countries. While legislative frameworks in the UK remain essentially the same, their coercive nature may change to incorporate pre-entry screening on the US model. Historical perspectives throw long shadows on contemporary debates, and are helpful in explaining how the screening systems that exist today were created; relationships between science, politics, and policy; and continuities in different framings of immigration and medical examination.

Related Topics

- ► Communicable disease of public health significance
- ► Immigration processes and health in the U.S.: A brief history
- ► Inadmissibility on health grounds
- ► Sexually transmitted diseases

Suggested Readings

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Suggested Resources

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Medical Interpretation

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Introduction

As the immigrant population in the United States becomes more diverse, there is greater demand for medical interpreters. For legal, medical, and ethical reasons, a reliable and accurate medical interpreter is necessary in any medical setting where the provider and the patient do not share the same language. Medical interpreters are especially needed to ensure the legal rights of those who are linguistically diverse and are not able to communicate their symptoms to their healthcare providers so that these professionals can accurately diagnose and treat them. The profession has evolved, as well as the different technologies to provide language services. There are also barriers such as the lack of certified medical interpreters and the lack of reimbursement for language services across most states. Medical interpreters play a pivotal role in meeting the communication needs of the immigrant populations and are integral components of a comprehensive immigrant health policy.

Medical Interpreter Profession Overview

Translation refers to the written word while interpreting refers to the spoken word. While the interpreting profession is well established in the conference and business settings, medical interpreting, or health care interpreting, as it is sometimes called, is a relatively new specialization. According to the Bureau of Labor Statistics, Employment of interpreters and translators is projected to increase 22% over the 2008–2018 decade, which is much faster than the average for all occupations.

There is more to medical interpreting than just simply repeating what the physician has said in another language. While the interpreter seems to simply be "stating" in one language what was "said" by another speaker in another, the interpreter actually has to convert the messages by rephrasing them into the other language, which is the act of interpreting. It requires that the interpreter have a high fluency in both languages, and be very attuned to active listening in order to be able to properly "interpret" the message uttered. They are responsible for ensuring that the patients and providers understand everything that is being discussed. This is done primarily in the consecutive mode (the interpreter will interpret after a speaker finishes their utterance), and also in the simultaneous mode (the interpreter will start interpreting and continue as the speaker continues as well to speak so that both parties are speaking with a small time lag called *décalage*). There is also sight translation, when an interpreter reads a document, such as a discharge instruction, in one language, and interprets it orally into the other language.

In addition to interpreting for patients and providers, they engage in other activities. As other allied health professionals, interpreters document their work to produce statistics that will be later utilized for regulatory, operational, and quality measure purposes. They develop glossaries, engage in terminology research, provide cultural consultation to providers in situations where cultural issues take place, assist providers in identifying medications from other countries, provide medical translations, and many other tasks related to ensuring linguistic access to patients. Most medical interpreters state that their work is varied and interesting as they are able to participate in varied medical interactions, from a cesarean delivery (c-section) to an emergency stab wound treatment, to a psychological assessment. Staff interpreters see as many as 15 patients a day or as few as 5. Remote interpreters working primarily over the phone might interpret for many more interactions as phone interpreting encounters tend to average under 20 min and there is no travel time required from one interpretation to the other.

Interpreter Education

Medical interpreters are trained in their target language and culture and also in medical terminology and procedures. They must complete specialized training in the techniques of interpreting in various modes, and also in the knowledge of specialized medical terminology, standards of practice, ethical codes, and more. Many interpreters are nationally certified, and receive the CMI credential (Certified Medical Interpreters). The level of education and certification required to work varies from state to state.

Universities, community colleges, and training organizations offer different types of educational programs for medical interpreters. Some specialize only in medical interpreting while others work from a generalist-specialist model, where the student is trained to interpret in different settings. There are also different associations, both medical and language related, that provide continuing education opportunities. The programs vary in length and intensity depending on the school itself and where it is located.

Medical interpreters work for health care organizations, health plans or physician organizations, and translation and interpreting companies. There are both freelance interpreters and those that work for hospitals/health care facilities or organization. Those who work for hospitals will have more consistent hours and a more stable pay but sometimes do not get paid as much. Freelance interpreters are essentially on constant call so they must be available at a moment's notice, and they generally do get paid more. Many hospitals around the country are now hiring interpreters for staff positions, as well as hiring individuals to work on a per diem basis or as independent contractors. Telephone interpreting companies are hiring interpreters to work in their call centers or to work from home.

Standards of Practice

There are several published standards of practice for the medical interpreter profession. *Medical Interpreting Standards of Practice*, by the International Medical Interpreters Association and Educational Development Center, was the first to be published and is the most well known. If all that the provider and patient need to achieve the goals of the clinical encounter is this linguistic conversion, then simply providing such a conversion fulfills the interpreter's role. The standards, however, go beyond the skills of conversion and recognize the complexities of interpretation and the clinical interview. The medical encounter is a highly interactive process in which the provider uses language (the provider's and the patient's) as a powerful pool to understand, evaluate, and diagnose symptoms and to mutually inform and instruct. The interpreter, therefore, cannot simply be a "black box converter" but must know how to engage both the provider and the patient effectively and efficiently in accessing the nuances and hidden sociocultural assumptions embedded in each other's language, which could lead to dangerous consequences if left unexplored.

These standards of practice also recognize the importance of the medical encounter in establishing a therapeutic connection between the provider and the patient. The formulation of a therapeutic relationship is especially difficult when parties cannot communicate directly, and it becomes even more complex when different culturally based belief systems are involved. A competent interpreter can mediate these barriers by attending not only to the linguistic but also to the extra-linguistic aspects of communication. The standards are organized into three major task areas: (1) interpretation, (2) cultural interface, and (3) ethical behavior. They are intended for use by all stakeholders, with varying levels of knowledge in the field of medical interpreting.

Ethical Guidelines of Medical Interpreters

There are several codes of ethics that interpreters abide by. The International Medical Interpreters Association was the first organization to author an ethical code of conduct specifically for medical interpreters. It has been translated into 11 languages and has worldwide adoption. Multiple codes of ethics have since followed. The various interpreter codes of ethics include tenets of confidentiality, transparency, professionalism, advocacy, and impartiality.

Interpreter Roles

There are four roles that are well established in the medical interpreting field. The first role is that of *linguistic conduit role*; and that is the role in which the interpreter primarily focuses in listening to messages from one party in one language and recreating them in another language. The second role involves the *clarification role*, which is paramount for interpreters to completely understand the messages they are to interpret. This is when an interpreter will request any type of clarification to ensure understanding. The third role has been labeled as *cultural interface role*, also called cultural clarifier. This role involves identifying, exploring, or clarifying for either party a cultural context or belief or tradition that could be interfering with understanding. Culture is embedded in language and often a literal interpretation will simply not suffice for mutual understanding. The fourth role is that of *patient advocate*.

The Interpreter's Role of Patient Advocate in Immigrant Health

Most in the field agree that the role of patient advocate is a role that needs to be addressed with much professional maturity and care and not simultaneously with the act of interpreting, as it interferes with the ethical code of impartiality. Patient advocacy in the interpreting field refers more to advocacy and patient education for their language rights, access to health care, and intervening mostly when patient care is compromised. This is a role which is very sought out by immigrant patients who are at different levels of acculturation into the dominant culture and therefore need more assistance to navigate a new health care system from an operational as well as cultural perspective.

There are also other newer interpreter roles that are beginning to be explored in the field such as that of facilitator, navigator, and educator.

Language Access Laws and Regulations

There are several laws and regulations which form a framework for language access and they vary by state. At a federal level, Title VI of 1964 prohibits discrimination against national origin. The Americans with Disability Act covers the communication rights of the deaf and hard of hearing. The United States Health and Human Services Office of Minority Health Standards for Culturally and Linguistically Appropriate Services (CLAS) published in 2001 gave health care organizations across the country very specific guidelines. The Joint Commission which accredits hospitals values effective communication as a means to deter medical errors and has taken special interest in issues of language access. This legal framework has been very helpful in the provision of language services, but there are anti-immigrant sentiments and English-only laws that threaten these services to immigrants.

The Triadic Encounter: How to Work with an Interpreter

Physicians themselves clearly find that language barriers have a strong impact on services to patients who do not speak English. Here are important guidelines when working with a medical interpreter:

- Ensure proper introductions and pre-sessions
- Avoid high register, speak to the patient in lay terms
- Look directly at the patient, not the interpreter
- Speak to the patient in the first person
- Pause for the interpretation
- Ensure that instructions are understood by asking the patient to teach back
- Document interpretation or how the language need was met in the medical record

Mental Health Interpreting

Mental health interpreting requires more advanced skills from interpreters for several reasons. Providers of mental health are relying on subtleties of communication to make their diagnosis and tone and affect are difficult to ascertain from someone who is speaking a different language. Mental health providers and medical interpreters need to work as a team in order to have the same effect as if there were no language or cultural barrier. The interpreter needs to interpret these subtleties in a way that the provider can understand the patient well. Sometimes, depending on the case, continuity with the same team can affect the treatment positively while a sudden change in the triadic composition can take the patient back a few steps due to the trust and comfort level with the new interpreter. Mental health providers often request that the same interpreter interpret throughout a case to achieve a more effective result.

Language Access Technology: Remote Interpreting

Technology allows medical interpreting to be provided via telemedicine, or remote interpreting, as it is called in the language field. Several health care organizations are utilizing remote interpreting as a means to effectively offer medical interpreting services in a larger variety or languages 24 hours a day, 7 days a week. When a face-to-face interpreter is not available, sign language interpreting for deaf and hard of hearing patients needs to be provided remotely via video as the patient needs to see the interpreter signing on the screen. Both remote modalities are becoming more common as health care professionals become more comfortable with the technology and understand the importance of relying on a professional medical interpreter. Remote services have certain advantages such as greater reliability of service, availability in remote areas or emerging languages, and timeliness, as the interpreter becomes available within a minute or less. The newest modality is the mobile phone interpreter service applications available now to the general public, making a professional interpreter directly accessible to the consumer.

Common Barriers to Language Access

1. *Providers or Patients Interacting with Limited Proficiency* – Some health care professionals know enough to get through a basic conversation with the patient but, without a good understanding of the patient's culture or language, inaccurate communication can create further confusion or misunderstandings or result in negative health outcomes. In order to have an effective conversation with the

patient, the health care professional should understand the patient's culture, how the culture affects the patient's language, and how to directly translate meaning, not just words. Immigrant patients have different levels of language acculturation and their understanding of English might suffice for one type of appointment whereas a discussion of treatment options might require a medical interpreter. Likewise, a provider with limited Spanish vocabulary will certainly not know what they did or did not understand and such types of communications are fertile grounds for miscommunication.

2. *Lack of Reimbursement for Medical Interpreter Services* – Only 14 states have Medicaid reimbursement and very few insurance companies pay for language services. This is changing and there is legislation in progress in US Congress advocating for this reimbursement. Without it, hospitals and small provider practices are left to pay for these services out of their administrative budgets, making this an unfunded mandate.
3. *Lack of Training on Cultural and Linguistic Issues in Health Care* – Medical schools are starting to incorporate stronger components of cultural competency into their curriculums and internships or residency programs. Most health care organizations do not have cultural and linguistic educators, but more is being done in this area than ever before.
4. *Reliance on Unqualified Interpreters* – When a qualified interpreter is not available or has not been scheduled, the provider is often left with the difficult decision of how to proceed. The provider may resort to relying on a bilingual staff member, family members, or friends as facilitators to the communication. These options are wrought with inadequacies, such as the confidentiality of personal health information and also the inability for most of these people to interpret medical terminology or act in an impartial and objective manner when a loved one's health is being discussed. Often the provider will, in effect, have a conversation with the facilitator and not the patient. When the family member or an untrained bilingual staff person does this, there is nobody to interpret for the patient who is simply left out of the equation. Remote interpreting is rapidly becoming a preferable option when a face-to-face interpreter is not available.

Conclusion

Medical interpreters certainly play an important role in immigrant health due to their unique position: they are knowledgeable in the culture of the patient and the Western health care system. They facilitate the delivery of linguistically and culturally appropriate health care services to newcomer populations and providers strive to eliminate ethnic and racial disparities in health care.

Related Topics

- ► Cultural competence
- ► Cultural humility
- ► Language acculturation
- ► Language barriers
- ► Safety

Suggested Readings

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Schenker, Y., Wang, F., Selig, S. J., Ng, R., & Fernandez, A. (2007). The impact of language barriers on documentation of informed consent at a hospital with on-site interpreter services. *Journal of General Internal Medicine, 22*(Suppl 2), 294–299.

Suggested Resources

American Translators Association – www.atanet.org
International Medical Interpreters Association – www.imiaweb.org
National Council on Interpreting in Health Care – www.ncihc.org

Medically Indigent

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"Medically indigent" is a term used in the USA that refers to individuals who do not have health insurance and are not eligible for other health care coverage such as Medicaid, Medicare, or are not able to afford private insurance. States, counties, and municipal agencies have established under legislative authority Medically Indigent Programs to provide critical medical services to the population. Funded by state and county or local taxes, they are usually authorized under a state public health or health and social services state code. The codes specify eligibility requirements, services allowed, acceptable providers and facilities, and application and administrative processes. The programs are considered the "last resort" when other options for coverage have been exhausted and are usually administered by agencies at the state or county level.

Eligibility

Eligibility requirements vary from state to state but most provide coverage for adults and children. Programs are designed for residents (and often specifically citizens) and applicants must document financial status, usually based on the Federal Poverty Guidelines, as well as non-eligibility for public programs and insurance. If eligibility changes, enrollees will be transferred to another program for which they are eligible. Eligibility may need to be reviewed and reapproved periodically. States vary in their eligibility requirements. Colorado includes residents, migrant farmers, and US citizens or legal immigrants. Virginia covers residents, citizens, or lawful aliens, while California covers undocumented residents only for emergency care.

Services

Eligible services are specified by type, duration, and place. Public facilities such as public hospitals or designated general hospitals in the patient's residential area are the primary source of services. Services include hospitalization (medical or surgical), emergency treatment, and psychiatric admission. In addition, skilled nursing and intermediate care services are often included. Some outpatient services may be offered such as laboratory diagnostic tests; dialysis; prescription drugs; physical, occupational, or respiratory therapy; mental health services; and dental care. Home health services may also be covered along with durable equipment. Childbirth and child health services may also be paid services.

Administration

Medical Indigent Programs are under strict requirements to verify eligibility requirements, proper facility, and provider care and optimal use of these resources dedicated as a last resort for care. Therefore, documentation of residency, income, and household composition and enrollment in other programs are the responsibility of the applicant. If the applicant is identified as a noncitizen, for example, additional verification information will be required.

This program provides important care for those without access to care through traditional public programs or private insurance. Immigrants will be limited in the ability to utilize this program, however. Since social security numbers, birth certificates, and income statements and residence verification are required, this may be a deterrent to enrollment. Legal immigrants and refugees may qualify in some states. A first effort would be to determine if Emergency Medicaid is an option. If the applicant is not eligible then the Medically Indigent Program criteria for eligibility will be applied. The variability of programs across states suggests that residents must explore the requirements within their resident state to determine the benefits for which they may be eligible. Since the intent of these programs is to provide care as a last resort to needy residents and citizens, the expansion of services to immigrants is unlikely. This is underscored by the strains on state budgets and the anti-immigrant sentiment in some states.

Related Topics

► Emergency services
► Hospitalization
► Poverty

Suggested Readings

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Suggested Resources

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Medicare

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Medicare is a federal health insurance program administered by the US government. Signed into law on July 30, 1965 as Title XVIII of the Social Security Act, Medicare is the major health insurance for those over 65 years of age who are covered by the Social Security system, regardless of income. Amendments to the Social Security Act in 1972 extended the benefits to those who do not meet the criteria for the regular Social Security Program, but who are willing to pay a premium for coverage. In 1973 a further amendment extended benefits to those entitled to Social Security disability benefits or those who suffer from chronic renal disease requiring a kidney transplant or routine dialysis. Many beneficiaries who qualify for Medicare also receive Medicaid. In 2008, the Medicare program had 45 million enrollees, and that number is expected to grow to 78 million by 2030, making the program a major national healthcare expenditure. Citizenship and payment into the Social Security System requirements preclude immigrants from participation in this program.

The Medicare program consists of four parts: Part A (hospital insurance), Part B (supplemental medical insurance), Part C (advantage plan), and Part D (prescription drugs). Part A coverage includes hospitalization, care in a skilled nursing facility, and home health or hospice care. Part B of Medicare, supplemental medical insurance, is an optional plan and must be paid for as a Social Security deduction. It pays for reasonable physician charges, inpatient and outpatient medical and surgical services such as renal dialysis, supplies, limited ambulance transportation, physical and speech therapy, ambulance and diagnostic tests, clinical laboratory tests, home health care, and outpatient diagnosis and treatment. Part B also covers patients' medical equipment (such as wheelchairs and walkers), prosthetics, and oxygen for home use. Parts A and B are generally less costly than additional private insurance and beneficiaries have a lower average out-of-pocket expenditures spending than Medicare beneficiaries overall. Under Part C, beneficiaries are given the option to receive Medicare benefits through their private health insurance plans and pay a monthly premium to cover costs not covered by Parts A (hospital insurance) and B (medical insurance), such as dental and vision care. With Part D, which went into effect on January 1, 2006 as part of the Medicare Prescription Drug, Improvement and Modernization Act, the program helps to subsidize the costs of prescription drugs for Medicare beneficiaries. Individuals can join Part D of the Medicare program or a private prescription drug plan for coverage.

Medicare beneficiaries are often required to pay out-of-pockets expenses such as premiums, deductibles, and co-payments through private insurance healthcare plans. Under Part A, most Medicare patients do not pay a monthly premium because they have paid Federal Insurance Contributions Act taxes. For those who have not, they must pay a monthly premium. However, all Part B enrollees must pay an insurance premium for coverage. The amount paid per monthly depends on household earnings; the higher the household income, the more one pays. Deductibles are set amounts patients must pay before Medicare begins to pay. For example, under Part A, patients must pay a deductible of $1,068 for a hospital stay of 1–60 days and $534 per day for 91–150 days of a hospital stay. Under Part B of the plan, after a patient meets the yearly deductible of $135, he or she is required to pay a coinsurance of 20% for all services, except for laboratory services that are completely covered. Co-payments are a percentage of the charges paid by a patient and may be required at the time of service. These expenses for deductibles, co-pays, and supplemental insurance for elderly persons may pose a significant financial burden and contribute to beneficiaries not seeking care when it is indicated. One in seven elderly Medicare beneficiaries does not have a usual source of care or has not seen a physician when they needed medical care.

Supplemental insurance, Part B has emerged as an option for the patients to lower co-payments, covers more services and decreases out-of-pocket expenses. The majority of elderly purchase this benefit. Beyond this, Part C (often referred to as Advantage), "Medigap insurance" was designed to cover what Medicare does not. Beneficiaries purchasing this insurance must already be enrolled in Parts A and B of Medicare and will continue to pay for Part B. While only standardized policies are sold under this benefit, private insurance requires premiums, deductibles, and co-pays to be paid by the beneficiary. Policies may vary substantially in cost. Medigap policies sold before the enactment of Part D in January 1, 2006 do provide coverage for prescription drugs, while Medigap plans sold after this date do not cover prescriptions since Part D was enacted. While these efforts have been developed to minimize financial barriers to care, many elderly may not enroll in the programs when their resources are insufficient to make these additional out-of-pocket expenses or they do not understand the program benefits.

Part D of Medicare, the prescription drug component, was instituted after a public outcry regarding the increasing costs of prescription drugs and the plight of the elderly, who reported high out-of-pocket expenses that often competed with the expenses of daily living. Part D, a low-cost drug program, was a major advance in the benefits offered by the Medicare program. Medicare beneficiaries must apply for this benefit to obtain medications through a private drug program subsidized by Medicare. They must have Parts A and B and be a permanent resident in a state with prescription drug programs. Medicare beneficiaries may also select their own prescription drug plan such as one offered by their former place of employment or through unions instead of Part D. Part D includes deductibles and not all medications may be covered. While there were obstacles in the implantation of this, such as deductible and a benefit gap, Medicaid patients were transferred to the program and an option for drug coverage became available subsidized by the Medicare program. Current efforts in the program are focused on access for the elderly who are poor and ensuring availability of acceptable programs in both quality and quality.

In addition to the type of service covered, Medicare benefits are paid for a specific period of time. For example, hospital care expenses that comprise over 55% of Medicare expenditures and skilled nursing home expenses that are increasing their share of the expenditures annually are not paid by Medicare beyond a specified number of days. Typically, the benefit period begins on the day a patient is admitted to a hospital and ends after 60 days in the hospital or facility care. When secondary insurance fails to cover the expenses beyond Medicare, patients pay out of pocket for the ongoing expenses. In many cases, this is beyond the capacity of many families and the elderly are enrolled in the Medicaid program, a state-federal program, to cover the nursing home costs. Medicaid and personal resources are the primary financial resources for nursing home care. With nursing home costs increasing and an aging population, long-term care will continue to be a major expenditure of healthcare resources.

The Medicare program receives its revenue through various funding sources: payroll taxes levied on employed personnel, general revenue, beneficiary premiums, payments from states, taxation of social security benefits, and interest earned on the trust funds. Part A received the majority of its funding through payroll taxes (85%), while Parts B and D receive most of their funding through general revenue, 73% and 77%, respectively.

In 2009, Medicare paid $484 billion in benefits payments: more than one-third of the payments were for patient care at inpatient hospital and nursing facilities (Part A), while 28% covered Part B services, including outpatient and physician care.

Medicare spending is growing steadily in absolute terms and as a proportion of the federal budget. In 2009, Medicare spending reached $511 billion, or 3.5% of the gross domestic product. Also, Medicare spending is expected to increase to $926 billion in 2018 and become 6.4% of the gross domestic product in 2030. Further, the Part A trust fund is projected to be depleted by 2017 and the monthly Part B premium is expected to increase to $111.50 in 2012. Going forward, Medicare will have difficulty maintaining financial viability, especially as the population continues to age and the number of enrollees increases each year. Fundamentally speaking, the ratio of personnel paying Medicare taxes to retirees who are receiving benefits is reducing. At the same time, the cost of providing healthcare services to individuals is increasing. Each year for the next 10 years, Medicare spending is expected to increase by 7%. The challenge for officials is to keep Medicare program efficient, effective, and equitable in providing coverage for a broad scope of services. A recent inclusion of preventive services such as immunizations in coverage suggests this process is continually being reviewed.

Benefits for immigrants as beneficiaries in public health programs have ignited a debate over the past decade. As a federal program, Medicare does not provide benefits for noncitizens and those who have not paid into the Social Security system. While some states may elect to provide benefits for the elderly, Medicare cannot be relied on to provide care for the immigrant elderly. The public health challenge is to maximize the functioning of this program, despite the financial and administrative setbacks. Notably, quality-of-life and end-of-life issues will influence the public policy discussions and the status of immigrants as an increasingly diverse population reaches age 65. The heart of public policy debates regarding Medicare and how to pay for it is expected to continue as health care in the USA undergoes reform.

Related Topics

► Access to care
► Health insurance
► Medicaid

Suggested Readings

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Meditation

► Religion, religiosity, and spirituality

Melting Pot

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The melting pot is an analogy for the idealized process of immigration and colonization whereby people of different national and cultural origin purportedly "melt together" into a new, harmonious, and egalitarian community. It was particularly used in the early twentieth century to describe utopian visions of the assimilation of immigrants in the United States, foretelling the emergence of an American "new man." The metaphor was popularized by the 1908 play

The Melting Pot by Israel Zangwill, though others had used similar imagery in the nineteenth century.

The suitability of the melting pot model in present-day society is somewhat contentious. The more contemporary analogy, the salad bowl, suggests that different cultures mix, but their distinct identities remain intact. Similarly the more widely used term of multiculturalism proposes that cultural differences within society are valuable and should be preserved.

Quantifying various dimensions of social integration such as culture and language may present some challenges to the social scientist; however, data on the health and economic well-being of immigrants is relatively easy to collect. Furthermore, while to most modern observers attempts to eradicate differences in the former dimensions in immigrant people would be considered objectionable, eradication of health and economic disparity would seem to be a desirable, if elusive, end.

One study looking at the effects of a melting pot policy in Israel clearly demonstrated an increase in socioeconomic disparity in second-generation immigrants. There is also a growing body of evidence that demonstrates increased morbidity in immigrant populations subject to socioeconomic disadvantage. A striking example of this effect is the high rates of serious mental illness, such as schizophrenia, in the British African Caribbean population. This effect would not appear to be due to the potentially stressful process of migration itself, as the native-born immigrants are less affected than subsequent generations. While it is likely to be multifactorial, a plausible mechanism for this adverse effect on immigrant health is yet to be demonstrated.

Related Topics

- ▶ Language acculturation
- ▶ New York City
- ▶ Occupational integration
- ▶ Psychological acculturation

Suggested Readings

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Menopause

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Menopause is defined as the cessation of ovarian function or of menstrual cycles. The diagnosis of menopause is made when a woman has not had a menstrual cycle for 12 consecutive months. The diagnosis can also be made by laboratory studies, which indicate a pattern of persistent elevation in follicle-stimulating hormone (FSH) and luteinizing hormone (LH). Menopause occurs because the ovary stops producing the hormones estrogen and progesterone. It is a normal process of aging with a median age of 51 years. The normal aging process involves the progressive decline in the number of oocytes, or eggs by atresia (degeneration of eggs) or ovulation. This is a gradual process, which occurs over an average of 4 years. The years prior to menopause are referred to as the menopause transition. During this time, fluctuations in FSH and LH cause irregular menses and a series of symptom complexes.

Common symptoms associated with the menopause transition are hot flashes, night sweats, and vaginal dryness. These symptoms are thought to be associated with the menopausal hormonal changes. Hot flashes and night sweats are referred to as vasomotor symptoms. Vasomotor symptoms typically occur around the final menstrual period and then gradually decrease in frequency. Vaginal dryness is a symptom of vaginal atrophy (wasting). Vaginal dryness is less common than vasomotor symptoms, affecting approximately one third of menopausal women. Other symptoms reported during menopause that are not directly related to changes in hormone levels include sleep disturbances, mood swings, cognitive difficulties, joint pain, headaches, and palpitations. The symptoms of menopause vary greatly between individuals. Studies suggest that a woman's educational levels, cultural background, acculturation, and lifestyle influence her perception of menopausal symptomatology. Immigrants in general were found to have lower rates of visiting physicians for menopausal symptoms or discussing health care maintenance such as hormone replacement therapy.

The diagnosis of menopause is confirmed by laboratory tests. An elevated FSH (greater than 30 mIU/mL) in the setting of absent menstrual cycles is diagnostic of menopause. LH levels are elevated in menopause but typically rise slowly over the menopause transition.

Menopausal women are at increased risk of osteoporosis, breast cancer, and endometrial cancer. These health problems are associated with the reduced hormone levels of menopause. Postmenopausal women should be regularly monitored for these health problems.

The treatment of menopausal symptoms includes both pharmacological and nonpharmacologic interventions. Hormone therapy is an effective treatment for many menopausal symptoms; however, controversy surrounds its use because of its many side effects including cardiovascular events, breast cancer, and thromboembolism (blood clots).

Related Topics

- ► Fertility
- ► Reproductive health

Suggested Readings

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Suggested Resources

National Library of Medicine, Medline Plus. www.nim.nih.gov/medlineplus/menopause.html

North American Menopause Society. www.menopuase.org

Mental Health

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Research into the mental health of immigrants has been a significant subspecialty of psychiatry for almost 100 years. Odegaard could be considered one of the founding fathers of this subspecialty. In his famous 1932 paper "Emigration and Insanity," he notes that Norwegian immigrants to the United States have higher rates of "insanity." He argues that this can be explained by the selective migration of "weak" people from Norway, as evidenced by histories of poor social adaption prior to migration. This hypothesis reflected popular beliefs at the time that European immigrants (especially those from Southern and Eastern Europe) to the United States were predisposed to "insanity" and other forms of "weakness" such as alcoholism. Unfortunately, these popular beliefs were somewhat perpetuated by significant figures within mainstream psychology and psychiatry, backed up by dubious empirical and theoretical scholarship. As cogently argued by Stephen Jay Gould, this was used to justify restrictive immigration policies to the United States in the name of "science." This misuse of psychiatric theory remains a stain on the investigation into immigrant mental health.

Fortunately, since the time of Odegaard, research and theoretical development in the field of immigrant mental health has multiplied and diversified, with a variety of perspectives and models going far beyond the stigmatizing "moral weakness" explanations of yesteryear. Teams of well-funded and sophisticated researchers in countries such as the United States, Canada, the United Kingdom, the Netherlands, Sweden, and Australia have emerged with their sole focus on the investigation of the mental health of immigrants.

Smaller teams continue to examine migration within the non-Western world, for example, from East African countries to Middle Eastern countries. The investigation of immigrant mental health has become a global phenomenon.

Mental Health and Immigrants

Contrary to Odegaard's theory, some research suggests that immigrants are mentally healthier than (1) the general population of the places from where they migrate and (2) the general population of the place to where they migrate. This phenomenon has become known as the "healthy migrant effect." It is explained by theory suggesting that in order to migrate, individuals must have a high level of resiliency and psychological resources. Furthermore, many Western countries also have strict medical requirements for immigrants. Potential immigrants face medical screening prior to the issuance of papers, which prevents those with preexisting health problems from emigrating.

However, other research suggests that this "healthy migrant effect" is temporary in terms of mental health, with immigrants soon suffering mental illness at a rate at least similar to the host population. Furthermore, the healthy migrant effect may be applicable only to skilled immigrants with preexisting economic, social, and symbolic capital. Vulnerable groups of immigrants, for example, refugees, asylum seekers, and those from predominantly Black populations, may be at higher risk.

Indeed, much research implies elevated levels of various mental disorders, especially schizophrenia, among immigrant populations in the Western world. This especially appears to be the case among dark-skinned immigrants and those coming from a developing country. Evidence is overwhelming that certain immigrant groups in Western Europe suffer a greater incidence of schizophrenia. This includes first- and second-generation Afro-Caribbean immigrants to the United Kingdom, first- and second-generation Surinamese and Moroccan immigrants to the Netherlands, and East African immigrants to Sweden. A recent meta-analysis of the incidence of schizophrenia in immigrants to various Western countries (of various nationalities and ethnicities) found strong evidence of significantly increased rates in both first- and second-generation migrants. A common finding is that risk increases with length of residence in the host country, and that this risk is even more severe in the second generation. This suggests a dose–response relationship. There is something toxic in the sociocultural environment for some immigrants to Western countries.

Models seeking to explain the relationship between immigration and mental illness have moved away from Odegaard's simplistic notion that elevated rates are accounted for by preexisting vulnerabilities. Though acknowledging the role of premigratory factors, newer models also emphasize postmigratory experience in the host country, as well as the nature of the process of migration itself. These models also emphasize resilience, acutely aware of the stigmatizing nature of the pathological emphasis that plagued early investigations into immigrant mental health.

Instead of focusing on preexisting *vulnerabilities* before migration, many contemporary researchers into immigrant mental health focus on premigratory *experience*. Many immigrants, especially refugees and asylum seekers, come to Western countries from war-torn regions, ravaged by poverty, persecution, civil violence, food shortages, drought, and violence. Some may have witnessed widespread death and destruction (even genocide). Experience of violence and/ or persecution may further leave people vulnerable to posttraumatic stress disorder and other mental disorders. They may carry the physical and psychological scars from such events with them as life progresses after migration. Indeed much therapy attempts to focus and reinterpret premigratory experience in immigrants in order to combat mental health problems such as posttraumatic stress disorder.

Other researchers have also focused on the *process* of immigration. Many refugees and asylum seekers have spent time in refugee camps or have traveled to their host country via circuitous and arduous journeys. In such camps, potential immigrants face crushing and chronic problems such as poor diet, inadequate physical activity, and lack of work. They may be tormented by uncertainty regarding the fate of loved ones, as well as uncertainty about the future. They may experience the loss, entrapment, and humiliation which are associated with depression and anxiety, especially among women. Such experience can be psychologically damaging and an ongoing risk factor for psychopathology.

In terms of the role of postmigratory experience in the development of mental illness, numerous common risk factors have emerged from the literature. One emerging risk factor that has received much attention is the concept of "social defeat," which has been posited as influential in the development of psychosis in migrants. Social defeat is an umbrella term that refers to various sociocultural (and economic) acute events and chronic processes often experienced by immigrants. These processes and events share in common aspects of subordination, humiliation, entrapment, thwarted expectations, and marginalization. What common experiences amount to social defeat for immigrants? First is the experience of obvious and subtle racism and discrimination. This may come in many forms, for example, being passed over for a job or being harassed by law enforcement. Second is a phenomenon known as aspiration-achievement discrepancy. This can refer to immigrants being unable to find a job commensurate with qualifications and experience – the proverbial doctor driving a taxi. Such discrepancy might be due to issues of language, nonrecognition of foreign qualifications, and other structural discrimination. Immigrants may have arrived with dreams of large cars, spacious houses, and well-paid jobs; the reality of immigrant life might be quite different. Third, social defeat may come about due to deliberate and subtle denigration of cultural identity. This is a plight facing many religious immigrants (and nonimmigrants) in Western countries today, where core symbols that express that person's identity are being questioned, and in some extreme cases, even outlawed. It should be noted that social defeat, and indeed other risk factors for immigrant mental illness, may vary by sociodemographic variables. Evidence suggests that factors such as gender, age, and ethnicity may mitigate (or worsen) the impact of these risk factors.

While the discussion so far has focused upon risk factors for mental illness, it should be noted that some studies suggest that numerous protective factors commonly exist among immigrant populations. A widely studied factor is known as "the ethnic density effect." This refers to a phenomenon whereby adverse mental health outcomes among individuals from ethnic minorities are higher in neighborhoods where they comprise a lower proportion of the population. In other words, living in neighborhoods with a high density of similar immigrants is good for immigrants' mental health. These neighborhoods may be more inclusive and welcoming, with less opportunity for social defeat. Dense social networks within these neighborhoods may also provide salutogenic social support and cultural validation.

Another protective factor for immigrants is religion and spirituality. Many immigrants hold a deep and abiding religious faith, which they continue to practice on arrival in a new country. Religious congregations may provide new arrivals with a ready-made community into which they can enter and find social, instrumental, emotional, and practical support. These "gateways" can even help immigrants find work and integrate into the host society. This is a resource which may have been underexploited in mainstream psychiatry, but which is undoubtedly protective for mental health.

Mental Health Services and Immigrants

Every Western country has developed its own mental health service system. All Western countries (except for the United States) provide basic mental health services that are free at the point of use. Regardless of the configuration of health services within a country, a common finding is that immigrants tend to underutilize mental health services. Numerous reasons have been put forward for this underutilization. These explanations tend to focus on either (1) individual-level factors, (2) community-level factors, or (3) service-level factors. There is a large overlap between these three factors – they are not orthogonal. In terms of individual-level factors, issues such as inability to speak the language of the host nation, or lack of health insurance, can prohibit use of conventional mental health services. Immigrants living in trying circumstances may also find it difficult to take time off work (which is often only paid hourly) to visit a mental health clinic regularly. In terms of community-level factors, stigma and the possession of differing explanatory models for mental illness are often identified as influential.

Explanatory models refer to notions held by individuals regarding the causes, nature, and consequences of emotional suffering. These are often shared within cultures. Many immigrants will consider emotional suffering as a moral or religious problem, or as part of everyday life unworthy of medical attention. They will thus seek help from family and friends first, religious and folk healers second, and mental health services last.

Another common explanation for immigrant underutilization of mental health services is stigma. It is posited that in certain communities, the manifestation of a mental health problem, and consequent use of mental health services, can indelibly stigmatize not only the individual concerned but also his or her entire family. It may affect secondary factors such as their job opportunities and marriage prospects (for them and their family). As such, stigma may be a prohibitive impediment to the use of mental health services in some immigrant groups.

In terms of systemic factors, many themes emerge accounting for immigrant underutilization of mental health services. Many have cited lack of cultural, linguistic, or religious competence in services as influential in deterring their use among immigrants. Some studies suggest that many immigrants find mental health professionals unsympathetic to “talk” and more interested in hastily dispensing psychiatric medication. This leads them to drop out of services in search of more holistic or respectful (to their eyes) models of health care.

More worryingly, some research suggests that mental health services are inherently Eurocentric and may even have some characteristics that could lead them to be accused of “institutional racism.” For example, a growing body of research suggests that dark-skinned first- and second-generation immigrants are significantly more likely to be brought to emergency psychiatric services by the police or ambulance, in comparison to the general population. Other studies suggest that dark-skinned first- and second-generation immigrants are less likely to be offered “talking therapies” and more likely to be over-medicated. Additionally, they are more likely to receive restraint and seclusion.

Though the situation for immigrant mental health may sound bleak, there are positive signs of progress. Transcultural psychiatry clinics now exist in various cities around the world, including Montreal, Toronto, London, Stockholm, and Amsterdam. These clinics provide culturally sensitive psychiatric services in a multicultural milieu to a multicultural population. They often make manifold use of culture brokers, interpreters, cultural psychiatrists, and other experts to assist in individual cases. These models are spreading throughout the world.

Another cause for optimism is that many national and regional governments have made commitments to improving knowledge and practice regarding immigrant mental health within their jurisdictions. For example, establishing greater knowledge and practice in this area has been highlighted as a key priority by various commentators and agencies concerned with immigrant mental health in the United Kingdom, Canada, and Australia.

Conclusion

Some clear themes have emerged from the study of immigrant mental health. Key findings include the elevated rate of schizophrenia for immigrants and the underutilization of mental health services by immigrants. Various explanations have been put forward accounting for these differences, and various strategies are in place to address these inequalities. The study of immigrant mental health faces a set of specific conceptual and methodological challenges. Social, cultural, religious, linguistic, geographical, and economic variables have all been hypothesized as important in determining mental health and health-service utilization among immigrants. Debate is ongoing regarding the relative influence of pre- and postmigratory factors in determining mental health outcomes. Unpacking the impact and interaction of these variables is difficult, and they may apply with differential weight to immigrant subgroups. Fortunately, the arena of immigrant mental health is occupied by dedicated and gifted teams of researchers and practitioners in various centers across the world. Many of these researchers and practitioners are themselves first- or second-generation immigrants and have developed vital links with community organizations in order to develop a strategy to improve community mental health. These teams meet regularly at conferences throughout the year to exchange findings and discuss emerging models of best practice. This situation gives cause for optimism vis-à-vis the promotion of mental health among immigrants.

Related Topics

- ► Acculturative stress
- ► Explanatory model of illness
- ► Healthy immigrant
- ► Immigration processes and health in the US: A brief history
- ► Medical examination (for immigration)
- ► Mental illness
- ► Posttraumatic stress disorder
- ► Racism
- ► Transcultural psychiatry

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Whitley, R., Kirmayer, L. J., & Groleau, D. (2006). Understanding immigrants' reluctance to use mental health services: A qualitative study from Montreal. *Canadian Journal of Psychiatry, 51*, 205–209.

Suggested Resources

Nathan Kline Institute Center of Excellence in Culturally Competent Mental Health Care. http://ssrdqst.rfmh.org/cecc/. Accessed April 30, 2011.

The Multicultural Mental Health Resource Center of Canada. http://www.mmhrc.ca/. Accessed April 30, 2011.

Mental Illness

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Immigrants, including refugees, face unique stressors that contribute to mental illness prior to, during, and after migration to a foreign country. Many factors affect immigrants' abilities to cope with these stressors. Diagnosis and treatment of mental illness is complicated due to accessibility barriers and cultural differences in the display and acceptance of mental health conditions.

Premigration Factors

Premigration trauma experienced in the country of origin may include environmental triggers such as war, torture, genocide, terrorism, natural disasters, and famine. The effects of these factors are exacerbated by the loss of family members and social networks through separation and/or death. The immediate residence prior to migration can also affect the mental health of immigrants and refugees. Prolonged stays in refugee camps and detention centers impact one's mental health in very different ways. For instance, the majority of refugee camp dwellers have sufficient cause to worry over their physical safety and material possessions. In addition to safety fears, refugees residing in camps often become dependent on ration cards and handouts which can perpetuate a felt loss of identity, independence, and self-sufficiency.

Expectancy bias is another premigration risk factor for mental illness. Expectancy bias ensues when life in the receiving country is not as one thought it would be.

Immigrants and refugees often have unrealistic expectations of their future in the USA, and are subsequently disappointed when they discover the realities of their postmigration situation. The disconnect associated with the reality of lived experiences and romanticized expectations amount to an increase in current stress levels that may exacerbate prior and contribute to nascent mental health afflictions.

Perimigration Factors

The process of migration can impact mental health outcomes. Immigrants face challenges leaving their country of origin that may include fleeing dangerous conditions, traversing geographical obstacles, and witnessing death and/or separation from loved ones. The formal application process and immigration status can also impact the mental health of immigrants. Polygamy, the practice of having multiple spouses, is practiced in various regions of the world. Polygamy is not legal in the USA; therefore, the USA will not accept multiple wives from the same family to be resettled as one family unit or as part of family reunification programs. Families seeking placement in the USA must either lie on their application forms or elect to leave certain members behind. Either of these options greatly affects family dynamics and can impact mental health.

Postmigration Factors

Postmigration stressors also play a pertinent role in the mental health status of immigrants. Postmigration stressors include issues such as financial concerns, acculturation, prejudice and discrimination, worries about family back home, loss of traditional ways of life, and dismal housing conditions. Postmigration difficulties in conjunction with premigration trauma and perimigration challenges coalesce to contribute to the mental health status of immigrants.

Finding gainful employment is the primary concern for immigrants and refugees immediately after migration. Immigrants to the USA are expected to quickly achieve a degree of financial self-sufficiency. Due to current economic conditions, it is difficult for non-English-speaking immigrants to obtain any type of employment. When immigrants obtain jobs, they are often overqualified for the position and receive minimal compensation for their efforts. Immigrants not only pay for the many expenses of life in the USA, but many also send money to family members still residing in their country of origin.

Another postmigration challenge that causes significant stress is the process of acculturation. Acculturation is especially difficult for individuals migrating from developing countries to industrialized societies. It is difficult to learn the nuances and fully engage in a culture different from one's own. Those that have gained proficiency in the dominant culture may still experience stress stemming from loss of cultural identity. Immigrants may also display signs of "margination," or opposition to acculturation. Elderly immigrants in particular maintain their original culture at the expense of the host culture and encourage younger family member to do the same. Margination is not an option for youth and adolescents, however, as they are immersed in school and struggle to fit in.

Not all immigrants have experienced prejudice and discrimination as a result of race or ethnicity prior to migration. While this is clearly not the case for refugees who may have fled due to racial or ethnic persecution, this is something that many immigrants did not account for prior to relocating to the USA. Most immigrants fit in and looked like the majority of other people in their country of origin. Upon arrival to the USA, however, many are dealing with discrimination and prejudice for the first time. Discrimination is increasingly recognized as a risk for mental illness.

Traditional ways of life and family dynamics also change dramatically as a result of migration. In many societies the elderly are the decision makers in their households and communities. Their knowledge and wisdom is appreciated and advice sought from the younger generations. After migration, however, the elderly feel that they have little wisdom to impart on the younger generations. The knowledge they have acquired throughout their life is no longer useful. The elderly also have difficulty adjusting to new ways of life, whereas children and adolescents adapt more quickly. Children learn English more quickly and often serve as the family interpreter – an essential service valuable for the migrating family. Where the elderly were once given the highest honor in the family, the power dynamic has shifted in favor of those who are able to learn English the quickest, thus altering traditional family structures.

Housing conditions also greatly affect the mental health of immigrants. Immigrant populations often have a limited income and subsequently reside in neighborhoods with low-cost housing. These areas tend to be urban, have higher crime rates, and lower performing schools compared to areas where nonimmigrant populations reside. Limited income also drives many immigrants to live in overcrowded conditions. The neighborhood environment and the quality of living conditions impact one's mental health status.

Protective Factors

It is important to note that not all immigrants experience mental illness. In fact, some immigrant groups have better mental health than nonimmigrant populations. For instance Mexican immigrants to the USA experience less mental illness than nonimmigrant populations in the USA. Many groups have protective factors associated with their culture that serve as a barrier to mental illness. Current studies are further investigating the concept of protective factors. The protective factors that some immigrant groups possess decline as families acculturate to life in the USA and these factors do not necessarily shield the second generation. Second-generation Hispanic adolescents have a dramatically higher rate of suicide and suicide attempts in the USA than nonimmigrant populations in the same age bracket.

Resilience is a factor with a positive impact on mental illness. Immigrants endure the challenges of relocating due to a strong desire for a better life for themselves and future generations. Immigrants have the resilience to move forward and achieve their goals. Indigenous religious and culturally prescribed practices among immigrant populations may have the ability to enhance resiliency and recovery efforts.

Illness and Diagnoses

Immigrants and refugees experience different mental health afflictions to a degree. Due to the inherent nature associated with a refugee's history, it is common for refugees to experience negative mental health effects after migration such as posttraumatic stress disorder (PTSD), anxiety, depression, and somatization. Statistics pertaining to psychiatric diagnoses within refugee populations in the USA have yet to be determined. Immigrants arriving in the USA primarily for economic reasons are less likely to experience PTSD and anxiety disorders, but are more likely to suffer from chronic stress and depression.

Barriers to Care

Immigrants and refugees face many barriers to effective care and treatment of mental illness. Barriers to care fall into two main categories – accessibility and acceptability. Accessibility barriers pertain to logistical barriers such as cognizance of services, the location of services and transportation to services, documentation, language barriers, and traversing a complex health care system. Acceptability barriers include the use of cultural healing modalities and the stigma associated with mental illness. For better outcomes with diagnosis and treatment of such illnesses, there is the need to consult cultural advisors when addressing mental illness in immigrant and refugee populations.

Related Topics

- ► Acculturation
- ► Acculturative stress
- ► Culture shock
- ► Depression
- ► Discrimination
- ► Health perception
- ► Posttraumatic stress disorder
- ► Refugee
- ► Resilience
- ► Trauma exposure

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Suggested Resources

American Psychiatric Association – Mental illness. http://www.healthyminds.org/Main-Topic/Mental-Illness.aspx

Mayo Clinic—Mental illness. http://www.mayoclinic.com/health/mental-illness/ds01104

Mental Health America. http://www.nmha.org/go/information/get-info/mi-and-the-family/recognizing-warning-signs-and-how-to-cope.
National Alliance on Mental Illness. http://www.nami.org

Metabolic Syndrome

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Metabolic syndrome is a disorder characterized by a cluster of the most dangerous heart attack risk factors: diabetes and prediabetes, abdominal obesity, high cholesterol, and high blood pressure. A consensus worldwide definition of metabolic syndrome, including ethnic specific criteria was compiled by the International Diabetes Federation. In the case of migrants, the country of origin or ethnic background is used to define the appropriate group.

It is estimated that around 20–25% of the world's adult population have the metabolic syndrome and they are twice as likely to die from and three times as likely to have a heart attack or stroke compared with people without the syndrome. In addition, people with metabolic syndrome have a fivefold greater risk of developing type 2 diabetes (adult onset). The clustering of cardiovascular disease (CVD) risk factors that typifies metabolic syndrome is now considered to be the driving force for a new CVD epidemic.

Each year, 3.2 million people around the world die from complications associated with diabetes. In residents and migrants from countries with a high diabetes incidence, such as those in the Pacific and the Middle East, as many as one in four deaths in adults aged between 35 and 64 years is due to the disease. Type 2 diabetes, which accounts for 90% of all diabetes, has become one of the major causes of premature illness and death, mainly through the increased risk of CVD which is responsible for up to 80% of these deaths.

However, even before levels of blood glucose (blood sugar) are high enough for a person to be diagnosed with diabetes, hyperglycaemia (elevated blood sugar) and related changes in blood lipids (increase in triglycerides and decrease in the "good" cholesterol HDL-c) increase a person's risk of CVD. The more components of the metabolic syndrome that are evident, the higher is the cardiovascular mortality rate.

High-risk migrant populations for the development of metabolic syndrome are those from South Asia (people from Pakistan, India, and Bangladesh). The prevalence of metabolic syndrome has been shown to be much higher in South Asian migrants when compared to African-Caribbean and White European migrants. It has been established that metabolic syndrome can increase the risk of developing cardiovascular disease fourfold in Punjabi Indians. According to reports primarily from the UK, the prevalence of metabolic syndrome ranges from 29% to 50% in migrant South Asians. It has also been shown that South Asians are twice as likely to develop cardiovascular disease when they suffer from metabolic syndrome, in comparison to non-sufferers. Although studies on migrant South Asian women are limited, the data that do exist suggest that the rate of mortality due to cardiovascular disease is higher in migrant South Asian women, when compared to men. As a subset of the South Asian population, Pakistanis tend to have a higher rate of hyperinsulinemia (elevated blood insulin) and insulin resistance when compared to people of other ethnic backgrounds. Furthermore, the prevalence of cardiovascular disease in migrant Pakistanis living in the UK, USA, and South Africa is 50% higher when compared to the general population of the host country.

Generally, migration and lifestyle change (such as an increase in energy dense foods and a reduction in physical activity) leads to a higher prevalence of metabolic syndrome in migrant populations, when compared to the host population. As weight gain has been shown to be the strongest predictor of metabolic syndrome, weight control is important in preventing the onset or reducing the severity of the syndrome. It has been shown that losing weight or stopping weight gain using an improved diet and increased physical activity may reduce the overall risk of the disorder.

The treatment of metabolic syndrome must be a multifaceted process with a primary focus on therapeutic lifestyle change; in more advanced cases, however, pharmacological intervention may also be required. Diet and lifestyle modification is the first line of defense against various chronic diseases, metabolic syndrome inclusive. When using therapeutic lifestyle change to treat metabolic syndrome in migrant groups, a culturally competent approach must be used. Culturally appropriate diet and lifestyle intervention programs ideally should be implemented at an early stage (preferably on migration) so as to encourage healthy eating and physical activity. Education in the migrants' native language is necessary in order to create awareness about metabolic syndrome and preventative measures so as to reduce the impact and effects of obesity on various populations. Furthermore, leisure activities in which individuals from culturally sensitive backgrounds can participate should be promoted as a means of endorsing a physically active lifestyle.

Related Topics

- ► Blood glucose
- ► Blood pressure
- ► Cardiovascular disease
- ► Cultural competence
- ► Diabetes mellitus
- ► Obesity

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Methamphetamine

- ► Addiction and substance abuse
- ► Drug abuse
- ► Drug use
- ► Substance use

Mexico

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Introduction

The United Mexican States, more commonly known as Mexico, is a federal republic located in North America. It is bordered by the United States of America to the north, the Pacific Ocean to the west and south, Guatemala and Belize to the southeast, and the Caribbean Sea and Gulf of Mexico to the east. In total, its land mass covers 761,600 square miles (1,972,550 km^2), making it the third largest country in North America behind Canada and the USA, and the third largest Latin American county behind Brazil and Argentina. Mexico is divided into 31 states and a federal district.

Mexico gained independence from Spain on August 24, 1821, after being ruled by the Viceroyalty of New Spain for nearly 300 years. However, independence was first declared on September 16, 1810, which serves as Mexico's Independence Day and one of the most celebrated patriotic events in the country. In 1521, Spanish explorer Hernan Cortez landed on the Mexican shores in search of wealth and eventually conquered the great Aztec empire, which ruled Mexico at the time. Spain and other European nations began colonizing the New World and forced the indigenous peoples into inferiority, which began the separation of social classes. This separation widened over time and unfair practices eventually became so intolerable that Mexico finally demanded its independence from Spain.

In 1836, American settlers in northern Mexico demanded independence due to the unfair practices of Mexican president Antonio Lopez de Santa Anna. Santa Anna sent troops to defend the territory, but after losing some key battles, he surrendered and lost what became the Republic of Texas. This altered the northern Mexican boundary and significantly decreased the area ruled by Mexico. In 1845, the USA annexed Texas, but disputes over the southern boundary culminated in the US–Mexican War, which resulted in another defeat for Mexico. Consequently, Mexico ceded most of the current southwestern USA, further altering the northern Mexican border. Finally in 1853, the Mexican government sold a strip of land to the USA in the Gadsden Purchase, which extended the southern boundaries of the US states of Arizona and New Mexico. This was the last significant boundary alteration of the Mexican Republic.

The Mexican Constitution was adopted on February 5, 1917, but has been amended several times. It established three levels of government - the federal, the state, and the municipal governments - and mandates that all officials are either elected by voters or appointed by elected officials. It also established that the president serves as the head of the government and is elected by the citizenry to a nonrenewable 6-year term.

Mexico has a free market economy in the trillion dollar class and has experienced a series of economic booms and recessions that have affected the middle- and lower-classes. The country's economy is fragile despite creating strong ties with the USA and Canada through the North American Free Trade Agreement (NAFTA) and 12 additional free trade agreements with over 40 countries. Mexico's current president, Felipe Calderon, has placed reducing poverty and creating jobs at the top of his economic priorities.

Spanish is Mexico's official language and the most widely spoken language, though several indigenous languages are also spoken throughout the country. Spanish is also the language of instruction in schools and universities, though many offer instruction in English as well.

Mexico City, located in the Federal District, is the nation's capital city and undisputed urban apex. It serves as the economic, social, educational, and industrial capital of Mexico and attracts millions of tourists and new residents annually. Also, its population of 22 million residents accounts for approximately one-sixth of the nation's population and ranks not only as the largest metropolitan area in the Western Hemisphere, but also one of the largest urban centers in the world.

One of Mexico's most iconic symbols is its national flag. Known as "El Tri" for the flag's three color bands (red, white, and green), it symbolizes the foundation of the country and represents the pride of the people. According to myth, an Aztec god ordered the tribe to search for a permanent home, which would be indicated by an eagle perched on a nopal cactus with a serpent in its beak. The tribe ultimately spotted the eagle, the cactus, and the serpent on an island in the ancient Lake Texcoco. There they established Tenochtitlan, which became the power Aztec capital city and eventually Mexico City. Today, the eagle, the cactus, and the serpent are depicted on the center white band of the flag, in remembrance of the foundation of the capital city.

History

The Americas was inhabited by people who many believe migrated from Asia tens of thousands of years ago via a former land bridge in the Bering Strait. Highly organized civilizations developed throughout North and South America and existed for thousands of years before Europeans arrived in the 15th and 16th centuries. The area that is now Mexico produced a string of great early civilizations, including the Olmecs, Toltecs, and Mayas. But when Hernan Cortez arrived in 1521, most people lived under the Aztec empire. Cortez sought wealth from the New World and felt threatened by the Aztecs. So he conquered the empire and claimed the land for the Viceroyalty of New Spain.

By 1525, Spanish rule had extended as far south as Guatemala and Honduras and as far north as the western USA. Spanish expansion was motivated by the hope of discovering precious metals and the need for defense against nomadic indigenous raiders and against the perceived threat of British and French invasion.

Following the arrival of Europeans, intermarriage between European settlers and the Natives resulted in an increasing mestizo population, which over the centuries, became the dominant ethnic group in Mexico.

However, the smaller group of direct European descendants and lighter-skinned Mexicans dominated the wealthiest echelons of Mexican society and controlled economic, political, and social policies. In contrast, mestizo and indigenous Indians belonged predominantly to the poor and working classes and seldom advanced to higher classes.

Centuries' worth of social, political, and economic inequalities eventually stimulated revolts by the lower classes, the most important occurring on September 16, 1810. On that day, a priest named Miguel Hidalgo y Costilla called for the end of Spanish rule, which began the Mexican War of Independence. War ensued and lasted for a decade before Mexican forces finally ousted the Spanish. Independence was eventually recognized on August 24, 1821, and Miguel Hidalgo has since been known as the "Father of Mexico."

Mexico's new and inexperienced government urged equality among all Mexican citizens with no distinction between Mexican and European, that Roman Catholicism would be the national religion, and that an imperial form of government would be implemented. On July 21, 1822, Agustin de Inturbide was crowned Mexico's first emperor, but his reign only lasted until 1824, when Mexico's first Constitution was adopted and a democratic form of government was established. On October 1, 1824, Guadalupe Victoria was elected president in Mexico's first national election.

The Mexican government endured several hardships throughout the nineteenth and twentieth centuries. Economic and political instability made borrowing money from foreign nations expensive, resulting in an escalating national debt. The Mexican government became incapable of providing funds for education and other social improvements, which many Mexican leaders thought were urgent requirements. Furthermore, the government was constantly overturned by revolting armies angered by insufficient compensation, which led to greater instability.

In addition to the economic and political instability plaguing the country, Mexico also suspended debt payments to its European lenders. Though tensions rose between Mexico and its lenders, France retaliated most aggressively. French ruler Napoleon III had been seeking expansion opportunities and was interested in Mexico's strategic location and economic potential. So when Mexico suspended payments to France, he seized his chance to gain control and launched an invasion. His forces eventually captured the capital and he established Mexico's second monarchy. Maximilian of Austria was appointed emperor and was expected to comply with Napoleon's scheme. At the same time, clerics in both Mexico and Europe welcomed Maximilian, hoping he would reestablish Roman Catholicism as the Mexico's exclusive religion and restore the Church's authority. Maximilian defied both Napoleon's and clerical request and operated his own agenda, which proved to be ineffective at securing governmental control or economic prosperity. Foreign nations began pressuring Napoleon to withdraw from Mexico. France withdrew in 1867, leaving Mexico once again vulnerable to rival armies.

Benito Juarez, who was president when the French invaded Mexico, was able to reestablish his presidency. He was greeted by an enthusiastic public that welcomed the end of the long and devastating civil war and the reestablishment of a government under the Constitution. He launched "La Reforma," a set of policies that eventually stabilized the Mexican government for the first time in its history. The aims were to improve public education, establish a sound economy, and ensure equal rights for all Mexicans. Juarez modernized Mexico's economy, established peaceful relations with foreign countries, and stabilized Mexican society. He was elected twice more before his death in 1872 and has been regarded as one of Mexico's greatest leaders.

The next major political figure to emerge was Porfirio Diaz, who was elected president in 1876. His progressive agenda dominated 35 years of Mexican history and modernized Mexico into a world economy. He emphasized economic development and social progress, but his policies only benefited rich Mexican supporters and foreign investors. He used European and US funds to build railways, provide electricity and streetcars for the cities, create industrial complexes, rehabilitate port facilities, and develop the mining of industrial metals. The Mexican petroleum industry was also created under Diaz, but concessions were only made to foreigners, which laid the groundwork for serious problems later. On one hand, Diaz propelled Mexico into the world market and greatly improved Mexican society. But on the other hand, his regime repressed and controlled the lower classes by maintaining low wages and long working hours. Urban workers were deprived of rights and most were unable to keep their land. Elites enjoyed most educational opportunities while indigenous groups were often shipped to plantations for cheap labor. Diaz also overrode elections and appointed officials who favored his policies. Diaz instilled fear and intimidation into the Mexican public, but the younger generation voiced dissent. Finally, when Diaz fraudulently won reelection in 1910, opponents revolted and the Mexican Revolution began.

Diaz was ousted almost immediately, once again leaving the presidency open for rival armies. Violence continued throughout most of the decade, but in 1917, several sides joined together to create a constitution to stabilize the government. Though the exact end of the Revolution remains speculative since skirmishes continued until the 1940's, the Constitution of 1917 still serves as Mexico's constitution.

World War II shifted Mexico's attention from domestic dilemmas to foreign affairs. Mexico aided the USA by supplying raw materials for the manufacture of war equipment and machinery. Also, the two sides signed a trade treaty, in which the USA agreed to buy Mexican silver at world prices, provide long-term loans to strengthen Mexico's economy, and provide military aid to professionalize Mexico's army, all of which stabilized the Mexican economy. The treaty also resolved strained relations between Mexico and the USA.

Mexico enjoyed considerable economic growth until the 1980's and 90's, when the economy was stricken by plummeting worldwide petroleum prices. Unemployment and inflation soared, private and foreign investment dropped, and the population began migrating from rural areas into the cities. Mexicans also began migrating to the USA in search of opportunities, but the flow of illegal immigrants became problematic and relations were strained again. But the creation of the North American Free Trade Agreement in the late 1990's helped Mexico's economy recover and eased the border tensions.

Society

Mexico's population is 112.5 million (2010), which ranks as the 11th highest in the world and the highest among Spanish-speaking countries. Its population growth rate is 1% and life expectancy is 76 years. The majority (65%) of Mexicans are between 15 and 64 years of age, while 29% are between 0 and 14 years of age and 6% are 65 years of age and older. More than 60% of the people are mestizo, about 20% is Native Indian, and most of the rest are European descendants. Though Mexico has no official religion since the Constitution guarantees separation of church and state, Roman Catholicism is practiced by more than 90% of the population.

Mexico's northern border cities have grown rapidly since the 1970s, largely because migrants from central Mexico have been attracted to jobs in the USA and in "maquiladoras," which are export-oriented manufacturing plants where duty-free imported parts are assembled on the Mexican side of the border. Migration has also helped to maintain Mexico's population at optimal levels. Remittances average around $21 billion (USD) per year and are the second-largest source of foreign revenue behind oil. Thus, migrations has served as a safety value for Mexico's social and economic pressures.

Mexican society experiences extremes of wealth and poverty – with a limited middle class wedged between elites and investors and masses of rural and urban poor. The largest segment of the urban population is the lowest socioeconomic class. Many city dwellers' incomes are below poverty level, whereas the relatively affluent middle- and upper-income groups enjoy the amenities of urban life and control most social, political, and economic activity.

Health

The Mexican population grew more than sixfold from 1910 to the early twenty-first century. The rapid rise of the population in the 1940s was primarily due to improvements in health care and food supplies. The death rate and infant mortality have drastically declined, but are still high when compared to other developed countries. The growth rate also slowed during the late 20th century, but the Mexican population is still increasing.

Disparity in health status is noted by difference in social classes. Poor and indigenous Mexicans tend to suffer from illnesses associated with unsafe water supplies, infections, and respiratory diseases. Also, rural areas have much higher mortality and morbidity than urban areas. But in general, the leading causes of death in Mexico are cardiovascular diseases, diabetes, cancers, accidents and violence, and diseases of the digestive and respiratory systems.

Mexico's health care system is comprised of public and private programs. Federally subsidized hospitals and clinics are available to all Mexican citizens and are found throughout the country. In rural areas, modern medicine is often considered too expensive, difficult to obtain, or is not trusted. Private care is superior to public care and is preferred by higher social classes. Overall, the quality of medical care in Mexico lags behind that available in the USA and Europe, so many Mexicans elect to travel outside the country for more sophisticated surgical procedures or treatments.

Education

Mexico strives to provide quality educational opportunities for its people by increasing the number of schools for children. School attendance is required for children ages 5 to 18. Adult literacy programs have also been promoted vigorously since the 1970s. Mexico's efforts were evident at the beginning of the 21st century when its literacy rate was 91%.

Mexican public schools are mostly located in rural areas and are poorly funded by the Mexican government. Many only offer a primary education, so citizens migrate to the cities for better schools and social opportunities that derive from higher education. Despite increases in the numbers of classrooms, teachers, and educational supplies, about one-seventh of all school-age children do not attend school, and almost one-third of adults have not completed primary school and over half have not complete secondary school.

Private schools are vastly superior to public schools, but are only afforded by upper-middle and upper class families. This contributes to the socioeconomic imbalance that greatly favors the middle and upper classes.

Universities are found only in the largest cities. Most college students study in Mexico City, where 20% of all Mexican universities are located. Less than 12.5% of the Mexican population has earned a college degree.

Immigration/Emigration

Mexican migration into the USA has increased sharply since the 1970's and has contributed to the largest US immigrant group. Between 8 and 13 million immigrants entered the USA between 1970 and 2000, with more than 170,000 in 2000 alone. Many cross the US-border illegally in search of jobs and better opportunities, while others are highly qualified professionals.

American migration into Mexico has also increased in recent decades. Most Americans simply commute daily for work or leisure, but many live in Mexico permanently since several US companies operate in Mexico and employ millions of US citizens.

Policies and Issues

A lack of adequate housing is one of Mexico's most serious problems. The federal government has built multiunit housing projects, but urban populations have increased more rapidly than new units can be constructed. Also, economic difficulties have reduced the funds available for new construction. The poorest social classes have resorted to building makeshift housing on unoccupied city lands that usually lack water, electricity, and sanitation. Widespread rural poverty is also a serious problem with a high proportion of the rural populations relying on limited means for survival.

Mexico's environmental issues include scarcity of hazardous waste disposal facilities, polluted natural fresh water resources, deforestation, widespread erosion, and desertification. Land subsidence around Mexico City causes destruction of homes and buildings and air pollution affects the capital city and urban centers along the US–Mexican border.

Illegal immigration from Mexico to the USA has been a source of tension between the two countries, especially in recent decades. Former Mexican president Vicente Fox tried to loosen strict US immigration policies to allow undocumented Mexicans to work in the USA. But the 2001 terrorist attack in the USA prompted the US government to strengthen its national defense.

Illegal drug trafficking is another issue of concern for both Mexico and the USA. Despite conducting the largest illicit-crop eradication program in the world, Mexico serves as a major producer of illegal drugs and a transport channel for most US-bound illegal drugs produced in South America. Millions of pounds of heroin, marijuana, and cocaine are smuggled into the USA every year, as violent drug cartels battle to control Mexico's drug-trafficking operations. These cartels are responsible for some of the highest annual death tolls in Mexico and in the world. Efforts by both Mexican and US governments have been ineffective in alleviating the problem.

Summary

Mexico is an upper middle-income and industrialized country located in North America. It has the 11th largest population in the world and the largest among Spanish speakers. Its history is extensive and dates far before European arrival to the New World. The economy is frail and relies heavily to its NAFTA partners, especially the USA. Finally, Mexico experiences several domestic and international issues, which are largely impacted by US legislature.

Related Topics

- ► Access to care
- ► Education
- ► Illegal immigration
- ► Latin America
- ► Latinos
- ► Maquiladora

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Mica

- ► Immigrant visa status
- ► Immigration status

Midwife

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Traditional midwives (TMs) or traditional birth attendants (TBAs) exist in most societies. Often, TMs are members of the local community and share culture and traditions with others. They also have high social standing and considerable influence on health practices of local people. More importantly, they play a vital role in pregnancy and birth in many societies. Newar women in Nepal, for example, give birth with the assistance of *aji*, a grandmother in local term, who can be an experienced older relative or a neighbor. For each family, there is a strong relationship between the family and a particular *aji*, who can be called upon whenever the birth takes place.

Lefeber and Voorhoever suggest that a TM does not just only deliver babies. Rather, she is familiar with the woman and her family. She also shares cultural ideas about the birth and the preparation of the birth with the woman. TM is knowledgeable about the traditional medicines and rituals which are required before, during, and after birth. As such, the work of a TM is adapted to the social and cultural matrix of which she is a part and her beliefs and practices are consistent with the needs of the local community.

The number of TMs has reduced dramatically in many traditional societies although there are still TMs delivering infants, particularly in remote areas where modern health care is not accessible to many poor women. It has been suggested that approximately 90% of poor women and those living in rural areas in India continue to give birth with the help of *dais*, or local TMs. Indeed, recent studies have pointed to the existence and persistence of traditional midwives in different societies.

In Thailand, a TM is called *mor tamyae* in some parts but referred to as *mae jang* in the North, is a caregiver of women in childbirth. *Mae jang* delivers babies in the villages, and assists women with postpartum practices during the first month after birth. When the labor begins, *mae jang* will be summoned to the woman's home. A husband is expected to assist *mae jang* and the laboring woman. The birth mostly takes place in the kitchen, where hot water can be prepared. Mattresses are folded up for the woman to prop her back up against when pushing. A husband provides physical support to a laboring woman. He sits behind her with his legs astride her shoulders so that when contractions are intense she holds on to his muscled thighs, which give her strength to push. A piece of strong wood or bamboo is tied to a post or a wall where the woman can push her feet against. If there is no husband assisting a woman at birth, a piece of long cloth or rope is hung onto the rafters of the room. This is for the woman to cling onto when contractions are intense. The TM squats at the woman's thighs and waits to catch the baby when it emerges so that the baby will not drop. After the birth, the husband boils the water which the midwife will use to wash the placenta, clean the body of the new mother and the newborn. He also cleans up the remnants of the birth and the floor, prepares a bed for his wife who must observe a postpartum ritual for the whole month, and buries the placenta of his newborn infant.

Mae jang may also help a woman to have an easy birth by manipulating her abdomen and uterus during pregnancy. This is known as "*klang tong*" or "*kwag tong*" in northern Thai. Essentially, the midwife massages and pushes the uterus upward to make it "loosen up." This will create enough space within the uterus, not only to make the baby move more easily in the womb, and hence, make it easy to emerge, but also to ensure that the baby is not squashed and deformed inside the womb. This ritual is done two to three times per week from the sixth month onward.

The Safe Motherhood Initiative has advocated, in a bid to reduce maternal mortality, for an increase in the number of skilled birth attendants including TMs, so that women in rural areas and resource-poor settings who have limited access to modern maternal health services and care may have safe births. Although attempts have been made in many societies, it seems that there are still many obstacles to achieving this outcome. Births assisted by TMs are still largely seen as unsafe. In societies where discourses of modernity are pervasive, such as in most Western societies, TMs would still be perceived as not only ignorant, but also dangerous and dirty. Thus, the presence of TMs in Western societies would still be unimaginable to many women, and there are lots more to be done to bring back TMs in many societies.

Immigrant women who reside in Western societies where TMs are not recognized face difficulties when they become pregnant and give birth in Western hospitals. They have to rely on the medical model of care and are isolated from familiar faces during a critical time. Most maternity hospitals in Western societies permit a husband to be present at birth. However, in a society where men are not culturally permitted during birth, it can lead to conflicts and emotional turmoil in the women, their husbands, and families. Also, women may wish to have other people such as their mothers, sisters, and particularly TMs who can provide culturally sensitive support during this critical period. Therefore, the lack of acceptance of TMs and their support in Western hospitals can impact on the well-being of many new mothers from immigrant backgrounds.

In many societies, traditional births are replaced by modern and medicalized birth. Although there is no denial that modern birth can be beneficial to many women, overmedicalized birth has made other types of birth, such as births assisted by TMs, irrelevant. It has, however, been evidenced that TMs can provide support during pregnancy and birth in clinical settings so that a more "humanized birth" can be achieved. In order to make birth less frightening to many women including immigrant mothers, there is a need for a trusting collaboration between modern obstetric and traditional midwifery care. Ultimately, this will lead to culturally sensitive birthing care to many women in traditional societies in general, and to immigrant mothers in particular.

Related Topics

- ► Access to care
- ► Reproductive health
- ► Women

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Migrant Day Laborers

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With the decline of the formal economy, especially since the 2008–2010 global economic crisis in the competitive global labor market, the health risks engendered by the rapid growth in migrant day labor have become a central occupational health problem. Migrant day labor can be defined as a type of work in the informal sector that holds no guarantee of future work and employs mainly recently arrived immigrants. In the search for better jobs and higher wages, immigrant workers have traditionally migrated from poor to rich countries primarily in Europe, Asia, and North America. During the past three decades, immigrants have filled day labor work positions and particularly migrant day laborers have constituted a large portion of their host country economy as agricultural, construction, manufacturing, and domestic-service workers. They create jobs and greatly boost the economy by producing cheap farm products and home goods. Nonetheless, migrant day laborers suffer from very low wages and repetitive, strenuous work in an unsafe, underground economy. Accordingly, the majority of migrant day laborers face high health risks as they toil in hazardous, exploitative working conditions.

The Characteristics of Migrant Day Laborers

According to an ILO report, there were approximately 86 million economically active immigrants worldwide in 2004, and a large proportion of them tended to work as unskilled day workers at the bottom of the employment ladder. Until now, the characteristics of migrant day laborers, their true size, and magnitude, have been difficult to establish. However, the ILO and EU Commission have recently estimated that globally the number of undocumented migrants was roughly between 20 and 30 million. Undocumented migrants, though ubiquitous around the world, are most populous in America (11.9 million), Europe (1.9–3.8 million), Russia (1.5 million), Canada (0.5 million), and Korea and Japan (0.5 million). Migrant day laborers mainly perform manual, labor-intensive work – work that is described as dirty, degrading, dangerous, and unappealing to native workers. They work excessive hours with inadequate safety equipment and no compensation insurance. Migrant day laborers who cannot obtain work permits are especially vulnerable to exploitation and employer abuse since they fear losing their jobs, incarceration, and deportation; thus they are hired at extremely low wages and are often underpaid or not paid at all. As the most vulnerable workers, female migrant laborers toil primarily in retail, housecleaning, or consumer services. Their working condition can be regarded to being exploited like a slave. Female undocumented migrant day laborers are often trapped into smuggling, sex trafficking, or servitude by migration agents or criminal organizations. The global economic crisis may force migrant laborers to face even greater challenges: large unemployment, xenophobic fear that they will "steal" local jobs, and non-renewal of work permits. Accordingly, the remittance amounts that migrant workers send to families in their home countries have decreased concomitant with their families' increased poverty.

The Health of Migrant Day Laborers

Migrant day laborers are exposed to a variety of work-related hazards (such as chemicals, pesticides, dust, and other toxic substances) without proper protective equipment, compensation insurance, and on-the-job training. The health issues to be considered for these workers are: (1) occupational safety, injuries, and diseases, (2) mental health, (3) barriers to accessing health services, and (4) health risks for their families. Because of their high-risk working conditions, injuries among migrant day laborers are all-pervading. For instance, the 2004 ILO report suggested that, worldwide, these workers fall victim to 335,000 accidents per year in the most dangerous of industries – agriculture, mining, and construction. Valenzuela and colleagues reported in 2006 that in the USA, one in five migrant day laborers had suffered from on-the-job injury, and that agricultural hazards accounted for 7.4% of their work-related deaths. Daily unstable working conditions and social isolation also induce a risk of poor mental health such as chronic stress, anxiety, and depression. Moreover, female undocumented workers are often victims of sex trafficking, exposing them to a great risk of contracting HIV/AIDS or other sexually transmitted diseases. While only a few of these laborers, when injured, received medical treatments covered by employer-sponsored insurance, the majority of these injured workers obtained no medical treatment. The most well-known barriers that prevent immigrant day workers from accessing the healthcare system are discriminatory government policies and financial constraints and, to a lesser extent, language barriers. Moreover, immigrant day laborers often conceal their need for medical care because they are afraid of being laid off or deported. Another important consideration is the enormous health effect on migrant workers' families and children. In particular, pregnant women are forbidden from accessing prenatal care. For children who have day laboring parents, being excluded from medical services and the educational system can lead to serious mental and physical problems. The global economic crisis has aggravated an already horrendous situation for these deprived, vulnerable workers – that is, has aggravated their hazardous working conditions and, correspondingly, their health.

Recommendations and Conclusion

For migrant day laborers, the excessive risk of injury and disease, linked to their dangerous employment and working conditions, is a global phenomenon. To reduce the employment-related health inequalities affecting laborers, future legislation backed by research, evaluation, and monitoring, country by country, is urgently needed because of insufficient understanding of (1) what are the true magnitude, mechanisms, and pathways underlying health inequality's relation to their employment conditions, (2) how health effects vary according to the hosting county's labor regulations and policies, and (3) how the current global economic recession amplifies health inequalities for these legal and undocumented migrant day laborers.

Being one of the most vulnerable groups of workers in the global labor market, migrant day laborers face common health-related challenges such as systematic exploitation and exclusion from health protection in dangerous workplaces. To ensure their health and safety, governments, unions, and international organizations should collaborate to implement fair labor standards by (1) administering adequate supervision, safety training, health surveillance, and work-related insurance for legal and undocumented laborers on par with citizen workers, and (2) standardizing labor migration policies while instituting legal support for these undocumented laborers to help eradicate sexual trafficking, smuggling, forced labor, and poverty wages.

Related Topics

► Ethical issues in research with immigrants and refugees

► Exclusion

- ► Illegal immigration
- ► Illegal Immigration Reform and Immigrant Responsibility Act of 1996 (U.S.)
- ► Immigration in the global context
- ► Immigration processes and health in the U.S.: A brief history
- ► Immigration status
- ► Irregular immigration
- ► Occupational and environmental health
- ► Trafficking

Suggested Resources

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Migrant Farmworkers

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Agricultural work accounts for half of the labor force in the world, but in advanced industrialized countries it is much less than 10%. Agricultural work with mining and construction are considered the three most dangerous occupations worldwide. In 2005, the highest incidence of fatal (13 deaths per 100,000) and nonfatal accidents at work (about 6,700 per 100,000) were among skilled agricultural and fishery workers

There is no accurate census of hired agricultural workers. Epidemiological research that aims to report their health status is limited by the absence of a reliable numerator and cross-sectional assessments of health outcomes. Quality of data collection by fatalities and injury by occupation varies by country. Data on the health status of agricultural workers is reported by occupation, and includes farmers and family members as well as hired workers. The temporary and transient characteristic of the hired farmwork-force makes it difficult to present an assessment of their health status. This entry will focus on migrant farmworkers in industrialized countries where more reliable and recent data can be found.

Migrant farmworkers are part of the hired agricultural force, defined as "a worker temporarily engaged during harvesting periods, who come from other regions in the country or neighboring countries."

Agricultural workers' health, in general, is negatively affected due to occupational risks and labor conditions. Occupational risks include use of heavy machinery and sharp tools, lifting heavy weights, long repetitive movements, exposure to pesticides, and working under adverse weather conditions. In many countries, labor laws protecting workers in other industries exempt agricultural workers. Comprehensive legislation on occupational safety and health is limited and poorly enforced. Cultural and language barriers add to the likelihood of injury and disease when workers do not receive adequate training in the use of machinery or pesticides.

In the European Union (EU), year-around, seasonal and migrant wage earners account for approximately 40% of persons involved in agricultural work. The EU employs 4.5 million seasonal and migrant workers, and about half a million come from countries outside the EU. Migrant workers in agriculture there are entitled to some protections. The International Labor Organization (ILO) since 1982 promoted Convention No. 184 that specifically states that "measures shall be taken to ensure temporary and seasonal workers receive the same health safety and protection and adequate and appropriate training. . . taking into account their level of education and differences in language." France, with one of the largest agricultural workforces in the European Union, has health coverage for 98% of farmers and agricultural workers. However, farmers, due to the high costs of social contributions, may not list hired migrant workers on their payrolls. Greece, Italy, and Spain also include some protections, but temporary workers are many times excluded.

In 2007, the US census reported three million people working in agriculture, where 1.1 million were hired farmworkers and about half a million were migrant farmworkers, who migrate from their homes to a single location, crossing state lines or an international border. Only 12% are follow-the-crop migrants and will work in several farms following specific geographical streams.

Among developed nations, the USA has the largest proportion of seasonal and migrant farmworkers who are foreign born (80%) and more than half lack working permits. In the European Union, one in ten workers comes from countries outside of the EU, and unauthorized workers account for a relatively small proportion of migrant farmworkers. In general, foreign-born migrant workers in the European Union and in the USA face more obstacles in obtaining health care due to access, high costs, transportation, language barriers, and legal status.

Access to Health Services

Since 1962, the US government established health coverage under the Migrant Health Act for migrant agricultural workers, and later in 1970 included seasonal workers. Health coverage for migrant farmworkers in the USA is restricted to accidents and illness at the workplace. Access to services is further limited due to the relatively small number of Migrant Health Centers in the nation. In 2008, there were about 500 Migrant Health Centers nationwide, and cover about one quarter of all migrant and seasonal farmworkers and their families.

Occupational Risk: Fatalities and Injuries at the Work Place

In the USA, agricultural workers overall account for 3% of the workforce but were 7.4% of work-related casualties. Data from 1996 to 2006 Department of Labor's Census of Fatal Occupational Injuries for the agricultural sector report that fatality rates increased from 22.2 to 29.4 per 100,000 workers. In 2007, there were 25.7 deaths per 100,000 in agriculture compared to an average rate of 3.7 deaths in other industries. As the number of foreign born increased in the farm workforce, so did the number of fatalities. In farming and forestry, 84 deaths occurred in 1992, a sharp increment of 54% by 2002. Many of these fatalities are the result of lack of training and difficulties following instruction for lack of English language.

Pesticides Illnesses

Governments have implemented rules and guidance on substances that can be used in agriculture. Pesticides are applied to prevent, destroy, or mitigate any pest, including insects, mice, and other animals, and weeds, fungi, and some microorganisms. In the USA, the Environmental Protection Agency regulates pesticide safety training for workers. Safety measures are not always enforced and language barriers impede full understanding of handling of pesticides with safety. Inhalation, ingestion, and absorption by the skin are ways through which pesticides can enter the body. Fields may not have available the sanitation facilities to wash themselves and their contaminated clothes. Under these conditions, pesticides can be brought home and affect workers' families, especially children. Also farmworkers' housing is exposed to drifts of pesticide applications in nearby fields. Immediate effects of smaller doses of pesticides include rash, dizziness, nausea, vomiting, eye irritation, headache, and muscle weakness. Long-term effects include increased risks of several cancers, sterility and neurological decline in adults, and other chronic health problems such as respiratory problems, memory disorders, and dermatological conditions. Pregnant women who are exposed face the danger of spontaneous abortion and deformed babies, and retarded neurobehavioral development in children.

Heat and Sun Exposure

Heat stress is an occupational risk that is the result of long hours under the sun and great physical exertion that causes body heat to rise, and if not attended to can lead to dehydration, electrolyte imbalance, neurological impairment, multi-organ failure, and death. Crop workers have a heat-related death rate of 0.39 per 100,000 workers compared to 0.02 for other civilian workers. These deaths could be easily avoided if appropriate clothing, shade, breaks, and drinking water were readily available in the fields. The 2005 National

Agricultural Workers Survey reported that one in five workers did not have access to drinking water and cups.

Musculoskeletal Injuries

Farmwork requires constant bending, climbing, crawling, twisting, overexertion, repetitive motions, excessive loads, and carrying heavy items. Moreover, because most are paid by piece rate, workers are pushed to labor for long hours, with no breaks and at high speed. All these factors increase the likelihood of injury. There are two main groups of musculoskeletal injuries: (a) peripheral neuropathies, e.g., carpal tunnel syndrome and (b) tendonitis. Others include strains and muscle pain, rotator cuff injuries, and bursitis. These disorders account for half of all agricultural occupational injuries and 30% of absences. Also, inadequate tools play a role in their injuries. These problems can be reduced by altering work procedures and by redesigning agricultural tools (ergonomics). Musculoskeletal injuries not attended may become a permanent disability.

Other serious health conditions that are more difficult to diagnose and implement a follow-up treatment are mental health and chronic conditions. These conditions are exacerbated by the isolation, job insecurity, long periods of family separation, and poverty. Health centers report increasing numbers of severe mental stress and depression and chronic conditions such as hypertension and diabetes.

Related Topics

- ► Language barriers
- ► Occupational and environmental health
- ► Occupational health

Suggested Readings

Arcury, T., & Quandt, S. (Eds.). (2009). *Latino farmworkers in the Eastern United States. Health, safety and justice.* New York: Springer.

Villarejo, D. (2003). The health of U.S. hired farm workers. *Annual Review of Public Health, 24*, 175–193.

Suggested Resources

ILC-88. (2000, June). International Labor Conference. 88th Session. Report VI (1) *Safety and health in agriculture.* Geneva: International Labor Conference. http://www.ilo.org/public/ebglish/standards/relm/ilc/ilc88/rep-vi-1.htm

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Migration

- ► Asylum
- ► Immigrant visa status
- ► Immigration in the global context
- ► Immigration status
- ► Refugee

Military-U.S.

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Roughly 8,000 noncitizens enlist in the US military every year. As of 2005, the Defense Manpower Data Center (DMDC) estimated that about 35,000 noncitizens currently serve in some branch of the active US military. Additionally, approximately 12,000 noncitizens were serving in the National Guard and Reserves. In 2003, the four services had the following numbers of noncitizens: Navy – 15,880 noncitizen sailors; Marine Corps – 6,440 noncitizen marines; Army – 5,596 noncitizen soldiers; Air Force – 3,056 noncitizen airmen.

The treatment of noncitizens across the US military services is not uniform. Each service branch has different policies regarding noncitizen service members. While limited English proficiency may impose a practical hurdle to potential noncitizen recruits, several of the services offer special enlistment programs for those seeking to enlist with limited English proficiency. Each branch has a differing proficiency requirement. Additionally, occupational choices available to a noncitizen may be limited. The greatest current limitation on noncitizens in the US military is their ability to obtain a security clearance, which requires US citizenship. Many military jobs require a clearance for entry and/or promotion. There are clearance-free jobs; however, the number varies from branch to branch. Reenlistment standards for noncitizens also vary among the services. Neither the Navy or the Marine Corps have restrictions on the reenlistment of noncitizens, the Army allows noncitizens to serve up to 8 years, either consecutive or not, and the Air Force limits noncitizens to one enlistment term of either 4 or 6 years, then requires a noncitizen to get their citizenship in order to reenlist. All enlistees, regardless of the branch of military service, must take the Oath of Enlistment and swear to support and defend the US Constitution.

Selective Service System

Conscription in the United States (more commonly known as “the draft”) has been used several times in US history. It was discontinued in 1973, with the transition of the US military to an all-volunteer force. However, the Selective Service System remains in place as a contingency plan. The Selective Service System is a means by which the United States maintains information on those potentially subject to the draft.

All males between the ages of 18 and 25 are required by law to register within 30 days of their 18th birthday. Currently, the law exempts women from registration. The issue of women being exempted was addressed in 1981 by the US Supreme Court in *Rostker v. Goldberg*. The Supreme Court determined that since women are excluded from combat, they would not be needed in the event of a draft, and therefore decided not to register them.

Selective Service (and the draft) in the United States is not limited to citizens. Noncitizen males between the ages of 18 and 26 living in the United States, who are permanent residents (holders of green cards), seasonal agricultural workers, refugees, parolees, asylees, and even illegal immigrants, are required to enlist in the Selective Service. Refusal to do so is grounds for denial of a future citizenship application. Foreign males in the United States as lawful nonimmigrants (international students, visitors, diplomats, etc.) are not required to register.

Naturalization

Noncitizens who serve in the United States military enjoy several naturalization benefits which are unavailable to noncitizens who do not serve. Members and certain veterans of the United States Armed Forces may be eligible for naturalization through their military service under Sections 328 or 329 of the Immigration and Nationality Act (INA).

A person who has served honorably in the US armed forces at any time may be eligible to apply for naturalization under Section 328 of the INA. The military community sometimes refers to this as “peacetime naturalization.” An applicant for peacetime naturalization under Section 328 of the INA must be aged 18 or older; have served honorably in the US armed forces for at least 1 year and, if separated from the US armed forces, have been discharged honorably; be a permanent resident at the time of examination on the naturalization application; be able to read, write, and speak basic English; have a knowledge of US history and government; be person of good moral character; have an attachment to the principles of the US Constitution and be well disposed to the good order and happiness of the US; and meet the residency and physical presence requirements. If the applicant has filed an application while still in the service or within 6 months of separation, the applicant is not required to meet the residence and physical presence requirements.

Members of the US armed forces who serve honorably for any period of time during specifically designated periods of hostilities are eligible for naturalization under Section 329. An applicant for naturalization under Section 329 must have served honorably in active-duty status, or as a member of the Selected Reserve of the Ready Reserve, for any amount of time during a designated period of hostilities and, if separated from the US armed forces, have been separated honorably; have been lawfully admitted as a permanent resident at any time after enlistment or induction, or have been physically present in the United States or certain territories at the time of enlistment or induction – regardless of whether the applicant was admitted as a permanent resident; be able to read, write, and speak basic English; have a knowledge of US history and government; be a person of good moral character; and have an attachment to the principles of the US Constitution and be well disposed to the good order and happiness of the United States. There is no minimum age requirement for an applicant under this section. Additionally, the Immigration and Nationality Act provides for posthumous naturalization under Section 329A. Posthumous naturalization can greatly impact the status of the deceased person's spouse and dependents.

Current members of the US armed forces who qualify for naturalization under Sections 328 or 329 of the Immigration and Nationality Act can proceed with their naturalization application either in the United States or overseas. For active-duty service members, the fees are waived.

Related Topics

- ► Citizenship
- ► Immigration and Naturalization Service
- ► Immigration status
- ► Naturalization
- ► Public health insurance

Suggested Readings

Asch, B. J., Buck, C., Klerman, J. A., Kleykamp, M., & Loughran, D. S. (2008). *Military enlistment of Hispanic youth: Obstacles and opportunities*. Santa Monica: RAND.

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Suggested Resources

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United States Citizenship and Immigration Services. *Military*. http://www.uscis.gov/military

Minorities

- ► Ethnic minority group

Mixed Methods

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Mixed methods research can be defined as the intentional combination of qualitative and quantitative methods within research. Qualitative research aims to gather an in-depth understanding of human experience and investigate *why* people have the attitudes, behaviors, values, and motivations that they do through a nonnumeric analysis of the world. Qualitative research mainly utilizes words, such as observations, interviews, and focus groups, to understand the contexts in which events occur. Conversely, quantitative research aims to gather a breadth of knowledge about a specific topic in a controlled context that can be generalized to the larger community. Quantitative researchers utilize questionnaires, surveys, physiological measures, and other standardized assessments that can be analyzed using numbers and advanced statistical techniques. These differing approaches to research are thought by many to be incompatible due to differences in their techniques, goals, scientific rigor, and overall philosophy. However, proponents of mixed methods research feel strongly that the combination of these techniques can overcome the weaknesses of qualitative and quantitative methodologies alone. When working with immigrant populations, the combined strengths of these methods allow investigators to obtain a complete look at the immigrant health experience – gaining an in-depth understanding of the specific experiences within a culture from the individuals themselves, while also gathering a breadth of general knowledge that may be generalized to the larger community.

Strengths of Mixed Methods Research

Many believe there is a strong case to be made for utilizing an approach that combines qualitative and quantitative methods. For one, combining these methods in order to study the same phenomenon serves to gain convergence and increase the validity of the results (triangulation). Also, this approach uses the strengths of each method to overcome the weaknesses of the other in order to enrich the study of a particular topic (compensatory). Lastly, using two methods increases the researcher's understanding of the findings through allowing a more complete picture of the phenomenon to be gathered (expansion). By using varied methods, one is encouraging inclusivity and demonstrating value in gaining as much knowledge as possible. There is no need to pick one method over another; all methods are imperfect and can be enhanced with the addition of methodology that complements its weaknesses.

One of the leading supporters of mixed methods research, Tom Weisner, explains that human development takes place along an endless amount of different pathways based on everyday cultural and community contexts. Behaviors and experiences do not take place within the control of a laboratory, but are a part of a complex environmental system, or context, that has reciprocal affects on one another. Research often neglects the questions of *why* outcomes are occurring, failing to understand what people's actual experiences are and what they mean to them. A mixed methods approach provides an opportunity to learn about the personal experiences of people within their contexts, including their cultural beliefs, motives, thoughts, and behaviors. Based on this, he believes that a mixed methods approach that combines scientific rigor and standardized assessments with in-depth methods that allow one to more closely examine the experiences of people within their contexts is the best practice for trying to understand development. Immigrant populations are just one example of a group whose health depends on many social contexts (i.e., culture of origin, new culture); because of this, researchers may benefit greatly from utilizing a mixed methods approach in order to learn more about the specific health, mental health, and developmental experiences of immigrants.

Mixed Methods as a Way to Understand Culture and Immigration: Etic Versus Emic

In considering the use of mixed methods research, it is important to think about the theoretical distinction between investigating culture from an *etic* perspective or an *emic* perspective. Those who consider culture through an *etic* lens see culture as "universal" and applicable to all. In other words, an *etic* account would be a description provided by an outside observer in a way that can be applied to other cultures (i.e., culturally neutral). An example within research is the creation of a measure to be utilized across cultures, based on the understanding that the items are applicable to those from all cultural backgrounds. Quantitative research often takes an *etic* approach.

Conversely, those who consider culture through an *emic* lens see outcomes as "culture specific." An *emic* account would be a description provided by someone within the culture, speaking to his or her specific cultural experiences. An example within research is the implementation of focus groups to speak directly to the population of interest due to the belief that using a standardized measure would likely not capture important cultural nuances in the psychological or health construct measured. Qualitative research often takes an *emic* approach. In combining these two approaches, mixed methods allows investigators to gather varying cultural beliefs, customs, and experiences from both a local (in-depth; emic) and universal (broad; etic) perspective. Taking the ideas of Weisner into account, it becomes clear as to how mixed methods can truly integrate the *etic* and *emic* perspectives in order to gather the most complete information about how immigrants from varying cultures, on varying developmental and health pathways, experience their lives.

Mixed Methods Used to Study Immigration: Examples from the Literature

A recent study by Corona, Gonzalez, Cohen, Edwards, and Edmonds in 2009 used a mixed methods approach to investigate the health concerns and service needs of Latino youth in Richmond, Virginia. Considering the growing number of children of Latino immigrants throughout the US, and specifically to the Richmond area over the last 10 years, the authors believed that additional culturally responsive services for children and their families were critically needed in the Richmond area. A mixed methods approach was chosen because very little health information was available regarding Latino youth. Additionally, mixed methods allowed for an in-depth investigation of health concerns and service needs in Latino youth, as well as provided the opportunity to gather information that could be generalized and applied more broadly. Using this approach, the study aimed to identify (1) the specific health concerns and service needs among Latinos in their community and (2) factors that may promote and inhibit Latino youth health. Quantitative data were collected through a community survey given to 212 self-identified Latino adults; 96% were immigrants and 99% completed the survey in Spanish. The survey inquired about family composition, educational attainment, ethnic origin, length of time in the US, socioeconomic status, perceived health and safety concerns, service needs, and suggestions for addressing those needs.

Qualitative data were gathered through interviews with identified key informants that represented a variety of organizations from the community (e.g., faith-based organizations, schools, law, media), as well as focus groups of Latino parents and youth. Interviews lasted approximately 90 min and focused on perceived community concerns, service needs, service barriers, and ways of promoting adolescent safety and health. Focus groups lasted approximately 2 hours and topics covered included (1) problems and barriers faced by adolescents, (2) violence and safety prevention needs, (3) family communication patterns, (4) difficulties parents and adolescents have with each other, (5) attitudes and beliefs about drugs, delinquency, AIDS, and sexual behavior, (6) suggestions for programs or services to address health, child development, and safety needs, and (7) feelings and attitudes about the changing racial/ethnic demographic and subsequent effect on interactions with other individuals. An additional qualitative piece of the study involved the creation of a steering committee of Latino adults and youth from the community. This group met twice and worked together to develop the questions to be included in the survey, interviews, and focus groups, as well as to come up with a plan for recruitment that would address barriers identified by these community members.

The use of mixed methods in this case was critical in order for the researchers to obtain a detailed picture of the perceived health concerns and service needs identified through the quantitative community survey. The use of the steering committee to formulate the topics to be addressed throughout the varying assessment methods ensured culturally appropriate content, as well as a sufficient overlap of topic area between the qualitative interviews and quantitative surveys. This consistency in topic area served to increase the depth of the information gathered in the topic areas across methodologies. In addition, the steering committee made suggestions regarding recruitment procedures that allowed increased accessibility to the population of interest by addressing community barriers that may have been previously unknown to the researchers. This mixed methods approach created a detailed picture of Latino immigrant health concerns and service needs, a topic lacking understanding throughout the research. It provided a quantitative numerical look at the survey results that could then be supported through the qualitative descriptions of actual immigrant experiences within the interviews/focus groups.

An additional example that utilized a mixed methods approach with immigrant populations was a study done by Sirin, Bikmen, Mir, Fine, Zaal, and Katsiaficas in 2007 that explored the dual identification of Muslim-American emerging adults. The authors of this study aimed to learn more about the identity negotiation process between identifying as Muslim and American within the context of post-9/11 New York area. The authors were less interested in which ethnic or racial boxes these emerging adults might select when asked how they identify, but more about the *process* of *how* they formulate and *experience* the identity they have chosen within their varying contexts. Past research suggests that the construction of identity for immigrants is based on the balance (or lack of balance) of two domains: (1) the degree to which one is willing/able to identify with one's home culture (e.g., Muslim) and (2) the degree to which one is willing/able to participate in one's host culture (e.g., American). The ability to balance these two domains well indicates biculturalism and often leads to more positive psychological and physical health outcomes.

Within this mixed methods study, the authors aimed to increase their knowledge of the Muslim-American identity through specifically exploring (1) the degree to which Muslim and American identities are related among a group of emerging young adults in post-9/11 New York, (2) the degree to which discrimination-related stress, religiosity, and social and cultural preferences shape Muslim and American identities, and (3) the effect of gender in the relationship between Muslim and American identities. All 97 participants within the study were self-identified Muslim-American youth who were children of recent immigrants or who themselves immigrated to the US at a young age and live in the post-9/11 New York area; 44% were first-generation immigrants and 56% second-generation.

Quantitative data were gathered through self-report measures of identity, acculturation practices, religiosity, frequency of discrimination, discrimination-related stress, and a demographic questionnaire. As a means to add to this quantitative data, qualitative data were gathered by asking participants to "draw a map" of their multiple identities. More specifically, participants were provided a blank piece of paper and drawing materials and given a standard description of their task: *Using the materials provided with this survey, please draw a map of your many ethnic, religious, and social identities. This should be an illustration of how you see yourself as a Muslim-American person. You are free to design the map as you wish. You can use drawings, colors, symbols, words. . .whatever you need to reflect your multiple selves.* Two independent raters used a previously established protocol with Muslim youth to code the identity maps into three categories: those that reflected an "integrated," "parallel," or "conflicted" identity. Initial agreement between raters was 87% and disagreements were discussed until full agreement could be reached.

The use of mixed methods was critical in this study for several reasons. First, coding based on the qualitative identity maps was used to form meaningful categorical groups (e.g., those Muslim-Americans with an integrated, parallel, or conflicted identity), which were used in quantitative statistical analyses to look at how they were similar and different in other components of identity that had been collected through quantitative measures. Using this method, participants' identity maps provided the authors with a unique look into their experiences, allowing them to learn that the majority of their participants successfully balanced the coexistence of both their Muslim and American identities, with only a small portion expressing conflict between their identities. Overall, similar to the study mentioned above, utilizing a mixed methods approach allowed an in-depth look at the actual experiences of dual identity from the participants within the study, while combining with a quantitative analysis of other immigrant constructs, such as acculturation and discrimination-related stress.

Overall, the topic of immigrant health is an area of growing importance and concern within the US due to the increasing number of immigrants within the country and much more research is needed. Due to the unique contexts and experiences of these individuals, researchers need to focus a piece of their investigation on the knowledge that can be gained directly from the immigrants themselves. When working with immigrant populations, the combined strengths of qualitative and quantitative methodologies truly allow investigators to obtain a complete look at the immigrant experience – gaining an in-depth understanding of the specific experiences within a culture from the individuals themselves, while also gathering a breadth of general knowledge that may possibly be generalized to the larger community.

Related Topics

- ► Emic
- ► Ethical issues in research with immigrants and refugees
- ► Etic
- ► Focus groups
- ► Methodological issues in immigrant health research
- ► Narrative research
- ► Scale validation
- ► Secondary data analysis
- ► Survey development

Suggested Readings

Corona, R., Gonzalez, T., Cohen, R., Edwards, C., & Edmonds, T. (2009). Richmond Latino needs assessment: A community–university partnership to identify health concerns and service needs for Latino youth. *Journal of Community Health, 34*, 195–201.

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Suggested Resources

The link below provides a detailed introduction to mixed methods research by the National Science Foundation, including key concepts, major differences between qualitative and quantitative techniques, and why you might use a mixed methods approach. Other helpful resources are also included within this link. http://www.nsf.gov/pubs/1997/nsf97153/chap_1.htm

Mood Disorders

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Mood disorders are a group of psychiatric disorders in which the primary symptom is disturbance of mood, which may be defined as one's sustained emotional state. The disturbance must be severe enough to cause subjective distress and usually results in impaired social, interpersonal, and occupational functioning. Mood disorders are classified in both the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR) and the World Health Organization's *International Statistical Classification of Diseases* (ICD-10). Though it is widely accepted that mood disorders are a cross-cultural phenomenon, the experience and expression of mood disturbance vary widely across cultures.

There are two general categories of mood disorders. Depressive disorders are characterized by episodic or chronic low mood, while bipolar disorders involve periods of abnormally elevated, expansive, or irritable mood. According to the World Health Organization, depression is the leading cause of disability worldwide. In the USA, approximately one out of ten adults has a mood disorder in any given year. Depression is an important risk factor for suicide and it is estimated that 90% of people who die by suicide have a mood disorder, substance abuse disorder, or both. Primary depressive disorders, as classified in DSM-IV-TR, include major depressive disorder, dysthymic disorder, and depressive disorder not otherwise specified. Primary bipolar disorders include bipolar I disorder, bipolar II disorder, cyclothymic disorder, and bipolar disorder not otherwise specified. Mood disorders can also be substance-induced or occur secondary to a general medical condition. For example, depressed mood is a side effect of certain medications for hypertension. Secondary mood disorders typically resolve with treatment of the underlying cause or withdrawal of the causative substance.

Major depressive disorder is an illness characterized by periods of low mood called major depressive episodes. A major depressive episode is a period of at least two weeks in which a person experiences low mood or loss of interest in normal activities plus several of the following symptoms: sleep disruption, change in appetite, feelings of guilt or worthlessness, change in energy level, and suicidal ideation. If a person has one or more major depressive episodes, he or she may be diagnosed with major depressive disorder. If left untreated, the frequency and severity of depressive episodes tend to increase with age. Depressive episodes can become so severe that individuals experience symptoms of psychosis, including auditory hallucinations and paranoia. Dysthymia is a depressive disorder characterized by at least 2 years of depressed mood for more days than not, accompanied by other depressive symptoms that do not meet criteria for a major depressive episode.

The best treatment for depressive disorders is a combination of psychotherapy and antidepressant medication. Selective serotonin reuptake inhibitors (SSRIs), including sertraline, fluoxetine, fluvoxamine, citalopram, and escitalopram, are considered first-line treatment. In concordance with the hypothesis that people with depression have a relative deficiency of serotonin, SSRIs block reuptake of this neurotransmitter so that more is available to neurons in the brain. Norepinephrine has also been implicated in the etiology of depression and another class of first-line medications for depressive disorders work by blocking reuptake of both serotonin and norepinephrine. These are called serotonin norepinephrine reuptake inhibitors (SNRIs) and include duloxamine and venlafaxine. Bupropion, which blocks reuptake of norepinephrine and dopamine, is another option. While SSRIs and SNRIs are generally not combined with each other or other serotonergic medications, bupropion may be safely added to as an adjunctive medication to either class.

Older classes of antidepressants, including the tricyclic antidepressants (TCAs) and monoamine oxidase inhibitors (MAOIs), are as effective as newer drugs but typically cause more side effects and have a higher risk of toxicity in overdose. In the case of psychotic depression, antipsychotic medications are always indicated in addition to an antidepressant.

St. Johns Wort is a popular over-the-counter herbal supplement for depression. It has serotonergic properties similar to the SSRIs and may be effective in the treatment of mild to moderate depression. It is very important for individuals to tell their healthcare provider if they are taking over-the-counter agents because of drug interactions. For example, combining St. Johns Wort with prescription antidepressants can lead to serotonin toxicity, a potentially life-threatening condition.

Side effects commonly limit the use of antidepressants. Sexual side effects, including decreased libido and orgasmic dysfunction, are the primary reason people discontinue SSRIs. There are several strategies for minimizing side effects, including lowering the dose, changing the class of medication, or even adding a medication. For example, bupropion may help reverse sexual side effects caused by SSRIs. Antidepressants are most helpful when combined with regular psychotherapy or counseling, which may be provided by a psychiatrist, psychologist, social worker, or licensed counselor.

Bipolar I disorder, commonly referred to as “manic depression,” is diagnosed when a person experiences one or more manic or mixed mood episode. A manic episode is a period of abnormally and persistently elevated, expansive, or irritable mood lasting several days, and characterized by several of the following symptoms: decreased need for sleep, inflated self-esteem or grandiosity, racing thoughts, a sense of pressure to continue talking, distractibility, and impulsivity. In a mixed episode, the criteria for both a manic episode and a major depressive episode are met nearly every day for several days.

In addition to manic and mixed episodes, people with bipolar I disorder usually experience major depressive episodes. The mood episodes in bipolar I disorder are often so severe that individuals lose touch with reality and become psychotic. For example, a manic individual may have grandiose delusions that he or she is the president of the USA. A patient experiencing a mixed or depressive episode may become paranoid that others are trying to poison his or her food, or hear self-deprecating voices. Bipolar disorder is different from schizophrenia and other psychotic disorders in that the psychosis only occurs within the context of a mood episode.

Bipolar II disorder is characterized by one or more hypomanic episodes, and at least one major depressive episode. Hypomania may be considered a less severe form of mania in which individuals typically do not perceive subjective distress or experience much impairment in occupational or social functioning. Cyclothymic disorder is characterized by at least 2 years of numerous periods of hypomanic symptoms that do not meet criteria for a manic episode and numerous periods of depressive symptoms that do not meet criteria for a major depressive episode. Bipolar disorder NOS is diagnosed when individuals have bipolar features that do not meet criteria for any of the above bipolar disorders.

There are several treatment options for bipolar I disorder. First-line agents include lithium, valproate, and carbamazepine, which are mood-stabilizing medications. Antipsychotic medications such as risperidone, quetiapine, and ziprasidone also have mood-stabilizing properties and may be used alone or in combination with mood stabilizers. Antipsychotics are always indicated when psychotic symptoms are present during a mood episode. The exact mechanism of lithium, valproate, carbamazepine, and other mood stabilizers is unknown, but they are thought to target hyperactive signaling pathways in the brain. Antidepressants are typically avoided in bipolar I patients as they are thought to induce mood cycling and may exacerbate mood episodes. Bipolar II disorder and cyclothymic disorder are also treated with mood stabilizers and sometimes antipsychotic medications. Antidepressants may be helpful in select cases. Mood-stabilizing and antipsychotic medications commonly cause unpleasant and sometimes dangerous side effects and require regular blood draws and other forms of monitoring. While depressive disorders are frequently diagnosed and treated in primary care settings, bipolar disorders are most often treated by psychiatrists.

The etiology of mood disorders involves a complex interaction of biological, genetic, social, psychological, and cultural factors. Some disorders, such as bipolar I disorder, have a strong biological and genetic basis. Young, poor women, especially those who have suffered abuse or neglect, appear to be at greatest risk for depression compared with all other population groups, thus implicating social factors. Psychological factors include personality style and coping skills. Cultural factors are extremely important in that culture heavily influences one’s subjective experience of life. A thought, feeling, or behavior becomes a symptom of mood disturbance only when it is interpreted as such based on cultural norms. For example, the conceptualization of depression as an illness is related to the modern, Western notion that individuals should rightly pursue and achieve their own happiness.

Research on the prevalence and experience of mood disorders among immigrants is limited by several factors including undocumented migrants and poor funding for mental health research. According to the World Health Organization, 27% of countries have no system for reporting mental health data. Existing studies reveal conflicting findings. Some support the hypothesis that stressors associated with immigration increase a person's risk for development or exacerbation of a mood disorder, while others show the opposite. In Israel, a society made up largely of immigrants, migration is considered a significant risk factor for mental illness including mood disorders. However, a study of 12,376 respondents living in Ontario, Canada showed a higher prevalence of depression among Canadian-born respondents than foreign-born respondents. Research conducted since the early 1980s has consistently found that immigrants to the USA from Latin America have a lower lifetime prevalence of mood disorders than US-born Hispanics. One study looked at two immigrant groups: one included 706 individuals born in Mexico who immigrated to the USA and the other included 538 individuals born in the USA but of Mexican descent. The group born in the USA had more depressive symptoms, even after adjustments were made for differences between the groups, including socioeconomic status, amount of stress, and social resources. One possible explanation for these results is a selective migration pattern in which foreign-born persons in good health are more likely to immigrate than those in poor health. This pattern also suggests that the process of adjustment to American society leads to an increasing risk for mood disorders. Another US study involving a survey of 3,056 immigrants found that downward social mobility was linked to an increased risk of depression. Thus, it appears that specific stressors associated with immigration, such as the process of cultural transition, may increase a person's risk for development or exacerbation of a mood disorder.

In summary, mood disorders are a group of psychiatric disorders characterized primarily by mood disturbance that result in significant morbidity and mortality worldwide. Mood episodes, whether depressed, manic, or mixed, represent emotional states outside the bounds of normal fluctuations from sadness to elation. Although sustained mood disturbance and associated symptoms are recognized in most cultures, mood disorders, as classified in the DSM-IV-TR and ICD-10, are primarily diagnosed and treated in cultures that subscribe to a Western, medical model of psychiatry. The etiology and course of mood disorders involves a complex interaction of genetic, biological, psychological, and sociocultural factors. There are several effective treatments for mood disorders including medication and psychotherapy; however, the relationship between the affected individual and his or her healthcare provider seems to be one of the most important factors in determining outcome. Immigrants face a unique challenge of having to integrate native cultural beliefs about mental illness with those of their host country while undergoing a broader process of cultural transition.

Related Topics

- ► Acculturative stress
- ► Addiction and substance abuse
- ► Anxiety
- ► Depression
- ► Mental health
- ► Mental illness
- ► Psychotherapy
- ► Transcultural psychiatry

Suggested Readings

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Kaplan, H. I., & Sadock, B. J. (2009). *Comprehensive textbook of psychiatry.* Philadelphia: Lippincott Williams & Wilkins.

Suggested Resources

National Alliance on Mental Illness. http://www.nami.org

World Health Organization. Health topics: Mental disorders. http://www.who.int/topics/mental_disorders/en/

Mortality and Morbidity

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Mortality and morbidity are often used as indicators of health status. Mortality is a unique and final event that is clearly defined and measurable. Morbidity events refer to diseases and illnesses. Both of these indicators can be used to look at the immigrant health.

Assessing immigrant health in terms of mortality and morbidity is a complex issue for a number of reasons. First, there are major deficiencies in national health statistics. Often the immigrant population as recorded in the official statistical systems does not differentiate between naturalized immigrants, permanent residents, nonimmigrants (e.g., temporary workers, students, and visitors), and illegal immigrants. Second, immigrant populations are heterogeneous, not only in terms of national origin but also racial, ethnic, and socioeconomic composition, even from within the same country. Third, migration selectivity renders the interpretation of immigrant health problematic. Finally, due to limitations of data, it is often not possible to compare immigrants' health with that of their counterparts in their country of origin. Most studies assess immigrant health in terms of the country of destination.

Despite variations in patterns and profiles for different immigrant groups in different countries, a few broad generalizations are still possible. Immigrant mortality and morbidity patterns are influenced by both their country of origin and their destination, and by the very process of migration itself. The immigrant mortality/morbidity rates for a particular cause of death or disease may remain similar to their country of origin, worsen in relation to their native country, improve in relation to their native country, or fluctuate in comparison to the host country. The stability of migrant mortality/morbidity rates may be attributable to genetics or factors such as diet, smoking, alcohol, and other health-related behaviors and practices that are brought from the native homeland. These may lead some immigrant groups to experience higher mortality rates from certain diseases such as cardiovascular diseases.

Some immigrant groups, however, may experience a better health outcome than the native-born individuals of their country of destination. This is often explained by reference to the "healthy migrant hypothesis." It states that migrants represent a selectively healthy group that is not representative of all potential migrants from origin societies. As a result, their health advantage stands out when they are compared with the general population at their destination. There is also the possibility that, over time, migrant mortality and morbidity rates might converge to the rates of the host population due to migrants' acculturation, that is, their acquisition of the health behaviors of their adopted country. However, studies on how acculturation affects health are often difficult to interpret because there are few well-validated and consistent measures of acculturation.

In summary, mortality and morbidity are indicators of health status and provide some clues to migrant health status but more studies that assess immigrant health comprehensively are needed. Understanding migration health is paramount in the context of global health but also to understanding and eradicating health disparities.

Related Topics

- ► Acculturation
- ► Healthy immigrant
- ► Immigration status

Suggested Readings

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Palloni, A., & Arias, E. (2004). Paradox lost: Explaining the Hispanic adult mortality advantage. *Demography, 41*, 385–415.

Suggested Resources

McKay, L., Macintyre, S., & Ellaway, A. (2003) *Migration and health: A review of the international literature.* Glasgow: MRC Social & Public Health Sciences Unit, Occasional Paper No 12. Retrieved June 10, 2010, from http://www.sphsu.mrc.ac.uk/files/File/library/occasional/OP012.pdf. Accessed June 10, 2010.

Multiculturalism

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There are at least two meanings of multiculturalism. Multiculturalism can be defined as a demographic condition in which diverse cultural groups coexist within local or national boundaries. Multiculturalism also describes a sociopolitical philosophy that promotes respect, understanding, and preservation of cultural differences. Both of these multiculturalisms have important consequences for the equitable provision of healthcare. As a demographic reality, multiculturalism demands public health policy that provides healthcare access to multiple and growing subpopulations. Multiculturalism as a sociopolitical ideal entails that such provision of healthcare be sensitive to different cultural practices and worldviews. As such, multiculturalism attunes health practitioners and policy makers to both the quantity and quality of healthcare for diverse populations.

Especially since the 1960s, when civil rights and independence movements and shifts in immigration policies helped to reconfigure and intensify global immigration flows, a number of countries have seen steady and rapid increases in their foreign-born populations. Today, countries with long immigration histories, like Australia, Canada, and the USA, have between 13% (US) and 24% (Australia) of their populations foreign born. Even historically ethnically homogeneous countries, like Ireland and Denmark, have received significant numbers of immigrants since the 1990s. Thus, immigration has been a major force in changing the racial, ethnic, and cultural composition of a number of increasingly multicultural societies.

Nations differ in their official responses to these demographic shifts. Canada and Australia have federal policies to encourage multiculturalism, sponsoring programs that respect cultural differences, and protect cultural groups' rights to maintain their customs and languages. In the USA, where no established multicultural policy exists at the federal level, the prevailing national narrative has favored assimilation over multiculturalism. However, since the lifting of national origin quotas with the Immigrant and Nationality Act of 1965, mass immigration from non-European countries has led to the emergence of large immigrant communities, especially in major cities. While individual immigrants follow different paths to incorporation in American societies, immigrant communities throughout the USA have been important for the maintenance of immigrants' cultures and languages.

Medical practice has been significantly impacted by these socio-demographic trends. Multiculturalism has exposed the limits of the one culture, one language model at the core of Western medicine. New approaches to healthcare attend to cross-cultural differences in how health and healthcare are perceived, how health services are utilized, and the ways that culture impacts health outcomes. Multiculturalism in healthcare relates to providing culturally competent healthcare to diverse populations and being aware of cultural differences that could impact the ways that healthcare is perceived, accessed, and adhered to. Within a multicultural framework, health practitioners are encouraged to understand and affirm patients' cultural similarities and differences while avoiding overgeneralizations. Multicultural approaches to healthcare also encourage health practitioners to be aware of their own culturally mediated frames of reference, beliefs, and behaviors as they interact with patients from different cultural backgrounds. Hiring choices made in the interest of multiculturalism can help ensure that health workforces reflect the diversity of the communities that they serve.

Hospitals, health clinics, and doctors' offices have applied the multiculturalism concept in a number of ways. Given the potentially life-threatening consequences of miscommunication between patient and provider, among the most common multicultural accommodations has been the provision of translation and interpretation services through bilingual staff, professional interpreters, and/or on-demand telephone translation services. Delivered effectively, language services in healthcare settings go beyond translating words, to the ideas and worldviews that can impact health outcomes. Whether translating between two languages or not, multicultural staff are often called upon to provide knowledge about cultural differences in how illness is perceived, folk models for the causes of disease, and the ways to treat illness, traditional healing systems, and different cultural scripts that guide patient–doctor relationships and interactions. Another increasingly common extension of the multicultural approach to health practice is the use of community health workers (CHW) – for example, *promotoras* – to provide basic health services in diverse communities. These lay health providers come from the communities they serve and are trained to be liaisons between fellow community members and professional healthcare providers. In this capacity, CHWs provide outreach, basic health information, referrals, advocacy, and support. This community-based, multicultural approach to healthcare has been used as a way to ensure that underserved communities have access to basic primary and preventative health services.

While shifts to multicultural models of healthcare have improved access to culturally competent healthcare, multiculturalism has its limits. Multiculturalism's emphasis on differences among culturally distinct ethnic minority groups assumes that such groups are internally homogeneous, bounded sets. This could lead health practitioners and policy makers to gloss over socioeconomic and linguistic variation within one cultural or ethnic group. In addition, with its emphasis on the cultural dimensions of healthcare, multicultural approaches risk ignoring political and structural forces that mediate the impacts of culture on health and healthcare access. Applied to the strategies and services described above, drawbacks of the multicultural concept can do more harm than good. For example, relying for translation on staff who are not fully bilingual or inadequately trained can lead to misinterpretation of patient's complaints or a provider's treatment plan and counsel. Even for fully bilingual staff, problems can arise if they lack knowledge about dialectal differences within one language group – differences in word meanings, pronunciations, or idioms. Simplistic use of cultural concepts thought to be relevant to particular cultural groups is also potentially harmful. As an instance, the concept of fatalism – assumed to be a deterrent to preventive behaviors among Hispanics – may lead health providers to focus blame on patients for their health problems rather than on persistent structural barriers that lead to disempowerment.

The adequate provision of multicultural health services hinges on providers' ability to identify, classify, and count the various groups that they serve. Race and ethnicity measurement errors, and poorly defined ethno-racial categories, lead to misclassification and miscounting, which, besides producing poor estimates of health resources needed, could also result in inadequate estimates of mortality and health outcomes among various ethnic and racial populations. Thus, proper accounting of demographic diversity requires understanding the ethno-racial labels that people use to identify themselves and the ways that people respond to ethno-racial identification questions in health questionnaires and patient intake forms. Along with multicultural healthcare approaches, accurate population counts are fundamental for understanding and eliminating health disparities in multicultural societies.

Related Topics

- ► Australia
- ► Canada
- ► Community health workers
- ► Cultural background
- ► Cultural competence
- ► Cultural humility
- ► Ethnicity
- ► Fatalism
- ► Immigration and Nationality Act Amendments of 1965 (U.S.)
- ► Ireland

Suggested Readings

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Suggested Resources

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Music Therapy

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According to the American Music Therapy Association, "music therapy is the clinical and evidence-based use of music interventions to accomplish individualized goals within a therapeutic relationship by a credentialed professional who has completed an approved music therapy program." Music therapy interventions may be systematically designed to promote wellness; manage stress; and improve communication/language, social/emotional, cognitive, and/or perceptual/motor skills, and more. Research in music therapy supports its effectiveness in a wide variety of healthcare, educational, and social service settings.

As early as the 1970s, pioneers in the music therapy field began to identify the role that music therapy could play for immigrants. Schorsch suggested the use of music to promote cultural integration, particularly as an aspect of a family therapy approach for immigrant and minority group members, as a future orientation in music therapy. Euper also suggested considering the role of music in family life and how musical activities could serve the needs of families who are disorganized or emotionally unbalanced. Parents in immigrant families may have difficulties adapting to their new environment, and children are often caught between values of the two cultures. Rather than treating patients individually, music therapy may be an excellent means to strengthen intrafamilial ties and help all family members become integrated into their new dominant culture. Music therapy might make a family's own ethnic music a respectable source of pride and unity for that family, while at the same time utilizing local music as an avenue to understanding of and participation in the life of a new community.

More recent studies have addressed the use of music therapy to teach English as a Second Language. Immigrant adults who transplant their families to the USA often seek enriching educational and occupational opportunities. However, their success with these opportunities is typically defined by their language abilities or limitations, and, thus, "immediate language acquisition" for their children is critical for academic, social, and economic integration. Comprehension and accurate expression of English is important not only to communicate thoughts, feelings, and needs but to gain new information, particularly vocabulary, in order to facilitate all other learning. Schunk found that pairing sign language with singing yielded the highest gain in receptive vocabulary skills for elementary students learning English as a Second Language, as compared to spoken text paired with sign, sung text, and spoken text only.

Kennedy utilized music therapy as a supplemental teaching strategy for kindergarten ESL students. While both of his groups performed well on story retelling and English speaking skills, the after-school group performed better than the public school group. Story retelling skills consisted of retelling most of the story; understanding the characters' roles; understanding ideas in the story; using conjunctions, verbs, and adjectives correctly; and using compound sentences. English speaking covered sticking to the topic, speaking clearly, taking turns and waiting to talk, talking loudly so others could hear, using courteous language, volunteering to answer, and speaking only to classmates. Music experiences included chanting and call and response, playing rhythm sticks, singing, moving to music, listening, and lyric analysis. Kennedy further suggested that perhaps the community setting might be more relaxed and less intimidating an environment for young children learning English, possibly because the after-school groups were held in the students' own neighborhoods and parents often were present in the room.

Schwantes conducted case studies of kindergarten, 4th grade, and 6th grade Latino students referred for short-term music therapy services by the ESL teacher. The younger students used traditional Spanish language children's music translated into English, with the premise being that music from the children's culture would help them retain their culture and also be more familiar to them as they worked to acquire English. However, the older students' sessions utilized Western "pop-culture" music because (a) it was thought that this music would help serve as a bridge between them and their peers and (b) they were very motivated to fit into American culture. Music experiences included singing, fill-in-the-blank activities, moving to music, and instrument playing, as well as identifying vocabulary words in the context of the song. All students progressed in acquiring receptive and expressive English abilities, increasing their vocabulary, answering "wh" questions with longer phrases, sequencing song events with greater accuracy, and increasing receptive language skills.

Not only are some music therapy programs, such as the ones mentioned above, specifically designed for immigrants, but any person, regardless of immigrant status or not, may derive benefit from music therapy services. Those with medical issues or special needs may be appropriate candidates, as are individuals who might wish to participate in wellness programs. Music therapy researchers have addressed current issues regarding multicultural training for and practices of music therapists, a topic very pertinent to immigrants being served in the field. Toppozada asserts that as cultural diversity continues to grow in our country, it is vital that music therapists be trained to be aware of and respond to needs and values of clients from a variety of cultures. Seventy-eight percent of professional music therapists responding to her survey supported multicultural training for music therapy students. Chase found the need for research of specific clinical issues in multicultural music therapy and offered the following clinical considerations for work with culturally diverse clients: (1) Know yourself. (2) Engage in new cultural experiences. (3) Treat each person as an individual. (4) Be musically flexible. (5) Ask for help if you need it. Music therapists working with immigrants, above all else, need to be respectful of that person's culture and familiar with appropriate music and customs.

Related Topics

- ► Cultural humility
- ► English as a Second Language
- ► Literacy

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Muslim

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Background

A Muslim is a follower of Islam, one of the three monotheistic religions to emerge out of geographic South West Asia. Muslims see themselves as a community of believers that descended from Abraham, whom they consider a prophet, and they profess actual and metaphoric kinship with members of the Jewish and Christian faith. A practicing Muslim follows the teachings of the Qur'an, which include references to people and events in the Old and New Testaments, and tries to emulate things Prophet Mohammad said and did during his lifetime, which were recorded in a set of writings called Hadith. Based on the Qur'an and Hadith, Muslim jurists throughout history established a body of law, called the Shari'a, to which believers turn to settle everyday questions and disputes. A pious Muslim will profess that there is only one God, pray several times daily, fast during the month of Ramadan, give alms to the poor, and, if health and income permit it, embark on a pilgrimage to Mecca at least once during her or his lifetime.

Muslim Migration

In the world today, there are an estimated 1.3–1.5 billion Muslims. Most of them live in the region that spans South Asia (Pakistan, India, Bangladesh), Southeast Asia (most importantly, Indonesia, Malaysia, and Thailand), South West Asia (also referred to as the Middle East), and North Africa. As such, most Muslims originate in the "global south," and as many of their non-Muslim, global southern fellow-citizens have migrated to Western Europe and the United States, where they constitute immigrant communities of an estimated 15 million and 7 million, respectively.

The reasons for migration are multiple, including the search for economic and educational opportunities, and the flight from war and political oppression. Moreover, the history of colonialism in much of the Muslim world established commercial and cultural ties between European centers of power and their colonial peripheries, which have enabled and sustained migratory flows. The first Muslim migrants to the United States arrived on slave ships from West Africa. While Muslim migrants constitute the clear majority of practitioners of the faith in the United States, there is a growing number of US converts. Some scholars believe that Islam is the fastest growing religion in the United States.

Muslims in the West

In both the United States and Europe, Muslim immigrants have been viewed with fear and suspicion, even before the al-Qaida attacks of 9/11 raised the specter of global terror. The negative attitudes among citizens of the global north stem in large part from their perception of religious and cultural practices among the immigrants. For instance, pious Muslims promote modest dress codes for men and especially women, a family structure that emphasizes the complementarity rather than the equality of spouses, and may practice polygamy. These norms do not mesh easily with Western notions of freedom, equality, and justice. So-called "headscarf affairs" have been reported in most European countries, with subtle to outright acts of discrimination against veiled Muslim women. In one instance in a courtroom in Dresden, Germany, in 2009, a veiled Egyptian woman was brutally murdered by the man she had taken to court for insulting her and pulling off her headscarf in public.

Despite these prevailing and dangerous prejudices and cultural misperceptions, Muslim immigrants to the United States and Europe have, on the whole, been able to build economically successful lives, and the majority is resolved to stay. President Barak Obama, in his historic 2009 address from a pulpit at the venerable al-Azhar University in Cairo, Egypt, celebrated the fact that the majority of Muslim Americans enjoy incomes and education significantly above the American average. Yet, with the events of 9/11 and the subsequent wars in Iraq and Afghanistan, as well as more recent tensions with Iran, many Muslim migrant communities have withdrawn onto themselves and live, now more than ever, in tight-knit communities isolated from the mainstream. This political climate of fear and suspicion has implications for Muslim immigrant health.

Muslim Immigrant Health: Reproductive and Mental Health and Culturally Sensitive Care

Because Muslim immigrants to the United States as well as to Europe come from a very diverse set of national, ethnic, and class origins, it is very difficult to classify or aggregate them in any meaningful way. A common misperception is that most Muslims are Arabs when in fact most of them come from South and South East Asia. Religious practices may unite or, quite often, separate the Muslim community, depending on the variety of branches of Islam. Additionally, not every member of the Muslim community is a consistent practitioner of the faith; as with every other belief system, members fall on the spectrum from pious to secular, with many in-between who consider themselves culturally Muslim and celebrate important holidays. In the United States, there are no census questions that track religious affiliation, and therefore Muslims are not quantifiable in the way that ethnic minority groups are. The most immediate implication of the lack of census data is the lack of epidemiological data, which can be derived for other groups. For instance, there is no "Muslim paradox" similar to the "Latina paradox" (favorable birth outcomes despite low socioeconomic status), although there is a solid body of work about reproductive health and fertility among Muslim families.

Yet still, it is possible to discuss Muslims as a community with shared health concerns based on the fact that many of them share a cultural repertoire that includes the importance and closeness of the family; different levels of respect afforded to members of a family according to their gender and age; and concern with a family's reputation within the wider community, which may circumscribe actions of individuals. And while the existing literature in the area of Muslim immigrant health is not as extensive as that of US-born minority groups, there is nevertheless a growing body of work that acknowledges the stresses and effects of discrimination on Muslims in the West that are not unlike those experienced by members of other minority groups. Those stresses may manifest themselves in Muslim individuals in the area of mental health. Discrimination may not only manifest itself in symptoms of Muslim patients, however, but it may lead to Muslim patients receiving lower quality or culturally insensitive care from health care providers.

Reproductive Health

Because families are central to most Muslim individuals, and children are important to the status of both women and men in most Muslim societies, reproductive health is of central concern also among Muslim immigrants. Couples that cannot conceive often go to great length to obtain medical assistance, with or without the blessing of their religious clergy. Couples that can conceive and that would like to have large families often run into host-country norms that prescribe small, nuclear families, and that consider deviations from that norm as backward and primitive. Reproductive choices, across societies, are often read as a yardstick for women's advancement. If a woman has many children, she may be considered less developed; if the same woman also wears a veil, she is very likely to be looked at as oppressed. Muslim immigrant women may receive special reproductive counseling from their doctors, whether or not they ask for it.

Mental Health

Muslims who live in the West face stereotypes and misperceptions that can lead to violence, as we saw, for instance, after the attacks of September 11, 2001, as well as during the current "war on terror." A climate of fear prevails, and Muslims are constantly under suspicion. The pressure to prove themselves to be different from the stereotype of a religious fanatic has led many to abandon religious dress and practice or distance themselves from members of their own community. As a result, community support networks that used to be available no longer operate. Isolation can lead to depression and other mental health conditions. Additionally, existing mental health conditions may get exacerbated, and individuals may be increasingly reluctant to seek help. Mental health problems, moreover, may carry stigma for the patient – a situation that can be found in other immigrant communities as well. Mental health patients may be considered "crazy" or "possessed" by community or family members, which may prevent them from seeking help.

Of course, mental health issues are prevalent among those Muslim immigrants who arrive in the West from a war zone. As war refugees or asylum seekers, they may receive treatment upon their arrival, but rarely do they obtain long-term care. Again, as stated above, existing stigma within the community may prevent patients from seeking such care. Nevertheless, the awareness of the rising number of mental health patients in the Muslim community led, in 2004, to the creation of a nonprofit organization, as well as the journal *Muslim Mental Health* Inc., with the explicit goal of promoting knowledge and awareness on this particular health issue.

Access to Culturally Sensitive Care

The lack of understanding of Muslim belief and practice among the non-Muslim mainstream in the West has repercussions in the health care field. Many providers appear to be ignorant about or insensitive to the cultural and religious values of their Muslim patients. Rarely are families integrated into the treatment process – one that focuses on the individual body instead. Rarely do medical practitioners ask their patients about their medical practices that they learned at home, and that might support or enhance the course of Western treatment. Most Muslim immigrants consider Western medical practice superior to the medical care that they might have received in their countries of origin – especially if those countries are poor – yet this alone is not a guarantee that they will comply with treatment instructions. Of course, there are also Muslim immigrants who have limited or no access to health care, and there are also pious Muslims who turn to their faith rather than to a doctor for help with an illness. Yet the majority does have at least some access to medical care providers, and it is crucial that we pay attention to what happens in the treatment room between doctors, nurses, and patients.

Related Topics

- ▶ Asylum
- ▶ Christianity
- ▶ Discrimination
- ▶ Islam
- ▶ Judaism
- ▶ Refugee
- ▶ Religion, religiosity, and spirituality
- ▶ South Asians
- ▶ Stigma

Suggested Readings

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Nimer, M. (Ed.). (2002). *The North American Muslim resource guide: Muslim community life in the United States and Canada*. New York: Routledge.

Sargent, C. F. (2006). Reproductive strategies and Islamic discourse: Malian migrants negotiate everyday life in Paris, France. *Medical Anthropology Quarterly, 20*(1), 31–49.

Volk, L. (2009). '*Kull wahad la haalu*': Feelings of isolation and distress among Yemeni immigrant Women in San Francisco's Tenderloin. *Medical Anthropology Quarterly, 23*(4), 397–416.

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Suggested Resources

Council on American-Islamic Relations. http://www.cair.com
Islamic Society of North America. http://www.isna.net
Muslim Health Network. http://www.muslimhealthnetwork.org/ms.shtml
Muslim Mental Health Inc. http://www.muslimmentalhealth.com

Myanmar

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History

Myanmar, known historically as Burma, has an ethnic heritage that includes a mixture of Indo-Aryans, who began arriving in the area around BC 700, and the Mongolian invaders, who penetrated the region in the thirteenth century. Anawrahta, who lived from AD 1044 to 1077, was the first great unifier of Myanmar.

In 1612, the British East India Company sent agents to Burma to establish posts along the Bay of Bengal. Although the Burmese resisted efforts of British, Dutch, and Portuguese traders, through the Anglo-Burmese War in 1824–1826 and two subsequent wars, the British East India Company expanded throughout Burma. In 1886, Burma was annexed to India, becoming a separate colony in 1937.

Burma was a key battleground during World War II; the 800-mile Burma Road was the Allies' vital supply line to China. The Japanese invaded and had occupied most of Burma by May 1942, effectively cutting off the Burma Road. After one of the most difficult campaigns of the war, Allied forces liberated most of Burma prior to the Japanese surrender in August 1945.

Although Burma became independent on January 4, 1948, in 1962 General Ne Win staged a coup, banned political opposition, suspended the constitution, and introduced the "Burmese way of socialism." Twenty-five years of economic hardship and oppression followed, culminating in massive demonstrations in 1987 and 1988. In March 1988, in response to the increasing ethnic conflict and deteriorating economic situation, student disturbances broke out in the capital city of Rangoon as they called for a regime change. Despite repeated violent crackdowns by the military and police, the general public joined the students and the demonstration began to swell in number. During mass demonstrations on August 8, 1988, military forces killed more than 1,000 demonstrators. Following the massacre a rally was held during which Aung San Suu Kyi, the daughter of General Aung San, made her first political speech and assumed the role of leader of the opposition.

On September 18, 1988, the military overthrew Ne Win, abolished the constitution, and established a new regime called the State Law and Order Restoration Council (SLORC). Shortly thereafter the SLORC sent the army into the streets to suppress the ongoing demonstrations. It is estimated that an additional 3,000 were killed, and that more than 10,000 students fled into the hills and border areas. The SLORC changed the country's name from Burma to Myanmar after the name of the ruling party. Notably, governments of many countries including Australia, Canada, France, the United Kingdom, and the United States still refer to the country as "Burma," with varying levels of recognition of the validity of the name change itself.

The SLORC ruled by martial law until national parliamentary elections were held on May 27, 1990. Although under house arrest, Aung San Suu Kyi's National League for Democracy (NLD) party won 392 of the 485 seats. However, the SLORC refused to call the Parliament into session and imprisoned many political activists. In 1992 General Than Shwe became leader, claiming the position of prime minister. Subsequently, many political prisoners were released, most martial law decrees were lifted, and plans were announced to draft a new constitution. Despite this, the army gave no sign that it would be returning governance to civilian control. Quickly, this drew the condemnation of the United Nations Security Council. Furthermore, the regime signed ceasefires with the insurgent ethnic groups except for the Karen, with the government launching a major attack against them in 1997.

In 1997, the ruling junta changed its name to the State Peace and Development Council (SPDC); however, the name change did not reflect a shift in policy. In 2000, the SPDC announced it would begin talks with the political opposition led by Aung San Suu Kyi, who numerous times had been under house arrest and released, only to be detained again. Following the talks, a sizable number of political prisoners were released, and there was some increase in political freedoms for Aung San Suu Kyi and the NLD. On May 6, 2002, she was allowed to leave her home and subsequently traveled widely throughout the country. On May 30, 2003, Aung San Suu Kyi and her convoy were attacked by a government-affiliated group. Many members of her convoy were killed or injured, while others remain unaccounted for. Aung San Suu Kyi was detained and put again under house arrest. She remained there until November 2010, when she was released once more.

Geography

Myanmar occupies the Thailand/Cambodia portion of the Indochinese peninsula – a peninsula in Southeast Asia that is roughly east of India and southwest of China. Myanmar is 678,500 km^2 in total area and covers a total land area of 657,741 km^2. India is situated to the northwest of Myanmar, while China is to the northeast. Bangladesh, Laos, and Thailand are also neighbors. The Bay of Bengal borders the southwest coast. In the south is the fertile delta of the Irrawaddy River, which contains a network of interconnecting canals and nine principal river mouths.

Health

Myanmar has an estimated population of 53,414,374 as of 2010; a growth rate of 1%; a birth rate of 19.5/1,000; an infant mortality rate of 50.7/1,000; and a life expectancy of 64.5 years. Rangoon (Yangon) is the capital, with a population of 4,344,100. The World Health Organization reports that approximately two-thirds of the population have easy access to improved water source – with urban and rural coverage being 92.1% and 74.4%, respectively, according to the 2003 MICS Survey. This reflects an increase from 32% in 1990 to 71.5% in 2000.

The World Health Organization's National Health Plan has four projects related to health and environment in Myanmar: prevention and control of environmental health hazards, occupational health and safety, prevention and control of agricultural hazards, and air and water pollution control. Environmental health awareness is increasing and steps to confront hazards are under active consideration; these hazards include impacts of urbanization, air pollution, solid and hazardous waste, traffic congestion, noise pollution, and substandard housing.

Emigration

Over the years, Burma – now Myanmar – has seen several sizable waves of migration. Indians were the largest Asian minority in Myanmar until the start of World War II, during which hundreds of thousands fled the Japanese invasion. Although many returned at war's end, the Indian minority never reached its prewar numbers. After gaining independence in 1948, the Myanmar government established firm restrictions on Indian migration. Between April 1963 and June 1965, the Indian population was reduced by 100,000. During this time, Indian immigrants were repatriated as part of an effort to increase the wealth and holdings of Myanmar nationals – the impetus of the program being the Indians' prominent position in Myanmar commerce.

Although the government sought to curtail both immigration and emigration, it is estimated that as many as 500,000 persons may have exited Myanmar between 1962 and 1971. About 187,000 Muslims fled to Bangladesh in 1978, leaving Myanmar because of alleged atrocities by its soldiers in Arakan State. With the help of UN agencies, they were repatriated by the end of 1981. They lost their citizenship in 1982. In addition to migration resulting from immigration and emigration, forced resettlement continues to be a concern for poor urban residents. Between 1989 and 1992, approximately 500,000 rural residents were subjected to forced resettlement in connection with counterinsurgency operations.

In 1992, 250,000 Muslim refugees claiming human right abuses in Myanmar's Northern Rakhine state began arriving in Bangladesh. Between 1994 and 1997, some 230,000 of these refugees returned home; however, as of October 1996, around 50,000 were still living in one of five refugee camps in the southern part of Bangladesh. Repatriation resumed in November 1998 following meetings between the United Nations High Commissioner for Refugees (UNHCR) and Myanmar authorities. However, due to procedural problems, returns were limited and slow.

Fleeing fighting and political conflicts in Myanmar, asylum seekers increased dramatically during the 1990s; Thailand was and continues to be a popular host country. Recent clashes between an ethnic rebel group in Myanmar and government soldiers pushed a wave of at least 10,000 refugees across a river into Thailand. This occurred in November of 2010, one day after Myanmar held its first election in 20 years. In the attack, ethnic Karen rebels seized a police station and post office in the border town of Myawaddy. The fighting is one skirmish in a decades-long civil war with a number of ethnic groups that have raged in remote mountains and jungles of Myanmar.

In the first election in more than two decades, military-backed candidates took the majority of the Parliament seats. Not surprisingly, as the junta set the rules for the election and the parties and Myanmar's current military leaders were expected to retain power, condemnation from Western nations ensued. While the United States was quick to condemn alleged violations of human rights and call upon the international community to take a similar stance, India and China undercut the sanctions in force by the United States and the European Union. Both neighbors of Myanmar, India and China, are competing for influence and access to raw materials; they have continued trade and diplomatic support for Myanmar's ruling generals. Notably, due to continuing unrest in parts of the minority ethnic areas, 1.5 million persons were excluded from the election.

In one of the world's longest running separatist insurgencies, minority groups in untamed regions of Myanmar have been fighting against government control since the country gained independence in 1948. The most recent wave of refugees has sought safety in camps along the border between Myanmar and Thailand. Thai officials said they would be sent back when the situation returned to normal.

Related Topics

► Internally displaced persons
► Refugees

Suggested Readings

Kyi, A. S., & Clements, A. (2008). *The voice of hope* (2nd ed.). New York: Seven Stories Press.

Myint-U, T. (2008). *The river of lost footsteps: A personal history of Burma*. New York: Farrar, Straus and Giroux.

Suggested Resources

For information from the Migration Information Source. http://www.migrationinformation.org/index.cfm

For information from the United Nations. http://www.un.org/

For information on the World Health Organization's Regional Office for South-East Asia. http://www.searo.who.int/index.htm

N

Nanny

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The International Nanny Association defines a nanny as one who is "employed by [a] family on either a live-in or live-out, part-time or full-time basis, to undertake all tasks related to the care of children." The history of the nanny can be traced back to the eighteenth- and nineteenth-century England, when virtually all upper-class parents hired nannies to take charge of childrearing. Nannies often had control of their own floor or wing of the house where they shared quarters with children and may have had the assistance of a nursemaid. While nannies and children spent most of their time together, the class difference between the two was always clear. Parents often hired more culturally similar caregivers as their children matured in order to reinforce their upper-class values. The late-twentieth century saw a drastic increase in the employment of nannies. In the United States, this was primarily accounted for by two concurrent social trends: (1) the dramatic increase in the number of dual-career families and (2) a shift in parenting practices to a "child-centered" approach. From 1975 to 2008, the labor force participation rate of mothers of children under age 6 rose by 25%. Furthermore, women increasingly worked in jobs that are well compensated and may require long hours with the expectation that childrearing will not affect their performance. In 2008, over half of all managers and roughly a third of lawyers and physicians were women. This has given rise to what some sociologists refer to as two-career households: a family where both parents hold down professional jobs in which the time demands are excessive or unpredictable.

Alongside this growth of the "professional class" has been a shift in parenting philosophies toward a "child-centered model": one which places the intellectual and developmental needs of a child at the center of a mother's life. This type of "intensive mothering" emphasizes continuous stimulation of a child's development in the form of reading, music, language, and other expert-guided activities. Continuous nurturing by a single energetic caregiver is the ideal. Women operating under this model may seek a nanny to act as a "mother surrogate," to take their place during the working day. Families who hire nannies cite the benefits of increased flexibility of schedule and a sense of control over their children's environment.

In order to meet the needs of the middle- and upper-class, the modern nanny has become part of the fabric of life in developed countries. As a whole, however, their profession is one without much formal statistical data or regulatory activity, prompting one Washington Post journalist to term this a "shadow industry" in the United States. The industry includes many immigrant workers, both legal and undocumented, and employers who may or may not pay taxes. It is estimated that there are 200,000 domestic workers in New York City alone. A survey conducted by Domestic Workers United in 2003 and 2004 found that 99% of domestic workers in New York were foreign-born. This survey did not report the immigration status of these workers. Another study of only 76 nannies in either Los Angeles or New York included women from 29 different countries. In 2006, a survey conducted for a county council outside of Washington DC found that only 28% of 280 nannies surveyed reported that money was deducted by their employers for Social Security taxes.

The unregulated nature of nanny work has raised a number of labor and human rights concerns. Human Rights Watch declares a larger group of domestic workers to be "among the most exploited and abused workers" worldwide. Grievances are many and include:

Sana Loue & Martha Sajatovic (eds.), *Encyclopedia of Immigrant Health*, DOI 10.1007/978-1-4419-5659-0,

exclusion from labor laws in multiple countries, wage exploitation, excessive work hours, unfair termination of contracts, and lack of basic employment benefits such as paid time off, health care, and maternity leave. There are reports of psychological, physical, and sexual abuse. In the United States, domestic workers are excluded from both the National Labor Relations Act and the Occupational Safety and Health Act Civil Rights Laws, which give employees the right to organize and bars employment discrimination on the basis of race, color, religion, sex, or national origin. As "casual employees," many domestic workers are also excluded from the Fair Labor Standards Act, which sets a federal minimum wage, maximum hours, and overtime for employees. The survey conducted in New York by Domestic Worker's United reported that 26% of domestic workers made wages below the poverty line, 67% did not receive overtime pay for overtime hours worked, and 90% of domestic workers did not receive health insurance from their employers. In this same survey, nearly 60% of the domestic workers identified themselves as the primary income earner for their family.

Recognizing the risks of exploitation that nannies and other domestic workers face, many governments have enacted laws to protect the rights of this population. Both Brazil and Mexico have incorporated rights for domestic workers into their constitution. Hong Kong affords domestic workers the ability to organize and join trade unions. Two-thirds of the 66 countries studied by the International Labor Organization have established a minimum wage for domestic workers. In the United States, the National Alliance of Domestic Workers is leading campaigns in both New York and California to enact a Domestic Workers Bill of Rights. Both of these legislative acts address common injustices such as inadequate notice of termination, lack of overtime pay, and paid sick leave. Success in California and New York, which could affect hundreds of thousands of domestic workers, would be a strong precedent for nationwide change.

Related Topics

► Child rearing

Suggested Readings

Tronto, J. C. (2002). The "nanny" question in feminism. *Hypatia, 17*, 34–51.

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Suggested Resources

Domestic Workers United. *Home is where the work is: Inside New York's domestic work industry. Executive summary.* [Database]. Retrieved from http://www.domesticworkersunited.org/media/files/8/homeexecsum.pdf

Human Rights Watch. *Decent work for domestic workers: The case for global labor standards.* [Report]. Retrieved from http://www.hrw.org/sites/default/files/related_material/HRW_ILO_brochure_lores.pdf

International Nanny Association. *Frequently asked questions: In-home child care definitions.* Retrieved from http://www.nanny.org/faqdefinitions.php

National Alliance of Domestic Workers. *Our campaigns*. Retrieved from http://www.nationaldomesticworkeralliance.org/

Schulte, B. (2007, September 4). Nannies on a quest for rights. *The Washington Post*. Retrieved from http://www.washingtonpost.com/wp- dyn/content/article/2007/09/03/AR2007090301223.html

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Narghile

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The narghile (also known as a shisha, hookah, hubble-bubble) is a type of water pipe. The device has been used for centuries, most commonly in the Middle East, but also in many other countries, including India, Africa, and China. Moistened and often sweetened tobacco is heated, and smoke is drawn into the lungs through water via a single or multistemmed tubing and mouthpiece. It is thought that globally, over 100 million people smoke tobacco in this way, often in cafés or shops where the social context is comforting and relaxed.

International Spread of the Narghile

Narghile smoking is gaining in popularity. With immigration and cultural adaptation, the use of the narghile has spread through Europe and has been increasing in the USA. Special "cafés" are sprouting up in the Middle East, across Asia, as well as in European and American cities – in college towns and urban settings. The café ("hookah bar") provides the narghile, and the inexpensive sweetened or flavored tobacco is readily available. The cafés are comfortable and provide an inviting, socially acceptable environment which is very attractive. Whereas for women in the Middle East, cigarette smoking is associated with cultural stigma, more and more women (and families) are smoking in the cafés. In the USA, adolescents and college students have been exposed to this form of tobacco use; it has become "trendy." Students say the reason they smoke is that it is "pleasurable," that it "adds to intimacy in a social gathering," that it helps "deal with pressure," and to be "accepted by peers."

Concerns About Narghile Smoking

There is a prevailing misconception that smoking using a narghile is less toxic than smoking cigarettes. Many smokers believe that the water filters out the carcinogens, tar and nicotine, but studies seem to prove otherwise. Tobacco for the various types of water pipes, sold in cardboard or plastic jars decorated with fruit illustrations and mixed with fruit, honey, or fruit oils, attracts the young and health-conscious. The smell, taste, and fragrance reinforce the belief that there is something "healthy" about smoking this tobacco. However in various studies, it has been shown that the percent nicotine content in the water-pipe tobacco is actually higher than tobacco used in cigarettes, increasing exposure to the cancer-causing chemicals, heavy metals, and hazardous gases. Because the smoke is cooled as it passes through a water-filled chamber, smokers take longer deeper puffs and, in the social setting around a narghile, smoke for a longer period. It is estimated that a single water-pipe session may lead to smoking the equivalent of 20–100 cigarettes. Typically, the water-pipe sessions are episodic, but this does not necessarily diminish the risk of developing nicotine dependence; addiction to nicotine may happen rapidly. Some experts believe that smoking tobacco in this way sets up the adolescent or naïve smoker to experiment or become addicted to cigarettes over time. While the data are limited, it appears that like cigarette exposure, the use of these pipes is linked to lung cancer and other respiratory and heart diseases. In addition, when the mouthpiece is shared from smoker to smoker, there may be an increase in orally transmitted infectious diseases.

Related Topics

- ► Cancer
- ► Stress
- ► Tobacco
- ► Tobacco control
- ► Tobacco use

Suggested Readings

Knishkowy, B., & Amitai, Y. (2005). Water-pipe (narghile) smoking: An emerging health risk behavior. *Pediatrics, 116*(1), e113–e119.

Suggested Resources

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Center for Substance Abuse Research, University of Maryland. (2008). Scientific evidence of the health risks of hookah smoking. http://www.cesar.umd.edu/cesar/cesarfax/vol17/17-23.pdf

WHO Study Group on Tobacco Product Regulation. (2005). Advisory note. Waterpipe tobacco smoking: Health effects, research needs and recommended actions by regulators. http://www.who.int/tobacco/global_interaction/tobreg/Waterpipe%20recommendation_Final.pdf

Narrative Research

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Narrative research is an inquiry method that collects and analyzes people's stories; it initially received great attention in the 1980s, in the scholarship of various helping professions including medicine, law, education, and social work. This qualitative research methodology reflects the core values intrinsic to feminist and cultural studies research by permitting the storyteller to guide the inquiry and as such, is a particularly appropriate research methodology for use with immigrant and refugee populations. The research participant or storyteller describes and interprets her/his life to the listener which creates a dynamic where she/he is not simply the object of inquiry, but is uniquely and intimately a part of the research process. In the telling of their story, participants describe and emphasize what is important in their own language and voice, and consequently their story reflects their unique social, political, historical, and cultural perspectives. This research methodology provides participants, who may not normally be part of the dominant discourse in our society, an opportunity to construct, direct, and interpret the meaning of their personal stories.

Narrative research analysis processes are distinctive. First, through a shared analysis, the participant and the researcher co-create a narrative where special attention to the cultural and political idioms used by the participant is important. The analysis consists of considering five specific factors: selectivity, silence, slippage, intertextuality, and the collective subjective. Selectivity recognizes what participants chose to include in parts of their stories (e.g., where to begin and end the narrative), silences are parts of the narrative where the participants chose to omit details; slippage are any inconsistencies or contradictions in the narrative.

Narrative analysis also employs the use of intertextuality – the comparison and analysis within and between different participants' narratives. Individual and group narratives will also be compared to the scholarly literature. The researcher utilizes direct quotations to ground the themes of the data. Throughout this process the researcher becomes both a conduit for the story and a learner about that story.

Researchers and philosophers use different terms to describe what Gramsci defined in 1980 as the collective subjective, the concept of recognizing and valuing the commonalties in participant stories that reflect the shared beliefs, problems, and language of a social group. For example, Bakhtin describes the collective subjective as "social dialect," West identifies it as "discourse," and Fish calls it an "interpretive community." Understanding the collective experiences provides a forum for the voices of the marginalized to be understood in a cultural context and to be valued and honored.

An understanding of self or "subjectivity" in relation to their participants and/or the general area of inquiry is also critical in narrative research. Self-reflection allows the researcher to explore her/his own life experiences and to examine how her/his beliefs and values may positively or negatively influence her/his research.

Narrative research methodology can be arduous and time consuming, requiring extensive time in building partnerships, interviewing, and the process of paying particular attention to fine details in analysis. Consequently, the number of participants is frequently limited.

Narrative research utilizes culturally relevant traditions of oral history when working cross-culturally with immigrants and refugees. Because narrative research does not require the storyteller to possess any specific educational background, it is particularity suitable for immigrants and refugees who may be illiterate or who may have limited language proficiency. From a mental health perspective, the narrative research process can be therapeutic and cathartic for the participant or storyteller. The process may allow the participant to reflect on her/his past struggles and problem-solving skills, acknowledging her/his inherent strength and resiliency.

Related Topics

- ▶ Community-based participatory research
- ▶ Ethnography
- ▶ Mental health
- ▶ Photonarrative

Suggested Readings

Casey, K. (1995–1996). The new narrative research in education. In *Review of research in education* (pp. 211–254). Washington, DC: AERA.

Clandinin, D. J., & Connelly, F. M. (2000). *Narrative inquiry: Experience and story in qualitative research.* San Francisco: Jossey-Bass.

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Reissman, C. (1993). *Narrative analysis.* London: Sage.

Silverman, D. (2000). *Doing qualitative research: A practical handbook.* London: Sage.

Suggested Resources

Website for American Educational Research Association (AERA). Special Interest Group on Qualitative Research. Retrieved September 26, 2010, from http://www.aera.net/Default.aspx?menu_id=208&id=772.

National Origins Act of 1924 (U.S.)

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The 1924 Immigration Act (National Origins Act or the Johnson-Reed Act) was the crowning achievement of nativists seeking to restrict immigration in the United States at the turn of the twentieth century. Nativists used a variety of scare tactics including health and disability, race, and assimilability to argue for limiting immigration.

Fueled by the eugenics movement and the belief that selective breeding could improve the population, and alarmed over the increasing number of immigrants originating from southern and eastern Europe (considered of racially inferior stock), intellectuals and the power elite began calling for immigration restrictions. For example, T.V. Powderly, the Commissioner-General of Immigration, warned in 1902 that immigration was a menace to the national health and defended the 1891 immigration law which barred certain groups including those suffering from loathsome or dangerous contagious diseases from entering the country. Further he linked certain communicable diseases such as favus and trachoma to immigrants from southern Europe and Asia.

Allan McLaughlin, a doctor for the US Public Health and Marine Hospital Service on Ellis Island, echoed this sentiment in a *Popular Science Monthly* in which he suggested that empirical data supported the view of immigrants as a menace to public health. McLaughlin asserted that the physique of immigrants from southern and eastern Europe represented a marked deterioration compared to that of the sturdy races of northern and western Europe. The result of this deterioration, he argued, was a corresponding increase in loathsome and dangerous diseases in the country. The solution was to mandate a standard physique for all immigrants and exclusion for those not making the grade.

In 1907 the US Congress formed the Dillingham Commission to study the immigration issue. Echoing popular sentiment, the Commission concluded that immigration from southern and eastern Europe posed a threat to the culture of the United States and recommended restricting their numbers. The Commission opined that the relative lack of restrictions from 1819 through 1882 had allowed "the diseased, defective, delinquent, and dependent" to easily enter the country. While the Commission acknowledged that the present immigration policy seemed to adequately identify unhealthy immigrants, it suggested that such screenings be done by American medical officials in the ports of origination.

Newspapers mimicked the theme of diseased and defective immigrants. A 1913 *New York Times* article entitled "Alien Defectives" cited a report by Ellis Island surgeon C.P. Knight who claimed that almost every ship to port in New York contained mentally defective immigrants. To minimize the impact of mental defectives, Dr. Knight supported a three-pronged solution: control procreation, regulate marriage, and limit immigration into the United States. The newspaper began warning of diseases emanating from immigrant processing facilities such as Ellis Island that could spread to the rest of the country.

Anti-immigrant sentiment extended beyond the intellectual and political elite into the mainstream as well. Anti-Asian sentiment further propelled the demands for immigration restriction. Even *Good Housekeeping* published articles on the issue including one in 1921 by then vice-president (later president) Calvin Coolidge entitled "Whose Country Is This?" Prominent novelists like Jack London and F. Scott Fitzgerald included elements of anti-immigrant sentiments in their writings.

Responding to mounting national pressure to act, Congress passed the Emergency Quota act in 1921 meant to temporarily impose immigration restrictions. This emergency bill limited the number of immigrants to 3% of the foreign-born population of a given nationality resident in the United States based on the 1910 census. While significantly curtailing immigration from these regions, the political and intellectual elite was unsatisfied. The author of the act, Albert Johnson, and his colleagues set to establish a more effective way to selectively screen immigrants.

The idea of initial immigrant screening from abroad found support on multiple fronts. Proposals by Johnson to having American consuls abroad prescreen immigrant applications became part of the 1924 National Origins Act. This act established quotas of 2% of the foreign-born individuals of each nationality resident in the United States as determined by the census of 1890. Further, persons deemed ineligible for citizenship (e.g., Asians) were excluded from the quota system.

The shift of immigrant screening abroad resulted in the eventual closing of the medical line inspections at Ellis Island in 1924. A year later a *New York Times* article cited suggestions that if the program of screening immigrants abroad was successful, Ellis Island might be abandoned. Its article in 1934 titled "Busy Ellis Island Now a Thing of the Past" cast support for the earlier prediction.

With the issue involving health screenings taking place abroad settled, attention turned to border control. Nativists were upset that the 1924 act excluded Mexicans from immigration quotas and anti-Mexican rhetoric mounted after the passage of the Act. For example, agencies in California charged that Mexicans were unhealthy, filthy, and prone towards criminality and mental defects. Such demands for greater border control resulted in the establishment of medical line inspections along the US-Mexico border. Mexican border crossers in general had to derobe, have their hair shorn, and clothing and baggage fumigated. Mexicans who commuted to work in the United States were required to report to immigration service weekly for bathing.

In sum, concerns over health were integral to the mounting hostility towards immigrants and calls for restrictions that ultimately culminated in the passage of the 1924 National Origins Act. Nativists unhappy with Mexico's exemption from the quota system began anew the claims of ill-health and mental degeneracy previously aimed at southern and eastern Europeans. Thus, while the law ended the medical line inspections at Ellis Island – the source of overcrowding which generated much negative press – it shifted attention to US borders, and particularly the US-Mexico border.

Related Topics

- ► Ellis Island
- ► Medical examination (for immigration)

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Nationality

► Identity

Nativism

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Nativism is opposition to a minority group because of their perceived "foreignness." The underpinnings of nativism are racial, cultural, religious, economic, and political. In general, nativism runs high during times of economic uncertainty. In such circumstances, individuals often scapegoat immigrants, citing concerns about threats to American culture and the fiscal costs of low-skilled immigrants.

The nativist sentiment often draws on myriad, interconnected rationales. Old nativist concerns primarily dealt with immigrant competition in the labor market; however, recent nativist concerns deal with the threat immigrants pose to the established American culture, which is perceived to be Anglo-Protestant. In the USA, most publicly available data regarding nativism is specific to the Latino community. Some scholars see Latin American immigrants, especially those from Mexico, as distinct from immigrants who came during of the turn of the twentieth century. The argument is that Latin American immigrants pose an economic threat because they are slow to assimilate socioeconomically. Latin American immigrants are also seen as a cultural and political threat to an American nation with a "single national language and a core Anglo-Protestant culture." The narrative at the center of nativist concerns has been called the "Latino Threat Narrative." The Latino Threat Narrative suggests that Latinos will not become part of the American nation like previous immigrants did, because they are either unwilling or incapable of integrating socially and culturally. In this way, Latinos are perceived to be an invading force from the south of the border and a threat to the American nation. A recent poll found that 78% of Americans believe that the USA could be doing more along its border to keep unauthorized immigrants out. The fact that nativist rhetoric focuses on the Latino community is problematic because people often cannot differentiate between authorized and unauthorized immigrants, which oftentimes perpetuates discrimination against the entire community.

There are three different anti-foreign sentiments that are at the core of the racialized nativism of the contemporary period in the USA. First, there is extreme antipathy toward non-English languages and a fear that linguistic difference will undermine the American national unity. Second, nativism expresses a concern that multiculturalism and affirmative action are retarding meritocracy and disproportionately distributing resources to non-Whites. Third, contemporary nativism focuses on the perceived drain of public resources by immigrants, both authorized and unauthorized, particularly as it relates to utilization of welfare, education, and healthcare services.

Debates over health care are a flashpoint of nativism in the USA. Because health care is seen as a scarce and expensive resource, many Americans are loath to share this resource with immigrants and unauthorized immigrants in particular. A recent poll found that 80% of Americans oppose providing health care to unauthorized immigrants. Americans view health care as a resource that belongs to legal members of the national political community, and not individuals who are here as unauthorized immigrants. A similar rhetoric was seen during the passage of Proposition 187 (Save our State initiative) in California. The goal of Proposition 187 was to prohibit unauthorized immigrants from using social services – one of the social services being health care. Consequently, the healthcare reform debate is an avenue for defining inclusion and exclusion. It is important to note that nativism is not a phenomenon confined to the USA. Many countries experience a rise in nativism as a result of new immigration.

Related Topics

- ► Exclusion
- ► Hispanics
- ► Illegal immigration
- ► Undocumented
- ► Xenophobia

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The Migration Policy Institute's Research Website. http://www.migrationinformation.org/.

Naturalization

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Unlike birthright citizenship, naturalization is the legal process whereby immigrants become citizens of the receiving state, gaining membership into the polity and access to its political rights. In some contexts, healthcare access has been construed as an exclusive right of citizens, rather than a universal human right. In the USA a number of local, state, and federal policies have had the effect of conjoining healthcare access with US citizenship. At the state level, Proposition 187, the 1994 California ballot initiative, sought to eliminate social services, including nonemergency medical care, for undocumented migrants. This ballot initiative also required public employees – including schoolteachers and healthcare providers – to report undocumented migrants, or individuals “suspected” of being undocumented, to the US Immigration and Naturalization Service. While the targeted population of this measure was undocumented migrants, criteria for suspicion of “illegality” were arbitrary, and therefore Latinos perceived that characteristics such as language, ethnicity, and skin color were likely suspects, irrespective of nativity or formal citizenship. At the national level, the Illegal Immigration Reform and Immigrant Responsibility Act of 1996 barred undocumented migrants from social security benefits. Such restrictions were extended to the legal permanent resident population with the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, which enacted restrictions on the eligibility of legal migrants for many benefits available under Federal law, and also authorized States to restrict benefits programs. Under these reforms, legal migrants were banned from receiving Medicaid during their first 5 years of residence in the USA. These provisions also allowed state elected officials to renew their attempts at excluding undocumented migrants from access to healthcare, for example California Governor Pete Wilson’s efforts to deny undocumented migrant women access to prenatal care. By seeking to restrict healthcare to birthright and naturalized US citizens these laws not only had implications for migrant health, they also mobilized a sizeable segment of the immigrant Latino population against what they considered an assault on their political and human rights.

Among its political effects, these reforms mobilized eligible migrants to seek naturalization out of fear of losing basic rights and services, among them access to healthcare. In the mid-1990s, naturalization figures soared from over 270,000 to over a million, with Mexican migrants alone accounting for 20.8% of those new citizens. Studies in Latino politics show that this increase in naturalizations was a direct effect of the hostile, anti-immigrant political climate fostered in places like California. The immigrant-targeting legislation of the 1990s, which sought to restrict access to services such as healthcare, triggered a wave of “defensive naturalization,” producing a cohort of politically engaged and informed new citizens. In places like California, these patterns of mobilization had clear partisan consequences, with newly registered Latinos largely registering Democratic. In sum, the rollback of civic and human rights for undocumented migrants and legal residents – healthcare access among them – mobilized eligible migrants to naturalize and turnout to vote, breaking with earlier patterns of low political participation. With the series of mass protests against anti-immigrant congressional legislation in 2006, naturalization rates once again increased significantly. Between January and October 2007, the US Citizenship and Immigration Services (USCIS) received 1,029,951 naturalization applications, a 59% increase from the same period in 2006.

In addition to their political effects, such policies and initiatives also have implications for migrant public health outcomes. Latinos constitute the subpopulation with the highest uninsured rates in the USA and the lowest percentage of individuals with employer-based health insurance. Survey data collected in the lead-up to the healthcare reform legislation under the Obama administration reported that a majority of Latinos (61%) agreed that the federal government should ensure that all people have health insurance. An even larger majority of Latinos (67%) believed that anyone living in the USA should be eligible to buy or receive healthcare regardless of citizenship status, compared to only 30% of non-Latino Americans.

In spite of these patterns, the healthcare reform bill left out undocumented migrants entirely, meaning that millions will continue to face high healthcare access barriers. This outcome is likely to have negative effects on immigrant health and on the healthcare system itself.

Unlike the USA, other immigrant-receiving democracies offer greater social services and benefits for migrant populations. Naturalization rates have historically been higher in these immigrant-receiving societies compared to the USA. For example, in 1997 only 35% of foreign-born residents living in the USA had become naturalized citizens. In Canada, on the other hand, 70% of immigrants were naturalized citizens. While migrants in the USA have been mobilized to naturalize out of fear of losing basic rights and services such as healthcare, higher naturalization rates in places like Canada are a product of greater citizenship promotion programs on behalf of local and federal governments, leading to different configurations between migrants, the state and national identity in the two countries.

Related Topics

► Citizenship
► Illegal Immigration Reform and Immigrant Responsibility Act of 1996 (U.S.)
► Immigrant visa status
► Latinos
► Undocumented

Suggested Readings

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Neoplasms

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Neoplasms are masses that develop as a result of abnormal or excessive cell division. These tumors may also form when cells do not die when they should, and thus accumulate into a mass. While malignant neoplasms are cancerous, there are also; benign neoplasms that are not cancerous.

Cancer in immigrants is a complex research and clinical topic. Risk factors for the development of cancer include genetic, environmental, and behavioral factors, including nutrition and exercise, as well as differential rates of infection with cancer-causing pathogens. Our understanding needs to include the factors responsible for changes in cancer risk with migration. For example, there are differences in cancer rates for populations that are similar genetically but living in different locales. These rates change over time and with generation of residence. Cancer rate differentials also exist in similar environments among people with different genetic risk for cancer.

Establishing a deeper understanding of cancer risk factors can lead to a more targeted modification of risk and the application of screening for early detection. For example, recent Latino and Asian immigrants have a high incidence of gastric cancer, partly due to the high prevalence of Helicobacter pylori infection in their countries of origin. Similarly, high rates of liver cancer reflect the chronic hepatitis B infection among these immigrants.

However, despite the need to consider risk by population group, data are too often aggregated (for instance, Asian Pacific Islanders are considered as one group, without regard to immigration status, length of stay, or even at times country of origin), and biologically and environmentally significant denominator data are impossible to obtain. Further, ethnic and racial minorities are underrepresented in cancer clinical trials. Immigrant minorities also face considerable barriers in accessing appropriate cancer care and information, as highlighted by the Institute of Medicine, the Presidents' Cancer Panel, and the National Academy of Sciences. These include systems, financial, and physical barriers, barriers related to language or education, and barriers related to cultural differences and biases in cancer care. Some immigrants may also face the additional barrier of immigration status.

These issues lead to disparities in cancer morbidity and mortality between socioeconomic groups, insured and uninsured populations, and certain racial and ethnic groups. Despite an observed decrease in overall cancer death rates in the USA, immigrants continue to experience disproportionately higher cancer incidence and mortality rates for many cancers, as well as decreased access to treatment, end-of-life care, and survivorship services.

For example, lung cancer among immigrant groups is, in large part, influenced by their use of tobacco. There is a higher smoking prevalence and lifetime smoking rate for Chinese American immigrant men in many areas. Globally, there is significant geographic variation in the incidence of oral cancer; notably, the Indian subcontinent has been cited as having a disproportionately high incidence. In India, the oral cavity is one of the top five leading sites for cancer, with tens of thousands of new cases of oral cancer each year. In the USA, oral cancer accounts for less than 5% of cancers diagnosed annually – yet immigrants from South Asia are at much greater risk. Use of areca nut and smokeless tobacco in the form of paan and gutka contribute to this increased risk.

Breast cancer, after lung cancer, is the second leading cause of cancer death in women. The proportion of Mexican and Dominican women with breast cancer has increased rapidly in New York City, for example. Cultural beliefs and decreased access to care may impede breast cancer screening in minority immigrant women, and can lead to later stage of disease presentation. Cervical cancer is the most common type of cancer among women worldwide. In the USA, deaths and death rates from cervical cancer have increased for foreign-born women and decreased for US-born women. For many immigrant groups, such as the Korean, Chinese, Vietnamese, and Indian populations, the rates of Pap testing are low. Invasive cervical cancer is diagnosed in more advanced stages in Haitian and English-speaking Caribbean immigrants than in US-born Black women in Brooklyn, New York. Mexican immigrants are also at risk. Diagnosis of invasive cancer due to lack of screening and follow-up is one cause of the elevated age-adjusted mortality rate from cervical cancer among minority immigrant women.

Prostate cancer is the leading cancer diagnosed among men in the USA. Although there is a genetic component to its incidence, environmental factors have been suggested to influence its course as well. Blacks, both immigrant and nonimmigrant aggregated, in the USA have rates of prostate cancer approximately seven times higher than Korean-American men, for example. The magnitude of the declines in prostate cancer death rates for Whites and Asian Pacific Islanders have not been mirrored in Blacks.

Colorectal cancer remains one of the top three most common cancers in the USA among all races/ethnicities. Each year many thousands of lives could be saved in the USA by significantly increasing rates of colorectal cancer screening. Disparities persist for minority populations. For Latinos/Hispanics, particularly immigrants, the screening rates are especially low. Efforts directed at providers (working with them to recommend and refer for screening more often) and community members, as well as systemic interventions, must be made to increase screening rates.

Much effort has focused on increasing access to screening for underserved populations. While screening disparities persist, disparities in cancer survival and mortality remain – even after adjusting for diagnostic stage. This indicates that other, post-diagnostic factors contribute to the mortality differentials, such as structural constraints and contextual factors that restrict access to healthcare. As a result, low-income and minority women, for instance, are less likely to receive adjuvant treatment for breast and gynecologic cancers, are more likely to terminate their treatment prematurely, and are more likely to have higher mortality rates.

Many immigrants are confronted with considerable social and economic barriers to cancer treatment adherence. Such barriers include poor housing, limited opportunities for education and employment, limited access to health insurance, cost of treatment, lack of child care and transportation, and inadequate nutrition, language barriers, additional cultural factors, and other economic, personal, and family health priorities. There are also significant cost-related barriers to cancer treatment, medications, diagnostic tests, and hospitalizations – and immigrants are more likely to be charged out-of-pocket costs. Even logistical, practical barriers – such as transportation or concern over losing jobs – may prevent many immigrants from attending their appointments. Further affecting some immigrants are difficulties understanding the disease and its treatment because of language and literacy.

Quality of life, an important outcome for cancer patients, is also subject to disparate outcomes. Socioeconomic factors, as well as socioecologic context, life stress, comorbidity variables, and living situation, not ethnicity, have been shown to impact quality of life among minority breast cancer survivors. Economic stress, including employment status, health care cost concerns, and worries about income lost due to illness, was also shown to impact quality of life among mostly Hispanic, low-income women with breast or gynecological cancer undergoing active treatment or follow-up.

Patient navigation was designed as a broad-based approach to address these social and economic factors, particularly barriers faced by vulnerable populations such as financial obstacles (poor access to health insurance and ineligibility for Medicaid or Medicare, losing employment, lack of affordable cancer care), logistic barriers (transportation, lack of nearby cancer care facilities), language, and sociocultural barriers. Patient navigation typically assists patients through a distinct set of health services.

Communication is the cornerstone of effective, quality cancer care, from primary prevention to survivorship. Language becomes a medium for messages of survival, safety, and comfort. Fostering an environment that encourages clear communication and expression is imperative. In the USA, many locales have experienced tremendous growth of populations limited in English proficiency. In New York City, for example, about a quarter of the population has limited English proficiency. To promote equitable cancer care, it will be crucial to implement strategies to address this language barrier. Such strategies include trained medical interpreter services, professional translations, and professional transcreations, which involve accurate translation of concepts and ideas beyond simply literal translation.

By some estimates, approximately half of cancers could be eliminated if today's knowledge of cancer prevention, cancer control, and population sciences were widely implemented. The National Cancer Institute (NCI) notes in its 2007 Strategic Plan that overcoming cancer health disparities are one of the best opportunities we have for eliminating the suffering and death due to cancer. Addressing the needs of the medically underserved is a key component of the NCI's objectives. The NCI's Strategic Plan for Leading the Nation to Eliminate the Suffering and Death Due to Cancer highlights the need for interdisciplinary teams to work together to eliminate cancer disparities; inclusion of the community is key. The varied risk factors for cancer disparities and their complex interplay compel an integrated approach. Access to linguistically and culturally appropriate outreach, screening, treatment, and follow-up is a critical component in addressing cancer disparities.

Related Topics

- ► Access to care
- ► Alternative and complementary medicine
- ► Ethical issues in research with immigrants and refugees
- ► Health beliefs

Suggested Readings

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Suggested Resources

American Cancer Society. www.cancer.org.
National Cancer Institute. www.cancer.gov.

Nervios

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Nervios (Spanish for "nerves," "nervousness," or "anxiety") is one of several "culture-bound syndromes" included in an Appendix of the Diagnostic and Statistical Manual IV (DSM-IV-TR) of the American Psychiatric Association. Culture-bound syndromes are illness labels that express particular constellations of bodily, psychological, and/or social distress. These labels are meaningful and variably shared among different cultural populations, but do not correspond directly to diagnostic categories recognized by biomedicine. In contrast to its acute form, *Ataque de nervios* ("Nerve Attacks"), *nervios* refers to a chronic state of stress that gradually weakens an individual's physical, mental, and emotional health. While anthropologists and psychiatrists have examined the condition most thoroughly in Mexico, Central America, Puerto Rico, and their respective US mainland immigrant populations, *nervios* has also been studied in the Mediterranean and northern Europe.

Whether the term *nervios* means the same thing in these varying cultural contexts remains unclear. Anthropologist Roberta Baer and colleagues, however, found considerable agreement regarding a core group of causes and symptoms of *nervios* among samples of Puerto Ricans, Guatemalans, Mexicans, and Mexican Americans. Causes of *nervios* reported in the literature include strong emotions (e.g., anger or worry), family tension or conflicts, not eating well, and substance abuse. Frights or shocks (*susto*), such as witnessing a death or accident, are also widely believed to cause and/or exacerbate *nervios*. Symptoms of *nervios* can include hopelessness, excessive crying, trembling, irritability or increased anger, insomnia, weight loss, headaches, stomachaches, chest pain, a feeling of choking, high or low blood pressure, dizziness, as well as intense worry over a wide range of family, social, political, or economic concerns. In Mexico and Guatemala at least, *nervios* is also believed to play a causal role in diabetes. Individuals suffering from *nervios* may use a variety of approaches to treatment, including relaxation, prayer, herbal teas, and over-the-counter remedies (e.g., aspirin, Vicks, Alka Selzer) alone or in combination with prescription medications such as antibiotics. They may or may not seek help from conventional healthcare practitioners such as physicians, counselors, or psychiatrists.

While prevalence rates of *nervios* are largely unknown, familiarity with the condition (as well as other culture-bound syndromes) appears very high among both native and immigrant Hispanic populations. One study, for example, found that in a convenience sample of Mexican American primary care patients in South Texas 97% of respondents were familiar with the disorder and 73% reported that a friend, family member, or they themselves had suffered from it. Research to date indicates that women tend to suffer higher rates of *nervios* than males. Women of lower socioeconomic status, as well as those who are harassed, abused, and/or neglected are also generally believed to be at higher risk for the disorder.

While there does appear to be broad agreement cross-culturally about the nature of the syndrome, significant variability in causes, symptoms, and treatments of *nervios* remains, and its link to biomedical diagnostic categories is unclear. As Susan Weller and colleagues demonstrated in a sample of primary care patients in Guadalajara, Mexico, individuals reporting *nervios* showed significantly higher levels of current stress and depressive symptoms than those who did not report *nervios*. Nonetheless, the majority of individuals with *nervios* did *not* have a psychiatric disorder. In other words, there was an extremely high likelihood that someone who was depressed would report *nervios*; but the majority of individuals reporting *nervios* were not depressed. An individual who reports "Sufro de los nervios" ("I suffer from nerves"), therefore, may meet DSM-IV-TR diagnostic criteria for none, one, or several of the following psychiatric ailments: adjustment, anxiety, depressive, dissociative, somatoform, or psychotic disorders. Similarly, a study of Hispanic patients referred for cardiac testing at Baylor Medical College found that a positive history of chronic *nervios* was associated with elevated risk for somatoform disorders. On the other hand, patients reporting a history of *nervios* were more likely to have *normal* cardiac stress tests compared to those not reporting *nervios*, even after adjusting for several known cardiovascular risk factors.

Hispanics are the fastest growing minority in the USA. Individuals who work closely with Hispanic immigrant populations need to maintain an awareness of culture-bound syndromes as meaningful idioms of distress in the community. Healthcare providers, in particular, ought to consider discussing them in a nonjudgmental manner with patients who present with symptoms that are consistent with these syndromes. The suggestion that harassed or abused women may be at an elevated risk of *nervios* warrants further exploration and may suggest a need for improved screening and support for family violence or conflict. Individuals must also be sensitive, however, to the variation in how *nervios* may be understood by immigrants from different regions and that it may not be considered to be a "mental illness." Nonetheless, someone suffering from *nervios* may potentially be experiencing significant difficulty functioning in familial, social, or occupational roles and be in need of additional resources for support.

Related Topics

- ► Ataque de nervios
- ► Culture-specific diagnoses
- ► Hispanics
- ► Latinos
- ► Mental illness

Suggested Readings

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New York City

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New York City is located on the eastern Atlantic coast of the USA, at the mouth of the Hudson River. The city is divided into five districts called boroughs: Bronx, Brooklyn, Manhattan, Queens, and Staten Island. Manhattan and Staten Island are completely on their own land mass while Brooklyn and Queens occupy the western portion of Long Island. The Bronx, to the north, remains attached to the New York State mainland. The city is often called the “Big Apple” and is the largest city in the USA with over eight million residents including 2.9 million foreign-born residents.

New York City has for centuries served as a major point of entry for immigrants. More than 100 million Americans are estimated to be directly related to immigrants who passed through Ellis Island during its tenure as a federal immigration station. As of 2005, about 36% of its population was foreign-born in the city. Over 70% of the city’s foreign-born entered the USA in 1980 or later, similar for the overall US foreign-born population. The five nations constituting the largest sources of modern immigration to New York City were Dominican Republic, China, Jamaica, Guyana, and Mexico, based on the Census 2000 data.

A few neighborhoods have large numerical concentrations although immigrants are dispersed throughout the city. The largest immigrant neighborhood in the city was Washington Heights in Manhattan in 2000, but the next nine largest immigrant neighborhoods were either in Queens or Brooklyn. Each borough has a unique mix with respect of immigrants’ area of origin. For example, in the Bronx, Latin Americans accounted for over one-half the foreign-born while Europeans and Asians comprised 36% and 28%, respectively, in Staten Island. Queens is the most diverse borough – nearly half of its residents were foreign-born in 2000, representing over 100 countries and collectively speaking almost 170 languages. Reflecting this cultural diversity, the no. 7 train, which runs through Queens, is called “International Express.” The train passes one ethnic neighborhood after another such as from Peruvian to Colombian. Manhattan also has many neighborhoods with the rich ethnic heritages of the resident’s original homelands such as Chinatown, Koreatown, Little Italy, and Spanish Harlem.

Immigrants play a crucial role in the city’s labor market, comprising 43% of all city residents in the labor force in 2000. With respect to industry, immigrants comprised a majority of employed workers in manufacturing, construction, and many service industries. The largest employer in New York City’s economy is educational, health, and social services, and immigrants accounted for 41% of this service sector, in fields such as hospitals, elementary and secondary schools, home health care, nursing facilities, and colleges and universities.

Related Topics

- ► Acculturation
- ► Melting pot

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NGO

► Non-governmental organization

Nigeria

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Nigeria is one of the largest developing yet impoverished countries in Africa. It is considered to be the most populated country with approximately 150 million people. Although the population growth rate is about 3%, there is still an extremely high maternal and infant/child death rate. Men slightly outnumber women and make up 50% of the population. The country is rich in multiethnic traditions and customs with more than 350 ethnic/linguistic groups. Adolescents constitute nearly 20% of the overall population with individuals younger than 15 years old constituting approximately 45% of the population. Those 15–64 years old make up 51% of the population and are considered to be Nigeria's economic workforce. Life expectancy has increased over the years to 46–53 years of age depending on gender; it is estimated that individuals older than 65 years of age may total 3–7% of the population and those 80 years of age or older could make up as much as 2% of Nigerian's population.

Nigeria, as a nation, is undergoing cultural as well as a demographic shifts. These shifts are due to an increasing number of older citizens secondary to increased life expectancy and the introduction of modern medicine. Similarly, Nigerian families are experiencing a cultural movement away from localized extended intergenerational families to smaller nuclear units largely due to socioeconomic, geographic, religious, and health-related factors.

In efforts to keep up with its dynamic population, Nigeria's system of health care delivery is also evolving. Nigeria's health care is largely managed by federal, state, and local governments. State and local government are responsible for all financial aspects of primary and secondary health care. Federal government develops policies, coordinates activities, and ensures quality management. Together, these different levels of administrative health care agencies comprise a comprehensive system consisting of specialized, federally managed tertiary referral university or teaching hospitals, state-run secondary referral general hospitals, and local governmental primary health centers, health clinics, or health posts. Private providers with *out-of-pocket* fees, donations, and community financing also have significant visible roles in maintaining Nigeria's health care delivery system.

Additionally, socioeconomic and political factors impact both the quality as well as accessibility of various health care facilities. Inadequate health care facilities impede effective delivery of appropriate health care to various health care centers in Nigeria such that standard care of common illnesses cannot be provided. Moreover, highly populated impoverished rural areas with little political influence can have limited access to medical facilities poorly equipped to manage medical needs as opposed to more affluent but less populated urban areas.

Over the last 50 years, the level of state and local government involvement in health care as well as investment in health care programs and education has helped to transform Nigeria's health care system to begin to appropriately meet the needs of all of its citizens. Historically, Nigeria's health care was only accessible to a select few in more urbanized areas. Likewise, more traditional health care delivery systems consisted of largely herbal remedies and faith healing. However, with the advent of more modern medicine, there has been an increase in the use of modern health care delivery systems all be it in tandem with more traditional treatments.

In addition, since 1988, a national health policy was adopted with the goal of providing a comprehensive health care system with a primary health care focus. Included in this goal was patient education, primary and secondary prevention, promotion of food supply and adequate nutrition, family planning, maternal/women's health, immunization/vaccination and reducing disease burden to due malaria, tuberculosis, and the HIV/AIDS pandemic. In fact, the economic cost and loss of productivity associated with both malaria and especially HIV/AIDS in Nigeria highlight the need for affordable access to appropriate essential medications, immunizations, and the need for extensive patient education particularly in more rural areas. Promotion of public–private partnerships, medication quality regulation, and augmentation of mental health services especially depression and cognitive disorders are supplementary areas of interest.

In 1999, the government created the National Health Insurance Scheme to provide health care insurance coverage and broaden access to medical care. This scheme included coverage for children under 5 years of age, permanently disabled persons, and prison inmates. In 2004, additional legislative power was incorporated into the original 1999 act in hopes of balancing out state and local budgetary constraints with the health care needs of all Nigerian citizens.

Retention of Nigeria's workforce is a significant concern especially in relation to health care. Not only do more urbanized areas within Nigeria receive an influx of workers but also countries bordering Nigeria employ a large percentage of the Nigerian trained workforce. However, in-migration of workers trained in other countries into Nigeria is limited severely due to the overall poor healthcare delivery system. For instance, health care workers such as physicians, specialists, nurses, and community and mental health workers face many challenges such as inadequate compensation, lack of appropriate general/emergency medical facilities, and lack of opportunities for professional development/research. As a result, many educated, trained Nigerian nurses and doctors practice medicine in other countries, further taxing Nigeria's already frail healthcare system. This combination of prominent out-migration and limited in-migration of Nigeria's overall workforce ultimately affects every aspect of Nigerian life compromising the delivery of primary care, maternal health, and high-risk obstetric care.

In summary, despite many positive and well-meaning legislative policies, overall patient dissatisfaction is high, job satisfaction is low, and the essential basic medical needs of Nigerian citizens are disproportionably met if at all.

Related Topics

- ▶ Depression
- ▶ Human immunodeficiency virus
- ▶ Immunization
- ▶ Infant mortality
- ▶ Intergenerational differences
- ▶ Life expectancy
- ▶ Malaria
- ▶ Multiculturalism
- ▶ Nurse/Nurse practitioner
- ▶ Nursing shortage
- ▶ Nutrition
- ▶ Tuberculosis

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Non-Governmental Organization

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Non-governmental organizations can be traced to the early 1900s. In 1910, the League of Nations referred to these unions, institutes, and organizations as its "liaison with private organizations." Formal recognition occurred in 1945 when the United Nations (UN) differentiated participation between international intergovernmental organizations and international private organizations in Article 70 and 71 of the United Nations Charter. These private organizations, designated as NGOs were required to be: (a) independent from governmental control; (b) not seeking to challenge governments either as a political party or by a focus on human rights; (c) nonprofit making; and (d) noncriminal and nonviolent. The significance of the UN action was to allow specialized agencies and NGOs to participate without vote in the UN deliberations and engage in consultation arrangements with the UN. The consultation role was further strengthened in Chapter 27 where the role of NGOs in sustainable development generated intense consultation with the

UN. A plea for global social responsibility by the World Economic Forum in 1999 engaged NGOs in the global advancement of social, economic, and human causes of the twentieth century.

There is no generally accepted legal definition of NGOs and multiple definitions have been articulated to address the diverse functions of NGOs. More than 40,000 international NGOs are often referred to as private voluntary organizations, civic societal organizations, grassroots organizations, social movement organizations, or self-help organizations. Those working in NGOs state they are "the voice of the people." NGOs are distinguished by important differences between themselves, political parties, interest groups, and government. They may also be described by membership associations, humanitarian NGOs, human rights NGOs, educational NGOs, environmental NGOs, women's NGOs, children's NGO, youth NGOs, and peace and conflict NGOs. The World Bank classifies them by orientation and level of cooperation. Others distinguish NGOs by their location (local, provincial, regional, national, or international). The World Bank notes these challenges. "The diversity of NGOs strains any simple definition. They include many groups and institutions that are entirely or largely independent of government and that have primarily humanitarian or cooperative rather than commercial objectives. They are private agencies in industrial countries that support international development; indigenous groups organized regionally or nationally; and member-groups in villages. NGOs include charitable and religious associations that mobilize private funds for development, distribute food and family planning services and promote community organization. They also include independent cooperatives, community associations, water-use societies, women's groups and pastoral associations. Citizen Groups that raise awareness and influence policy are also NGOs."

The diversity of NGOs can be noted by the following: OXFAM, CARE, International Red Cross, and American Civil Liberties Union. *OXFAM International* is 14 organizations with 300 partners in 100 countries dedicated to making lasting solutions in poverty, hunger, and injustice. *International Red Cross and Red Crescent Movement* is the largest humanitarian network with 97 million volunteers, supporters in 186 countries. The intent of their work is to provide protection and assistance to people affected by natural and man-made disasters and conflicts. *CARE* tackles poverty and encourages self-sufficiency emphasizing work with women in communities to make lasting social change. Programs in agriculture, water, nutrition health, and education support these efforts. *American Civil Liberties Union* primarily focuses on guarding liberty and working in the courts, legislatures, and communities to defend and preserve individual rights and liberties that the Constitution and laws of the United States guarantees to everyone in the country. Focus areas include human rights, immigrant rights, free speech, reproductive freedom, voting rights, and capital punishment.

NGOs play a critical role in proving information, services, protection, legal representation, and advocacy for immigrant groups internationally. In addition, numerous groups specialize in addressing the needs of immigrants and refugees. American Immigration Law Foundation, Central American Refugee Center, Citizen and Immigrants for Social Justice, Canadian Council for Refugees, Immigration and Refugee Service of America, and the National Immigration Forum represent some of the many organizations worldwide that may serve immigrant populations. Despite the challenges that NGOs face remaining free of governmental influence and gaining adequate resources to provide services, NGOs offer services to immigrants to support health, social and economic security, and safety in difficult and compromising circumstances. The UN endorsement of NGOs role underscores their influence, capacity, and status to make changes that benefit immigrant populations.

Related Topics

- ► Amnesty International
- ► Doctors Without Borders
- ► Human rights
- ► United Nations High Commissioner for Refugees

Suggested Readings

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Nonimmigrant Visa

- ► Immigration status
- ► Immigrant visa status
- ► Student visa

NRA

- ► Nursing Relief Act of 1989 (U.S.)

Nuclear Trauma

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Definition

Trauma is variously defined, but whether physical or psychological, it is usually an unexpected and uncontrollable event, and often, outside the scope of ordinary human experience. Exposure to a potentially traumatic event may not necessarily result in maladaptive or harmful bio-psycho-social responses in a given individual or community, but in the right context, recognizing the potential of such a response is critical. Posttraumatic distress manifests in myriad ways, and may be crippling in the short and long term.

After any disaster or traumatic experience, the impact on psychological, social, spiritual, and physical health can be enormous. When that disaster is a nuclear event, added is the uniquely troubling aspect of the poorly understood and invisible nature of the "contagion." With several hundred nuclear reactors worldwide and increasing use of radioactive constituents for medical, military, and research purposes, nuclear "disasters" are not rare.

The Chernobyl Example

To date and from all accounts, the 1986 Chernobyl disaster has been considered to be the worst nuclear disaster in history (The post-tsunami nuclear event in Japan 2011 has not yet been fully studied, nor are the longer term sequelae known). When the nuclear reactor in the former Soviet Union (now Ukraine) exploded, the blast and fire, equal to about 100 of the bombs dropped on Hiroshima and Nagasaki, released a plume of radiation into the atmosphere. Though there was some intense contamination around the power plant, the bulk of the radioactive material was carried by the wind across northern Ukraine and toward southern Belarus and Russia. It is estimated that 60% of the fallout "settled" in Belarus, but increased radioactivity was picked up as far away as Western Europe (e.g., radioactive rain in Ireland). The "The Human Consequences of the Chernobyl Nuclear Accident" reported the health, socioeconomic and environmental effects on the people and communities 15 years after the accident. In response to the catastrophe in the region, hundreds of billions of dollars have been spent to address the potential economic and health-related losses, and to rehabilitate people and the land. A group of experts convened by the World Health Organization and the International Atomic Energy earlier predicted many deaths amongst the millions exposed to the radioactive cloud, but the most current number is "only"' 4000 radiation-related cancer deaths.

A reality is that the long-term mental health effects are perhaps the most costly in human terms. Beyond those who were in the contamination zone, there is a much larger group, totaling several million in Ukraine, Belarus, and Russia who, even though not exposed to dangerous levels of radiation, are affected by the actual or *potential* impact of the accident; they self-identify as "victims" of Chernobyl.

Some of the most difficult legacies of Chernobyl are the psychological effects in the population related to the lack of information and government's poor coordination in the immediate post-disaster time frame. Secrecy and poor management fostered a lack of trust in the science around the radiation risks and potential effects. The additional stress and potential trauma possibly intensified preexisting social, economic, spiritual, psychological, and medical problems. There is no doubt that the traditional list of exacerbating risk factors for distress may apply. Some of these will include:

- Perceived life-threatening danger or physical harm (especially to children)
- Extreme environmental destruction or human violence
- Loss of family, home, neighborhood, or community
- Extended exposure to danger, loss, emotional/physical strain
- Exposure to toxic contamination (such as gas, fumes, chemicals, radioactivity, or biological agents)
- History of chronic medical illness or psychological problems
- Chronic poverty, homelessness, unemployment, or discrimination
- Recent or earlier major life stressors or emotional strain

Immigration

There have been more than 500,000 immigrants to the USA from the former Soviet Union since the Chernobyl disaster. Several studies of the mental health of these immigrants document that those who were closest to the disaster site and had greater exposure to it have higher levels of anxiety and posttraumatic reactions than those who lived further away. Fear of medical illness, symptoms of depression, and cancer-related anxiety is more commonly expressed by this group than others. Similar concerns are heard from Russian immigrants to Israel. Amongst those exposed, there remain misconceptions and myths about radiation that have resulted in a paralyzing fatalism.

Conclusion

Any traumatic event or accident can increase stress symptoms, depression, anxiety, and unexplainable physical symptoms. Nuclear trauma is much more likely to be a public health catastrophe, affecting multiple people, entire communities or countries, and may require a broad multidisciplinary response. The insidious nature of radiation exposure, the general lack of understanding about nuclear energy, its uses, misuses, and unknown effects allows for fear to predominate in a way that is different from more visible and understandable disasters (earthquake, car accident, etc.).

Truthful and accurate information about the nuclear exposure, based on dependable scientific research and coupled to good quality counseling and health care if needed, will be a priority for anyone who is experiencing distressing symptoms. Addressing expressed needs and fostering a process of healing may alleviate longer-term posttraumatic stress disorder and its attendant suffering.

Related Topics

- ► Air pollution
- ► Cancer
- ► Chemical exposure
- ► Chernobyl sequelae
- ► Disaster
- ► Environmental exposure
- ► Mental health

Suggested Readings

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Nuremberg Code

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The Nuremberg Code is a set of ten principles with relevance in the field of human experimentation. It was issued in 1947, being one of the outcomes of the Nuremberg Trials at the end of the Second World War.

The Nuremberg Code was the first international document that regulated from an ethical perspective the field of human experimentation.

The provisions of the Nuremberg Code emphasize mainly respect for research participants and their protection. From this perspective, the Nuremberg Code is the first official statement that empowers research subjects emphasizing the necessity of their informed consent, the lack of coercion against them, and the obligation of the investigator to protect them from any type of injuries.

According to the Nuremberg Code, informed consent of research subjects for participation is essential in all types of human experimentation. Research subjects have to exercise their power of choice, without any form of constraint or coercion. At the same time, they need to demonstrate comprehension of the study protocol (type, duration, and objectives of the experiment), its benefits and risks. Also, human subjects should feel free to end the experiment whenever they want if the continuation of experiment seems impossible for them.

The researcher has to avoid any physical and mental suffering and injury of human subjects. Moreover, when there is a reason to believe that death or a severe injury may occur, the experiment should not be done except the cases when the investigators are also the subjects.

Humanitarian importance of the investigated problem has to dictate the risks assumed by human subjects. In each experiment all tests and work conditions have to be well prepared in order to protect human subjects and all experiments have to be conducted only by scientifically qualified persons. The investigators have to be prepared to terminate the experiment at any stage if there is any possibility to produce injuries to the human subjects.

Any type of study has to be useful for society; at the same time, the expected results of the study cannot be obtained through other methods. The experiment has to be based on both previous knowledge regarding the natural history of the diseases and on results from animal experimentation.

Over time, several weak aspects of the Nuremberg Code have been pointed out. The Code refers only to human experimentation and ignores other types of scientific research. Also, it makes no difference between therapeutic and nontherapeutic human experimentation. Moreover, it implies that research subjects have to be competent to make decisions and so, it excludes children and incompetent persons from research hindering the possibility to achieve information that could improve their lives. Furthermore, the Nuremberg Code makes no statement regarding ways to supervise the investigators and to management of research results.

These problems have been solved by further international documents such as the Declaration of Helsinki or CIOMS Guidelines.

Even if the Nuremberg Code empowers research subjects, specific case is the one of immigrants. Mainly when a particular disease is investigated, it is mandatory to have study participants who have that disease; at times, they may be immigrants (for instance, African people involved in studies regarding onchocerciasis, filariasis, leishmaniasis). In the case of immigrants, informed consent is an important issue due to language barriers or different levels of education. In addition to this, the lack of coercion is another problem. If we consider immigration based on poverty in the origin country, any form of benefit, even minimal may represent a form of coercion which is difficult to be controlled.

Related Topics

- ► Communication barriers
- ► Cross-cultural medicine
- ► Cultural background
- ► Cultural competence
- ► Ethical issues in research with immigrants and refugees
- ► European Court of Human Rights
- ► Helsinki Declarations
- ► Trafficking Victims Protection Act

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Nurse/Nurse Practitioner

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Although the word nurse is used to describe a variety of people, a nurse is actually a "licensed healthcare professional who practices independently or is supervised by a physician, surgeon, or dentist and who is skilled in promoting and maintaining health." According to the American Nurses Association, "Nursing is the protection, promotion, and optimization of health and abilities, prevention of illness and injury, alleviation of suffering through the diagnosis and treatment of human response, and advocacy in the care of individuals, families, communities, and populations." Registered nurses not only treat patients but educate patients, families, and the community about medical conditions. They also give advice, promote preventive health screening, and provide emotional support. Nurses assist patients to attain and maintain their highest level of health.

Registered nurses represent the largest healthcare occupation with over 2.6 million jobs in the USA. Approximately 60% of nurses are employed in hospitals. However, nurses also work in clinics, physicians' offices, patients' homes, public health agencies, skilled nursing facilities, and schools. Nurses provide a wide variety of services in these areas. They work independently and/or in collaboration with physicians to provide immunizations in local community clinics and public health agencies. Nurses also work in schools screening children for health-related issues. Skilled nursing facilities employ nurses to care for the elderly population requiring full-time nursing care. Nurses assist physicians in their offices to administer medications and therapies. However, in all areas of employment, nurses are responsible for educating patients, families, and communities on health-related issues.

Classification and Specialization of Nurses

The classification of nurses varies from nation to nation. In the USA, nurses are classified as licensed practical nurses (LPNs), registered nurses (RNs), and advanced practice nurses (APN/NPs). LPNs have 1–2 years of training and must pass a state or national certification board. They can perform some medical functions but are required to practice under the supervision of a registered nurse or physician. A registered nurse must graduate from an approved nursing program with a diploma, associate's or bachelor's degree in nursing and pass a national licensing examination. Registered nurses are able to assess, plan, implement, and evaluate care independently of physicians, and they provide support from basic triage to emergency surgery.

Registered nurses, like many other healthcare professionals, often specialize in a particular area of practice. Specialization is done in one of four ways: by work setting, disease or condition, body organ system, or population served. For example, specialization by work setting includes ambulatory care nurses who treat patients outside the hospital, and intensive care nurses who treat patients in the hospital unit. Specialization by disease may include diabetes nurses who educate patients on their disease process. Specialization of nurses by body organ includes cardiology nurses and oncology nurses who focus on a particular part of the body. The specialization by population includes pediatrics and geriatrics. Nurse Practitioners (NPs), according to the American College of Nurse Practitioners, are advanced practice "professional nurses who are prepared, through advanced graduate education and clinical training, to provide a wide range of health care services, including the diagnosis and management of common, as well as complex, medical conditions to individuals of all ages." NPs are licensed registered nurses with either a master's or doctoral degree. They are nationally board certified in a specific area such as pediatric, family, adult, women's health, psychiatric, or acute care.

NPs provide comprehensive care within their area of specialty. NPs are able to evaluate patients' health, diagnose medical conditions, manage health problems, promote optimal health through education, and collaborate with other healthcare professionals to provide coordination and management of patient care in a variety of settings. Each state has its own regulations for the practice of nurse practitioners. NPs can serve as a patient's primary healthcare provider in many states. They are legally authorized to provide comprehensive care management, including the ability to prescribe medications. In some states, NPs practice in their own offices and may admit patients to the hospital.

Nurses and Immigration

In 2005, the Center for Immigration Studies in Washington, DC reported that a rapidly growing immigrant population has made small private pay clinics their medical home. Many of these new immigrants and refugees lack health insurance and are ineligible for publicly funded clinics due to their immigration status. They have limited access to mainstream healthcare and look to these small private clinics for their health needs. These clinics vary in the services they provide. Some specialize in acute care illnesses while others provide basic healthcare screening for cancer or women's health. Many of these clinics are staffed by nurses and nurse practitioners.

Because of the influx of immigrants to the USA, the demand for bilingual and bicultural nurses has skyrocketed. Hispanics currently represent approximately 15% of the population of the USA; however, only 2% of registered nurses are Hispanic. This discrepancy highlights a major problem within the US health system. The lack of bicultural and bilingual nurses has created high demand for nurses with these skills.

Nursing Shortage

There is an ongoing shortage of registered nurses. The *2000 Sample Survey of Registered Nurses* reported by the US Department of Health and Human Services found too few young people are choosing careers in nursing, and the average age of registered nurses has increased substantially. In 1980, 52.9% of RNs were younger than age 40 and 26% of RNs were under the age of 30. By the year 2000, only 31.7% of nurses were younger than age 40 and less than 10% were under age 30.

As a result of the nursing shortage and aging nursing population, healthcare facilities in the USA are actively recruiting foreign nurses. In fact, nurses have regularly been imported from other countries for the last 50 years. In 2003, 14% of registered nurses were trained in foreign countries. While Filipino nurses represented more than half of the foreign graduates taking the US licensure exam in 2001, foreign nurses also immigrated from Canada, the United Kingdom, India, Korea, and Nigeria. As demand for nurses increases, the number of foreign nurses is likely to rise in response to this need.

As the USA continues their recruitment of foreign nurses throughout the world, the sending countries are increasingly questioning the impact on their own healthcare systems. A 2001 article in the *Wall Street Journal* discussed a domestic shortage of nurses in the Philippines as their nurses migrate to the USA creating a strain on their own system. The loss of qualified nurses from some of the nations in Africa is having a significant economic impact as well. The United Nations Conference for Trade and Development in 1998 estimated an economic loss of $184,000 annually for every professional between 25 and 35 years of age who migrated from South Africa. In Ghana, the government is actively urging recruiters to stop taking its nurses. In addition, the South African Nursing Council has considered a tariff on nurses wishing to practice abroad. In light of the global nursing shortage, the ethics of recruiting foreign nurses from developing nations to the USA continues to be debated internationally.

Related Topics

- ► Community health workers
- ► Health care
- ► Hospice
- ► Hospitalization
- ► Nursing Relief Act of 1989 (U.S.)
- ► Nursing shortage
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Nursing Relief Act of 1989 (U.S.)

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The Immigration Nursing Relief Act of 1989 (INRA), Public Law No. 101–238 altered the United States' immigration laws to admit more nonimmigrant registered nurses (RNs) to enter the United States, and to allow the nonimmigrant RNs already in the United States to remain for longer periods of time. RNs had to be employed in that capacity for at least 3 years. In addition, their continued nursing employment had to meet certain labor requirements, through a process known as labor certification. Congress enacted the H-1A nonimmigrant visa category in order to address and compensate for the ongoing shortage of qualified RNs in the United States at the time. The INRA was allowed to sunset (expire) in 1995; however, the goals of the INRA were carried on by other forms of federal legislation, albeit with much stricter requirements for visas and for the employers wishing to hire the immigrating nurses. An understanding of nurses' ability to immigrate to practice their profession requires a brief review of immigration-related legislation and the structure of the US immigration system.

In the past, RNs initially came to the United States to work temporarily under the nonimmigrant H-1 classification. (In general, a "nonimmigrant" is someone who is going to remain in the country only temporarily and is coming for a specific purpose, to be fulfilled within a specific time period. In most cases, nonimmigrants must intend to leave the country once that specified period of time is over.) As originally written in the Immigration and Nationality Act of 1952 (INA), the H-1 described a person "of distinguished merit and ability," with a residence abroad that he/she had no intention of abandoning, who was coming to the United States for temporary employment. At the time there was no limit on the number of H-1 visas that could be issued annually.

The INA gave nonimmigrants an avenue to permanent residence and, eventually, citizenship status. Certain persons, who for family reasons, child welfare reasons, asylum, persecution or political retribution, were permitted to remain in the United States. Also included were any immigrants possessing much needed labor skills, such as physicians, attorneys, teachers, and other professional occupations. In 1967, RNs were added to the list of "professions" allowed temporary visas. The administration of immigration matters was assigned to the United States Citizenship and Immigration Service (USCIS), formerly part of the Immigration and Naturalization Service (INS), presently folded into the Department of Homeland Security (DHS).

Traditionally, RNs have been considered "professionals" under US immigration laws. From 1952 to 1989, US employers could hire foreign-born nurses using H-1 temporary visas. In 1989, the Immigration Nursing Relief Act (INRA) was enacted for a period of 5 years. INRA provided that only health care facilities with publicly filed attestations approved by the Labor Department could obtain H-1A status to employ nurses on a temporary basis in the United States. The Immigration Nursing Relief Act of 1989 was enacted in an effort to curtail the nursing shortage in the United States by giving health care facilities the permission to employ qualified nonimmigrant aliens as RNs. The passage of the INRA allowed nonimmigrant nurses who had been working in the United States for the preceding 5 years or more to stay in the United States, provided their respective qualified employers provided the INS with documentation regarding the nonimmigrant nurse, the qualifications of the nurse, the qualifications of the health care facility, and the assurances (attestations) that the facility had first taken adequate steps to recruit United States Citizens for the positions. The INRA enacted a new nonimmigrant category for temporary admission of qualified RNs denoted as the H1-A. Any RN seeking to remain in the United States would be required to show a passing score on either the NCLEX-RN or the Commission on Graduates of Foreign Nursing Schools (CGFNS) exam, or, alternatively, obtain a full and unrestricted license as an RN in their respective state. The INRA also required that employers of the nonimmigrant RNs provide specified documentation to the Department of Labor.

The INRA was allowed to expire in 1995. The nonimmigrant RNs who had arrived and stayed under the auspices of the INRA and an H1-A category were expected to leave by 1998.

On November 12, 1999, then President Bill Clinton signed into law the Nursing Relief for Disadvantaged Areas Act of 1999 (NDRAA). This was a limited extension of the INRA giving hiring precedence to disadvantaged urban and rural communities. The NRDAA officially expired in 2005; in 2006, Congress reauthorized the H-1C program for an additional 3 years. On April 5, 2010, the Department of Labor issued a Final Rule and allowed continued granting of H-1C visas, but still under the stringent guidelines of the 1999 NRDAA.

In 2010, a foreign RN may either enter the United States under an immigrant category or a nonimmigrant category. Currently, there are limited options for nonimmigrant RNs who wish to work in the United States. These include an H-1C visa and, for Canadian and Mexican RNs, a Trade NAFTA (TN) work permit, which is valid up to 3 years. Immigrant RNs (those seeking permission to remain in the United States on a permanent basis) may apply for a permanent residence (commonly called a "green card") through the visa petition process. To qualify, the RN must either have a CGFNS certificate or a full and unrestricted nursing license from the state of intended employment. Many nonimmigrant RNs find applying for the permanent residence/green card to be the most user friendly route to working as an RN in the United States.

Related Topics

- ► Nurse/Nurse practitioner
- ► Nursing shortage

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Nursing Shortage

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A nursing shortage occurs when an increased demand for nurses outstrips the supply of practicing nurses in the workforce, as is experienced in the USA and other countries around the globe. In the USA, for example, the current nursing shortage is estimated at 150,000 and, by 2020, the deficit is expected to increased to 800,000, despite the creation of more than 650,000 new jobs in nursing over the next decade. The shortage is exacerbated by a loss of an estimated 450,000 nurses through retirement. Further, globally, the supply of an estimated 12 million nurses is insufficient to meet the global needs now and in the future and in 2002 the nursing shortage was termed a global crisis.

The global nursing shortage is of concern to immigrants who find themselves subject to local- and country-specific policies, practices, and financial disincentives that limit access to health care. This includes appropriate access to, and utilization of, nurses, who may find themselves confined by geography and specialization. These issues merit developing comprehensive, coordinated strategies among countries to address the ever-growing nursing shortage and, thus, the particular health needs of immigrants seeking care.

Nursing shortages can lead to increased patient loads, workplace errors, burnout, high turnover rates, and work injuries. Shortages may contribute to limited access to care, poorer quality of care, treatment errors, and dissolution of services that impact both individuals and health systems. In Botswana, for example, the government is unable to provide free antiretroviral therapy to address HIV/AIDS to its eligible citizens because of its nursing shortage.

Studies suggest several reasons for the shortage. First of all, nursing schools, confronted with reduced student enrollment and a shortage of school faculty cannot meet the projected increased demand. For example, the World Health Organization reported the number of people graduating has decreased by 70%, or 7,000 people, in the last 10 years. In Chile, out of 18,000 nurses in the country, only 8,000 are working in the field. Both the lack of new nurses entering the field as well as nurses qualified but not employed in the field contributes to the shortage. Secondly, a lack of minority nursing students and faculty creates a deficiency in providing culturally sensitive care for minority and culturally diverse populations and augments the lack of diversity in the profession. While enrollment has increased it is still disproportional to the minorities in the population. While 11% of US population is Hispanic, only 1.7% registered nurses are Hispanic, for example. Thirdly, nurses' demographics are changing. As of 2010, 40% of registered nurses in the USA are older than age 50 and planning for retirement. Further, the advancing age of the nursing workforce may increase the likelihood of illness or injury in this group. In addition to an aging nursing population, the population of nurses who are employed full time has declined as much as 35% below those working full time 20 years ago. Fourth, job dissatisfaction and burnout across employment settings have caused many nurses to leave the profession. Long hours, salaries, and stress have been cited as reasons for departure from the profession. Efforts to improve recruitment and retention have focused on enhanced benefits, salary increases, professional development, and flexible schedules.

The effects of the nursing shortages are magnified in developing countries, where the shortages are acute, the need is dramatic, and where nurses are often recruited to work in wealthier developed countries. This migration has generated accelerated debates regarding appropriate strategies to address global demand for nurses. For example, in the Philippines, the government sponsors a training program for nurses who want to work internationally. This may alleviate shortages in the host country but depletes the supply of qualified nurses in the local region.

Even though progress has been made regarding increased nurses' salaries, expanded work opportunities, and newly developed federal laws supporting nursing education, these strategies have not been uniformly employed globally. Thus, there is a disparity among certain countries and populations as a result of the nursing shortage. For example, in countries where nurses are not valued, governmental support and infrastructure may be inadequate to resolve a local shortage. These nurses may not be permitted to use their skills effectively to impact individual and population health due to system constraints.

To better address the growing global nursing shortage, 66 countries (2001) developed strategies in four key areas: (a) creating a policy agenda, (b) developing retention and recruitment efforts, (c) attracting returning nurses, and (d) importing nurses from other countries. This collaborative approach is expected to highlight the crisis and generate support for country-specific approaches in concert with the global agenda to address the nursing shortage.

Related Topics

- ► Access to care
- ► Cross-cultural health
- ► Health barriers
- ► Health services utilization

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Nutrient Intake

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As individuals from one country migrate to another, many changes occur, inclusive of their dietary habits and consequent nutrient intakes. For some, dietary changes may be forced upon them due to the lack of available traditional foods at the markets and grocery stores in their new country. It takes time to adjust to using and cooking with new foods, and during this time nutrient intakes may suffer. For others, immigration is parceled with a lower socioeconomic status, making healthy food choice and, concomitantly, adequate nutrient intake, difficult to obtain. In some countries, immigrants are more likely to experience food insecurity, and use public assistance food programs that may not always provide adequately for nutrient requirements. Regardless of the reasons, the limited research that has been conducted on immigrant nutrient intake has found that immigrants' nutrient intakes are poorer than native inhabitants of the country in which the research has been conducted. Furthermore, these deficiencies may eventually lead to nutrient-related chronic conditions.

Researchers have argued that individuals who are in particularly good health tend to be the ones who are able to immigrate to other countries and these individuals are often in better health than the average citizen in their adopted land. This phenomenon has been termed the "healthy migrant effect." Studies have also found that soon after arriving in their new country, immigrants adopt customs, practices, and even foods more typical of their new country, a process termed acculturation. Acculturation among immigrants has been associated with poorer dietary intake choices, including higher fats and refined sugars, and lower intakes of vegetables and fruits. Thus, immigrants often experience similar diseases and even have higher rates of nutrition-related disease and death than native inhabitants of their new country. To help facilitate healthier new citizens, health professionals need to work proactively with immigrant populations to ensure that adequate nutrient intakes are obtained.

Related Topics

- ► Acculturation
- ► Food insecurity
- ► Food stamps
- ► Healthy immigrant
- ► Nutrition

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U.S. Committee for Refugees and Immigrants, Food and Nutrition Program. http://www.refugees.org/article.aspx?id=1644&subm=178&area=Participate

Nutrition

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Nutrition is the science of how food nourishes the body. More specifically, it is a study of foods (including beverages), their nutrients and other chemical constituents, and the effects of foods on health. Humans need enough food in their diet to provide energy (calories), nutrients, and other substances for proper growth and health. There is ample evidence to show that there is a strong connection between a person's diet and its effects on health. For example, several of the leading causes of death in the USA are diet-related, including heart disease, cancers, strokes, and diabetes.

This entry first provides an overview of fundamental nutrition information that covers topics such as what constitutes as essential nutrients, the understanding of the dietary reference intakes (DRIs), and the various dietary guidelines and objectives set forth by the US government. With the important background information established, it then proceeds to discuss individuals' difficulty in keeping a proper diet recommended by the government and, more importantly, the major factors that influence dietary intake among immigrants in the USA. Finally, the entry discusses two forms of malnutrition: undernutrition and overnutrition and concludes with a phenomenon called "nutrition transition" that could determine the nutritional well-being of people worldwide.

Essential Nutrients

There are six categories of essential nutrients the body needs: carbohydrate, protein, fat, vitamin, mineral, and water. They are called essential because the body cannot make these nutrients for itself and will develop deficiencies if one does not ingest them. Carbohydrate, due to its availability in an abundance of foods, is the least expensive and the primary source of energy worldwide. Carbohydrates such as starches and sugars are usually obtained from plant-based foods. Protein provides amino acids that are used to build and maintain body tissues such as muscle and connective tissue. In addition, protein is needed in the production of enzymes, hormones, and serum proteins such as albumin. Protein is available in meat, fish, poultry, eggs, nuts, legumes, and milk and milk products. Fat is an important source of energy as well and provides fatty acids for the synthesis of many compounds the body needs. Fatty acids are generally classified as saturated and unsaturated. Saturated fats are mainly found in animal products and unsaturated fats in plant foods. Unsaturated fatty acids can be further classified as monounsaturated (MUFA) and polyunsaturated (PUFA). A diet high in saturated fatty acids usually contains a high amount of low-density lipoprotein (LDL) that could lead to heart disease. On the contrary, certain unsaturated fatty acids (such as omega-3 fatty acid that is plentiful in fish oils) could help prevent heart disease. Carbohydrate, protein, and fat are also referred to as macronutrients.

As opposed to macronutrients, micronutrients include vitamins and minerals. Vitamins such as C, B1, B2, and B6 are water-soluble whereas vitamins A, D, E, and K are fat-soluble. Water-soluble vitamins can be readily excreted from the body; however, excessive intake of fat-soluble vitamins can lead to symptoms of toxicity. These organic substances are essential regulators of body metabolism. Minerals, on the other hand, are inorganic substances that are important for diverse functions in the body. For example, calcium helps build bones and teeth, and iron forms a major part of hemoglobin inside the blood cell. Finally, water is vital and functions as a solvent, a temperature regulator, and a medium for transporting nutrients to cells and waste products for excretion in the body.

Dietary Reference Intakes

So, how does an individual know that he/she is consuming enough nutrients each day? Taking into account of factors such as age, gender, growth, pregnancy, and lactation, the US government has developed a set of dietary standards for Americans: the Dietary Reference Intakes (DRIs). The DRIs, established by the Food and Nutrition Board and the Institute of Medicine, part of the National Academy of Sciences, are nutrient intake levels to be used as reference values for planning and assessing the diets of healthy individuals. It is a generic term that includes four types of reference intake values: Recommended Dietary Allowances (RDAs), Adequate Intakes (AIs), Estimated Average Requirements (EARs), and Tolerable Upper Intake Levels (ULs).

The RDAs are levels of essential nutrient intake judged to be adequate to meet the known nutrient needs of over 98% of healthy population whereas the AI values are similar to the RDAs but are based on less conclusive scientific evidence. The EARs are levels that are estimated to meet the requirements of 50% of the healthy individuals in a group while the ULs are upper limits of nutrient intake that are likely to pose no risk of adverse health effects. The risk of adverse effects increases when intake levels are above the ULs. It is recommended that individuals meet the RDA levels of nutrient intake to decrease the risk of certain chronic diseases and to promote health.

Dietary Guidelines and Objectives

In addition to the above dietary intake standards, the US government also publishes the Dietary Guidelines for Americans, sets public health dietary goals in documents such as Healthy People 2010, conducts nutritional surveillance and surveys such as the Behavioral Risk Factor Surveillance System to assess if the population is meeting these guidelines, and plans food and nutrition education programs following these recommendations. Dietary Guidelines for Americans is jointly published every 5 years by the Department of Health and Human Services (DHHS) and the Department of Agriculture (USDA). The US DHHS sets 10-year health objectives and goals for the nation in its publication Healthy People. The current version, Healthy People 2010, has an array of food and nutrition-related objectives. For example, objective 19–5 is to increase the proportion of persons aged 2 years and older who consume at least two daily servings of fruit, and objective 19–6 is to increase the proportion of persons aged 2 years and older who consume at least three daily servings of vegetables with at least one third being dark green or orange vegetables. These guidelines and objectives are to support national health promotion and disease prevention efforts.

Factors Associated with Dietary Intake Among US Immigrants

Even with the efforts put forth by the government, Americans do not seem to consume appropriate foods for adequate nutrition to stay in good health. Take fruit and vegetable consumption as an example. According to the most recent nutritional surveillance data from the 2005 Behavioral Risk Factor Surveillance System, only 32.6% of adults consumed fruit two or more times per day and only 27.2% ate vegetables three or more times per day. It is even more critical to assess how many people eat the recommended amounts of both fruit and vegetables. A study of the National Health and Nutrition Examination Survey (NHANES) data from 1988–2002 showed that only 11% of adults meet the combined fruit and vegetable recommendation of five servings a day.

Additional research reveals that fruit and vegetable consumption varies across other characteristics as well. Non-Hispanic Blacks are significantly less likely to meet these guidelines than Whites. Hispanics have reported higher intakes of fruit and vegetables than Whites and Blacks, but it has also been reported that Hispanics' consumption decreased when they became more acculturated. In fact, in addition to common barriers faced by the general population, such as a lack of time to prepare healthy foods, there are factors that uniquely impact immigrants' dietary intake and nutritional status. The following discusses two major factors that strongly influence immigrants' diet and nutrition: acculturation and food insecurity.

Acculturation

Despite having a seemingly healthy dietary habit before immigration, many immigrants, after arriving in the USA, adopt unhealthy dietary practices, such as drinking sugar-sweetened beverages and eating high-fat and high-calorie fast foods, as they become acculturated to the US lifestyle. Indeed, acculturation has been shown to be strongly associated with deterioration of dietary intake among immigrants in the USA. For example, according to a study conducted in Washington state among Hispanic immigrants from Mexico, results show that highly acculturated immigrants had a higher fat intake and ate fewer servings of fruit and vegetable per day compared with those not acculturated. Immigrants of other ethnicities also exhibit a similar trend. For example, a study conducted in Pennsylvania showed that Chinese immigrants increased consumption of Western-style foods and decreased consumption of traditional Chinese foods. In addition, the dietary patterns of the Chinese immigrants worsened and fat and sweets consumption increased significantly after immigrating to the USA.

Food Insecurity

Other than acculturation, food insecurity is also an important factor that affects immigrants' nutrient intake and health. Due to lack of financial resources or money, many low-income immigrant families worry about obtaining adequate food to feed the family. They often do not have a choice but to purchase calorie-dense, processed, and less healthful foods instead of fresh produce or other healthy food items that are usually more expensive than the unhealthy alternatives. As a result, food insecurity negatively impacts the nutritional status of members of immigrant households, especially among young children.

Prior literature has indicated that children in food insecure households were less likely to meet Food Guide Pyramid guidelines than other children. One study examining children of Mexican descent in the USA, for example, has shown that children experiencing food insecurity consumed more fat, sweets, and fried snacks than those not experiencing food insecurity. Thus, the consumption of calorie-dense and less healthy foods could contribute to unhealthy dietary habits and childhood obesity among low-income immigrant households.

For families experiencing more severe food access issues, such as adults and children skipping meals, and adults or children going without food for an entire day, their risks extend beyond food and nutrition inadequacy. For instance, immigrants who reported experiencing hunger, the most severe form of food insecurity, also reported more days of poor mental and physical health as well as poorer overall health compared with those not experiencing hunger.

Global Trend: Malnutrition and the "Nutrition Transition"

Nutritional problems often are not confined to one geographical area. Dietary deficiencies, especially, tend to be prevalent worldwide. For example, vitamin D and calcium insufficiencies present a nutritional crisis that has reached a global level. According to a research paper that examines 46 recent studies from Europe, North America, South-East Asia, and the South Pacific area, a low-vitamin D status and inadequate calcium nutrition are highly prevalent in the general population, with a range from 30% to 80%. The insufficiencies affect both genders, but are particularly high in people of low socioeconomic status and in ethnic minorities and immigrants.

However, it is important to note that malnutrition comes in two forms. It can be undernutrition that leads to nutrient insufficiencies such as the example shown above, or it can be overnutrition as exemplified by the global obesity epidemic seen in recent decades. Most of the data regarding obesity come from industrialized or developed nations. According to a recent World Health Organization (WHO) report, the levels of obesity have risen dramatically from 1977 to 2004 among Organization for Economic Cooperation and Development (OECD) countries. The 2004 Health Statistics Data of the OECD reported that the rates of people who were overweight and obese rose from less than 20% in 1976 to more than 50% by 2001.

The rates of obesity among developing countries, nevertheless, could also be of great concern as many of these countries become increasingly industrialized and adopt many of the same food production and eating patterns, which have led to the epidemic seen in OECD countries and other developed nations. This could lead to a period of time where overnutrition (e.g., obesity) and undernutrition (e.g., nutrient or calorie insufficiency) exist in juxtaposition to one another in developing countries. Many developing countries are in fact in a time of nutritional transition. The "nutrition transition" proposes that, if the trends continue, obesity rates among developing countries could parallel those of the developed countries. Thus, in order to stay healthy, consuming a balanced diet for proper nutrition is of paramount importance to all.

Related Topics

- ► Acculturation
- ► Food insecurity
- ► Nutrient intake
- ► Obesity

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Nutrition Knowledge

► Nutrition programs

Nutrition Programs

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As the number of Americans considered to be obese increases, a greater focus is being placed on healthy eating and nutrition. Obesity, defined as a body mass index (BMI) of 30 or greater, is a major risk factor for cardiovascular disease, type 2 diabetes, and some types of cancer. In the USA, only Colorado and the District of Columbia have less than 20% of their populations classified as obese (the obesity prevalence rate); 24 states have obesity rates between 25% and 30%; and nine states have an obesity prevalence of over 30%. According to the US Centers for Disease Control and Prevention (CDC), one in seven low-income children is obese. For immigrants, there are many risk factors to poor nutrition, which can lead to obesity and ill-health; factors may include poverty, limited access to fresh fruit and vegetables, cultural practices regarding food preparation, dietary changes to a diet higher in fat and sugar, and lack of culturally appropriate information regarding nutrition, among others. In addition, environmental factors also contribute to overweight and obesity, such as a lack of open green areas, sidewalks in poor repair and safety issues.

While attention has generally been paid to appropriate translation of nutrition information into different languages, there are few examples of the development of culturally appropriate nutrition programs for immigrants; most of these tend to focus on ethnic minorities or immigrants with type 2 diabetes. Two studies targeting different populations (Korean Americans with uncontrolled type 2 diabetes and Norwegian-Pakistani women without a history of type 2 diabetes) identified barriers to the adoption of a healthier diet: difficulty with the concept of a "serving size," difficulty measuring the amount of fat used while cooking, family members' dislike of food taste, and broader community expectations regarding food preparation. The authors of the studies highlight the need for community, rather than individual-based nutrition interventions for these immigrant communities.

Designing a Program for a Specific Immigrant Group: Latinos

Latinos in the USA are facing a serious health crisis as incidences of obesity, cancer, diabetes, and heart disease continue climbing. There has been a visible shift in how Latinos in the USA shop, cook and eat, resulting in these concerning trends. The encouraging news is that studies show eating a healthy and balanced diet lowers the risk of many of these diseases. Border states such as

Texas, California, Arizona, and New Mexico are well-known areas with concentrated Latino populations, but there has been significant growth in the Latino population in places such as Arkansas, Georgia, North Carolina, and Tennessee. This means that health professionals and retailers across the country can help inspire Latinos to reconnect with their flavorful and healthy food traditions in order to improve their health. To build awareness that making healthy food and lifestyle choices can reduce the rise of chronic diseases facing the Latino community, The Latino Nutrition Coalition (LNC) was developed and is dedicated to inspiring Latinos to improve and maintain their health through traditional foods and active lifestyles.

The Latino Nutrition Coalition (LNC) is an Oldways' educational program inspiring Latinos to improve and maintain their health through traditional foods and active lifestyles. Oldways is a nonprofit food issues think tank that creates and organizes a wide variety of programs and materials about healthy eating, drinking, lifestyle, and the traditional pleasures of the table. Its educational programs are for consumers, scientists, the food industry, health professionals, chefs, journalists, and policy makers. It is internationally respected and is changing the way people eat through practical and positive programs grounded in science, traditions, and delicious foods and drinks. Oldways is best known for developing consumer-friendly health promotion tools such as the Whole Grain Stamp. The Latino Nutrition Coalition (LNC), created in 2005, is one of Oldways' five core programs aimed at raising awareness and promoting broad-ranging nutrition education efforts for people of all ethnicities.

The LNC creates practical, culturally aware materials in English and Spanish that specifically help Latinos combine the best of their healthy food traditions with the realities of modern American life. The LNC is a multifaceted alliance of industry, scientists, chefs, policy makers, and other leaders who are united in their goal to address and transform the current dietary trends in Latinos living in the USA, thereby reducing the associated deleterious health effects among this population. It utilizes the support, expertise, and passion of its members to develop education and community outreach programs, to heighten public awareness of the need for Latino-focused public health, and establish culturally relevant nutrition tools.

LNC is charged to help carry out the goals of the Consensus Statement and to provide the Latino community with easy-to-understand nutrition information that can be easily applied to modern life. To build awareness that making healthy food and lifestyle choices can reduce the rise of chronic disease facing the Latino community, LNC has created numerous resources and materials to help educate consumers and health professionals alike. Examples of some of the educational materials are: a list of Latin American Super-Foods, Time Savers and Smart Swaps, Exercise Tips and Ideas for the Whole Family, a bilingual Latin American Diet Pyramid, and a 7-Day Healthy Latino Meal Plan with recipes that includes a grocery list. LNC also has information for health professionals and registered dietitians, such as statistics concerning obesity, nutrition, diabetes, cardiovascular diseases, and cancer rates in the Latin American population.

Related Topics

- ► Assimilation
- ► Diabetes mellitus
- ► Dietary patterns
- ► Health education
- ► Health promotion
- ► Hispanics
- ► Latinos
- ► Nutrition
- ► Pediatrics

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Suggested Resources

Centers for Disease Prevention and Control. http://www.cdc.gov/obesity/index.html.

Oldways. http://www.oldwayspt.org.

The Latino Nutrition Coalition. www.latinonutrition.org.

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Obesity

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Obesity has emerged as a worldwide health issue in recent years. The USA has led the way, with the prevalence of obesity more than doubling in the past three decades, from 15% to over 30%; overweight and obesity have a combined prevalence of over 60%. According to the World Health Organization (WHO) obesity has also risen dramatically in Organization for Economic Cooperation and Development (OECD) countries. A 2004 report found that the rate of overweight and obesity in 2001 was 50% – two and half times the rate in 1976.

Being either obese or overweight increases one's risk for many chronic diseases, including heart disease, high blood pressure, type 2 diabetes, certain cancers, and arthritis. Perhaps not surprisingly therefore, obesity is associated with increased health care costs, reduced quality of life, and increased risk for premature death.

Differences Among Populations

Overall in the USA one third of adults are obese, and another one-third are overweight, and approximately one-third of all children ages 2–19 are overweight or obese; however, certain racial/ethnic populations are affected disproportionately. There appears to be considerable variation among different population groups, and among various immigrant groups according to country of origin, race, length of time in the USA, generation, age, and gender. Most of the existing US data on obesity among immigrants represents immigrants of Hispanic origin since they comprise the largest and fastest-growing proportion of immigrants in the USA; within that, most data are collected about Mexican immigrants. In collecting obesity data, Black immigrants, who may include people from a variety of African, Caribbean, and South American cultures, are often not distinguished from American-born Blacks.

According to the Behavioral Risk Factor Surveillance System (BRFSS) surveys conducted from 2006 to 2008, the age-adjusted estimated prevalence of obesity overall was 25.6% among non-Hispanic Blacks, non-Hispanic Whites, and Hispanics. Non-Hispanic Blacks had the greatest prevalence of obesity (35.7%), followed by Hispanics (28.7%), and non-Hispanic Whites (23.7%). In other words, when compared with non-Hispanic Whites, non-Hispanic Blacks and Hispanics had a 51% and 21% higher prevalence respectively. Data from the 2003–2004 National Health and Nutrition Examination Survey (NHANES) found even higher prevalences: the prevalence of obesity was 45.0% among non-Hispanic Blacks, 36.8% among Mexican-Americans, and 30.6% among non-Hispanic Whites. However, the differences among the groups held to the BRFSS pattern: non-Hispanic Blacks had the greatest prevalence of obesity, followed by Hispanics and non-Hispanic Whites.

On the other hand, the percentage of Asian Americans classified as obese is very low, with considerable variation among geographic and gender subgroups. For example, only 9% of Vietnamese or Chinese women are overweight, but 25% of Asian Indian women are overweight. Furthermore, Vietnamese men have a low prevalence of overweight (17%) compared with Japanese (42%).

Obesity in Children and Adolescent Immigrants

Although obesity and overweight have been increasing among people of all ages, races, and ethnicities, the rate

Sana Loue & Martha Sajatovic (eds.), *Encyclopedia of Immigrant Health*, DOI 10.1007/978-1-4419-5659-0,

of increase among children in general and immigrant children in particular in the USA is particularly alarming. Overweight children are at higher risk for type 2 diabetes and other conditions that raise their risk for cardiovascular disease, and are more likely to become overweight as adults. According to NHANES 2005–2006, the prevalence for overweight among children overall was 15.5%. For Mexican-American male and female children, the prevalence was 23.2% and 18.5%, respectively. On the other hand, the children of Chinese, Vietnamese, Hmong, and Pacific Islander immigrants have the fastest growing rates of overweight and obesity. Adolescents fare just as badly: 30% of Hispanic adolescents are obese, as compared to 21% of Asian-Americans and 24% of White non-Hispanic adolescents.

Definition and Measurement Limitations

Obesity is defined as a body mass index (BMI) equal to or greater than 30. BMI is calculated by dividing a person’s body weight (kg) by his or her height in meters squared (m^2). Overweight is defined as a BMI equal to or greater than 25. In children, obesity is defined as at or above the 95% percentile of the sex-specific BMI for age-growth charts. The prevalence of obesity as defined by BMI varies considerably by gender, age, race, and ethnicity. However, these data should be approached with caution; although BMI has been useful for measuring trends in obesity, it is an imperfect measure for several reasons. For example, in the BRFSS, which is a national telephone survey and a mainstay in measuring the nation’s health, the weight and height are self-reported and thus are likely inaccurate. Another surveillance and monitoring mechanism, called NHANES (the National Health and Nutrition Examination Survey) for which the height and weight of adults are measured by survey staff members, is thought to be more accurate. As mentioned earlier, the NHANES figures are in fact higher than those from the BRFSS.

Another limitation of the BMI is that it relies on body weight and weight does not distinguish between body fat and lean tissue (muscle) nor does it accurately reflect the distribution of body fat – both of which influence obesity-related risk of disease. Recently, the amount of abdominal fat, as indicated by the waist circumference, has come to be considered a more accurate measure of risk of diabetes and heart disease. This is important in relation to racial and ethnic groups. For example, relative to White men and women, Black men and women of the same BMI tend to have more lean mass and less fat mass. On the other hand, Asians tend to have a higher percentage of body fat per body weight, and both Asians and Hispanics tend toward upper-body obesity. As a result, there is considerable discussion about how this might affect public health and policy issues regarding using different cutoff points for different ethnic and racial groups.

Factors Affecting Immigrant Obesity

Many factors have been associated with overweight and obesity. These include age, sex, marital status, socioeconomic status (education, income, employment status), health behaviors (diet, physical activity), and access to health care. Other factors such as gut bacteria and the role of genetics are also being studied. For immigrants, we must add another factor that intertwines with the others: acculturation.

Acculturation Effects

Interestingly, the majority of immigrants who have immigrated to developed countries usually arrive with a lower body weight than native-born residents. However, with time, immigrants and their children have tended to experience increased rates of obesity that meet and even surpass those of their native-born counterparts. Although this has been most evident in the USA, Canada, Britain, Austria, Germany, Sweden, Australia, and Israel have experienced the same pattern. Internal migration within developing countries has yielded this pattern as well, with poor rural immigrants gaining weight when they move to urban areas.

The overall obesity rate for immigrants who have been living in the USA less than a year averages about 8%. This rate rises slowly for the first 10 years after immigration, but by 15 years it jumps to 19%, except in foreign-born Blacks. Other data demonstrate a notable fourfold increase in the risk of obesity in longer-term immigrants (15 years or more) compared with immigrants of 5 years or less. The pattern intensifies with each generation, with a striking increase in overweight between first- and second-generation immigrants. For example, Asian-American and Hispanic adolescents born in the USA (second generation) are more than twice as likely to be obese as are first-generation adolescent immigrants. In addition, the younger the immigrant at the time of arrival, the more pronounced the effect. There is also evidence that Black immigrants tend to follow the pattern of lower rates of obesity upon arrival and increasing rates with duration of residence, as well as in subsequent generations. In a recent study focusing on low-income Blacks, foreign-born Blacks were 40% less likely to be obese than US-born Blacks, and those with foreign-born parents were significantly less likely to be obese than those whose parents were native to the USA.

Food and Physical Activity

Acculturation implies that immigrants are exchanging their active lifestyles and traditional whole foods – which are generally low in fat and sugar – for a sedentary lifestyle and high-fat, highly processed foods.

Indeed, researchers have found that acculturation generally worsens immigrant diets as they adopt the eating patterns and menus of their new country. While there are many possible reasons for eating obesigenic foods, a new concept that applies to immigrants, "nostalgic foods" may add to our understanding of this shift in eating. A subset of "comfort foods," nostalgic foods refers to the phenomenon of dropping the healthier traditional foods while emphasizing the less healthy traditional foods; at the same time, immigrants are adopting the fatty, sugary "comfort" foods plentiful and affordable in the new culture. It is thought that the stresses of immigration contribute to the need for comfort through food.

On the other hand, acculturation appears to have a rather mixed effect on physical activity. In one study, Hispanic women who were less acculturated had a 58% rate of inactivity compared with 28% for those who were more acculturated, and studies show that Asian females, too, become more active with acculturation. Yet, the physical environment in the USA, which depends on cars for transport, does not encourage the walking and bicycling that is common in immigrants' countries of origin. For example, rural immigrants routinely walked to an open market every day in their birthplace, but in the USA, they make weekly trips to a supermarket.

Living Conditions and Socioeconomic Status

The impact of changing living conditions inherent in immigration, and interactions with socioeconomic status (SES) must also be considered.

Many immigrants are of low SES which may create unique conditions relating to access issues, with many immigrants lacking access to healthy foods and places to be physically active. For example, low-income neighborhoods generally have few or no stores that sell healthy foods such as fresh vegetables; on the other hand, they may have plenty of fast-food restaurants. In addition, people living in low-income and high-minority neighborhoods have reduced access to physical activity facilities due to lack of transportation, lack of facilities or programs, personal or neighborhood safety concerns, and cost. Interestingly, rural minority women are more likely to be completely sedentary than their urban counterparts, perhaps as a result of poor access to exercise programs and facilities.

Other factors affecting immigrants' diets include lack of familiar foods in their new country; lack of familiarity with the community; language barriers; memories of hunger, deprivation, and malnutrition before migration; high-caloric foods equated with status; and traditional plant-based diet equated with poverty. Recent research suggests that the cultural acceptance of curvier body types in some immigrant cultures could help encourage women's overweight and obesity trends. At the same time, the mainstream ideal of thinness could be setting impossible standards and thus actually be countereffective in helping women to keep a normal weight.

Prevention and Treatment

Since immigrants face more barriers to quality health care and are less likely to receive preventive care than are native-born Americans, preventing obesity in the first place is urgent. An overarching goal of *Healthy People 2010* is to eliminate health disparities among racial/ethnic populations. However, as of 2007, no state had met the objective to reduce to 15% the prevalence of obesity among US adults. Interventions will need to be culturally specific if they are to be effective, and encourage immigrants to maintain the healthy aspects of their cultural traditions while adopting healthy aspects of western life.

In 2009, the Centers for Disease Control and Prevention released a set of strategies to prevent obesity in the USA, as well as ways to measure them. The 24 strategies are divided into six categories: (1) strategies to promote the availability of affordable healthy food and beverages, (2) strategies to support healthy food and beverage choices, (3) a strategy to encourage breast-feeding, (4) strategies to encourage physical activity or limit sedentary activity among children and youth, (5) strategies to create safe communities that support physical activity, and (6) a strategy to encourage communities to organize for change.

Related Topics

- ► Acculturation
- ► Body mass index
- ► Body shape
- ► Healthy immigrant
- ► Leisure-time physical activity
- ► Nutrition
- ► Nutrition programs
- ► Percent body fat
- ► Physical activity
- ► Weight control

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Occupational Health

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Understanding Immigrant Work and Health

Immigrants form a significant part of the US population. Patterns and trends in immigration in the USA have changed widely over time. Much of the migration to the USA today is from the developing countries of Mexico, Central America, the Caribbean and increasingly from Asian countries since the 1980s. The pressures to migrate in these countries are high. Schenker notes that developing countries have 342 candidates for every 100 jobs. According to the International Labour Organization (ILO), many developing countries face serious social dislocation due to economic insecurities such as persistent poverty, growing unemployment, and loss of traditional trading patterns.

The American Community Survey estimates that in 2009 there were 38.5 million foreign-born in the USA, comprising 12.5% of the total US population and 16% or about 20 million of the total US civilian labor force. Undocumented immigrants are also a significant part of the US economy; Migration Policy Institute (MPI) notes that they make up 30% of the foreign born population with about 44% of them having arrived since 2000. Approximately, 11.9 million workers in the US labor force were undocumented in 2008 and these undocumented immigrants contributed $50 billion in federal taxes between 1996 and 2003. The US economic recession of 2008–2010 resulted in official unemployment as high as 10% which may have impacted the labor opportunities - of the immigrants even more. Bureau of Labor Statistics (BLS) data show that while unemployment for Whites is 8.8%, unemployment for Blacks was twice as high (16.5%), and unemployment for Hispanics was 12.6%. MPI estimates that the number of undocumented immigrants fell by about one million between 2007 and 2009 due to the recession.

Although the majority of the migrant workers are men, more women and children are becoming international labor migrants. McCauley in her article on immigrant workers in the USA notes that 95% of these working immigrants live in metropolitan areas. Another report by Benach and colleagues notes that in some cases people are forced to migrate from rural to urban areas as some of them are evicted from their territories due to changing economic practices or due to corporate economic pressures. While a small portion of the new immigrants hold white collar jobs, most move into situations of vulnerability – they are young, poor, lack higher education, language skills, and they work in low-wage sectors performing labor-intensive, high-risk jobs. Murray notes that longstanding social divisions in the USA have led to the disproportionate concentration of Black, Hispanic, and other minorities in low-paying dangerous jobs. The Urban Institute in their profile of a low-wage immigrant workforce notes that in the USA one in five of all low-wage workers is an immigrant. On the positive side, Benach and colleagues note that immigrant workers are an asset, they contribute to economic growth of the high-income countries and create new demands for housing, products, and services. The countries of origin also benefit from their large remittances. On the negative side, migration presents a brain drain and loss of healthy workers in low and middle income jobs, leaving behind many children and wives.

Depending on the country of destination, migrant workers are present in industry sectors such as construction, manufacturing, food service, health care, domestic service, agriculture, and mining. With the shift in the structure of work from heavy manufacturing to service industries partially due to outsourcing and movement offshore, immigrant workers that concentrate in urban areas comprise the bulk of the service industry. Having a defined and consistent workplace is also becoming relative in some of these jobs. An increasing number of immigrant workers are in unstable work situations such as temporary work, part time work, day work, and contract work where workers are hired by outsourcing consultants. A report by Barten and colleagues showed that many businesses throughout the world and in the USA are using temporary workers and contractor-supplied services instead of hiring employees directly in order to retain more competitive position in the marketplace.

The growth of this “informal” economy is often unregulated, small-scale, and home-based, offering services such as food and beverage commerce, cleaning and domestic service and auto and electronic repair. Employers view contract labor or informal jobs as a favorable solution to fluctuating product demand, providing a supplement for staff absences, as a means of reducing labor costs, as a means to avoid unions and the resulting demand for higher wages and to avoid compliance with regulatory and immigration issues. Research by McCauley reported that nationally, one fourth of all hired crop workers are employed by a contractor rather than working directly for a grower or farm operator. While contractors can provide steady employment to workers who might otherwise float between day jobs and temporary positions, they can also transfer external costs to these marginal workers and derive revenue by charging workers fees for work transportation, tools and equipment, cashing checks, and providing assistance to workers with immigration problems. Undocumented workers have also been occupied in harmful illegal employment conditions such as servitude, bonded labor, trafficking, or slavery. These informal jobs are low wage and have little job or legal security, social work–related benefits, or access to occupational or health services.

Some migrants arrive at their new destination with many risks to their health. The WHO reports that migration itself can cause health risks from distress arising from displacement, insertion into a new environment, neighborhood segregation, social exclusion, and marginal access to social benefits and services. Ahonen and her colleagues reviewed the immigrant occupational health literature and found that an immigrant's health and quality of life may also suffer from the precarious occupational choices available to them upon arrival due to their immigrant status, deficient language skills, nontransferability of their education and training and economic need, but also marginalization of the job market, institutional and legal discrimination, and xenophobia. Lipscomb and colleagues note that social inequities in occupational settings remain a large problem which includes social issues and labor management relations in the workplace from autocratic management styles, exploitation of cheap labor, discriminatory employment practices, and the absence of mechanisms for promoting worker involvement in health and safety efforts.

According to the ILO, more than two million people die from occupational accidents or work-related diseases every year. Conservative global estimates quote 270 million occupational accidents and 160 million cases of occupational diseases with half of these possibly caused by hazardous chemical exposures. Information on immigrants' occupational fatality and morbidity rates is scarce. Few countries disaggregate data that permits analysis on occupational health issues. In the USA alone, BLS reported 3.7 million cases of occupational injury and illnesses in 2008, of which 2.5 million injuries (71%) occurred in service-providing industries and the remaining in goods-producing industries. Few migrants benefit from social security compensation or rehabilitation schemes for occupational disease or injury. Many immigrants do not have access to work and social support systems, health benefits, and access to health services.

Barten and colleagues note that occupational injuries and diseases are of greater consequence in the developing countries as 70% of the working population of the world live in areas where occupational safety and health is poorly regulated and is considered a low priority. By affecting the health of the working population, occupational injuries and diseases have profound effects on work productivity and on the economic and social well-being of workers, their families, and dependents. According to ILO, the cost of work-related health losses and associated productivity losses may amount to several percent of the total Gross National Product (GNP) of the countries of the world.

The reasons for establishing sound occupational health and safety standards are moral, economic, and legal. Work safety and health policies vary enormously from country to country depending on their economic factors and sociopolitical conditions. In the USA, the Occupational Health and Safety Act was passed in 1970. The Act established for the first time a nationwide federal program to protect the workforce from work-related death, injury, and illness. McCauley notes that many of the OSHA laws are applicable to all workers including immigrants. Immigrants are covered under the National Labor Relations Act and are entitled to organize a union to improve wages and working conditions. They are covered under the federal minimum wage and overtime law and by an array of state laws. They are protected from workplace discrimination and can bring legal action. In most states, undocumented workers are entitled to a broad range of constitutional and civil rights protections. Undocumented workers who are injured on the job are entitled to the protections of state workers' compensation laws. Additionally, OSHA and other national legislation movements have developed labor-management health and safety committees and such concepts as “Right to Know,” and at the community level, “COSH” (Community Occupational Safety and Health) groups in many cities to advocate for better worker health protection.

While some of the basic laws are in place to ensure equal protection of immigrant worker health and safety, Lipscomb and colleagues note that there has been a reluctance historically to dedicate appropriate resources to identifying hazards in the workplace and propose remedies due to its potential to adversely affect the profit margins of business. In recent years federal OSHA has emphasized a shift to voluntary industry standards and industrial consultation as opposed to the regulatory role it was established to serve. The lack of enforcement on the part of state and federal agencies can leave it to immigrant workers to take action on their own behalf, which may not occur given the vulnerable position of these workers. Exploitation of immigrant workers is made easier because they are desperate for work. Manipulation of this core factor results in a range of unethical labor practices which are known to increase health hazards and safety problems. The status of temporary workers, their lack of familiarity with union politics, their segregation from other native workers on the job and in the neighborhoods, fear of losing their job and income, employer retaliation, and deportation all combine to make immigrants unusually dependent on their employers and difficult to recruit into working class struggles. Sassen-Koob notes that it is this powerlessness that makes them exploitable. This leaves the worker in a vulnerable state with respect to work abuse ranging from violation of minimum wage for normal work hours and overtime work, discrimination, and lack of knowledge and access to work place benefits and workers compensation laws.

Eamranond and Hu in their article in "Environmental and Occupational Exposures in Immigrant Health" note that disparities in immigrant health are exacerbated by lack of adequate health care access and culturally appropriate health care. The Personal Responsibility and Work Opportunity and Reconciliation Act (PRWORA) of 1996 made legal immigrants ineligible for nonemergency Medicaid services and barred most future immigrants from applying for federal public benefits for the first 5 years in the USA. Even after 5 years, access to publically funded medical care is severely restricted to qualified aliens. And illegal immigrants are ineligible for federal, state, and local public benefits according to the 1996 Illegal Immigration Reform and Immigrant Responsibility Act (IIRAIRA). With a large majority of immigrants and illegal immigrants uninsured and without access to primary care follow-up, medicines or equipment, and long-term care facilities they largely rely on acute care facilities. This lack of appropriate health infrastructure has created an unnecessary health disparity for the immigrant populations.

The political will to correct these labor and basic human right injustices has been further weakened since 9/11 and the worldwide economic recession that followed. Deep ethnic boundaries have erupted in many places with immigrants increasingly exposed to xenophobic sentiments. There has not only been an increase in opposition to immigrants but also an increase in the US Immigration and Customs Enforcement (ICE) raids and deportations. Xenophobic rhetoric is also common in popular mass media outlets such as FOX-TV which deepens the process of "othering" toward immigrants. The dynamics of ethnic boundaries are a larger social process where social distances are created, that may be institutionalized and sustained through the practices of classifying and ranking – a stratification system that employs ethnic markers to determine differential access to opportunity. Social distance is also an underlying component of segregation that impedes assimilation. Assimilation is often seen as a one-way process on the part of the immigrant whereas it should be considered a two-way process on the part of both the hosts and the new comers.

A new code of ethics that inspires and strengthens efforts to democratize the work environment is needed. Dembe notes that a larger sociopolitical process is required to reduce the increasing xenophobic reactions toward immigrants, the elimination of job discrimination, and job ghettos. These efforts may widely range from legislative actions to broad-ranging social activities.

Effective policies and initiatives are vital catalysts in obtaining action. As the power of the immigrant employee is limited, they require the protection of the state to correct the unreasonable demands which the capitalistic system has exacted of labor. First, it is necessary to address the new demands posed by the changing face of labor. Labor legislation is needed to launch effective strategies that enforce a dynamic dialogue between hierarchical divisions in the workforce and to provide better understanding of the work organization and the social contexts within which workplace deaths, disability, violence, and discrimination occurs. Second, workers employed in the informal economy face a labor market that is largely unregulated. There are no personnel departments, formal training, skill certificates, centralized sites of employment, employer databases, labor laws, or workers' organizations to coordinate employment practices. The growing sectors of informal (contract jobs, temporary jobs, and day laborer jobs) and small-scale industries need better job and regulatory protection with a better enforcement of work and safety standards. Third, better understanding of risks is essential in high-risk trades to reduce work exposures, work-related injury and illness and to enforce effective regulatory policies. Fourth, nationwide effective health policies need to be extended equally to immigrants as well as the natives. The workplace could be used as an effective entry point for health services delivery and to convey public health messages to migrant workers and their families. Lastly, an effective immigration law is needed to improve employment conditions.

Earmond and Hu note that given the nature of the informal economy, an integrated rights-based approach and a more people-centered empowerment perspective is needed. Informal workers' representation, organization, and participation are important for ensuring the right to health of workers in the informal economy. Social mobilization may prove critical as it did in the past. Lipscomb notes that unionizing is the best way to guarantee safer workplaces. Unionized construction workers have been shown to have better health insurance coverage than nonunionized construction workers. However, unions are less common in low income work settings. Perhaps establishing community-based worker cooperatives would be a means to bring these disenfranchised workers together and provide opportunities to develop a political voice, increase workplace safety and determine rules and conditions of work, wage rates, and benefits.

In addition to policy measures, and broader community interventions, educational initiatives are essential to build precautionary measures and practices to prevent occupational illness and injuries. Linguistically and culturally sensitive health and safety training conducted at workplaces but also at community settings and in the popular media is needed. Surveillance of immigrant occupational fatality injury and disease is impaired by the lack of reliable data. Further research could also include more sophisticated techniques such as community-based participatory research, and more qualitative and ethnographic methods to gather comprehensive data. The single most important thing that could improve occupational surveillance would be to collect appropriate ethnicity data. Such data should be collected along with socioeconomic and educational background. Benach noted that there is also a need for studies to link immigrant worker health to employment using occupational titles, place of work, shifts, number of jobs, industry and site-specific details, and distinctive exposure-related attributes to work hazards and health risks. Enhancement of occupational health surveillance systems also requires improving the knowledge of occupational illness among physicians and other health care workers. More specific diagnosis of occupational conditions should include better reporting of exposures. Studies that evaluate the effectiveness of immigrant occupational health interventions are also needed.

Work is an essential activity and central to well-being. Lipscomb notes that work, if decent, can pave the way for broader social and economic advancement, strengthening individuals, their families, and communities.

Related Topics

- ► Access to care
- ► Acculturation
- ► Assimilation
- ► Barriers to care
- ► Bureau of Immigration and Customs Enforcement
- ► Chemical exposure
- ► Community-based participatory research
- ► Discrimination
- ► Employment
- ► English as a Second Language
- ► Environmental exposure
- ► Environmental justice
- ► Ethnic enclaves
- ► Falls
- ► Farmworkers
- ► Food industry
- ► Health insurance
- ► Hispanics
- ► Illegal immigration
- ► International Labour Organization
- ► Job stress
- ► Labor unions
- ► Migrant day laborers
- ► Migrant farmworkers
- ► Occupational injury
- ► Pesticides
- ► Trafficking
- ► Undocumented
- ► Vulnerable populations

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Occupational Injury

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Work figures prominently in the experiences of immigrants to the USA – most who relocate to the USA do so seeking employment opportunities, many seeking relief from economies that offer few opportunities to make a living. Immigration to the USA for employment takes many forms, including the recruitment of sought-after skilled professionals such as health care workers and scientists, the granting of temporary entry for seasonal work such as harvesting crops, and, in response to an increasing demand for cheap labor, the movement of undocumented workers into largely low-wage, labor-intensive jobs.

Immigrant Workers

Not all those who come to the USA for work should be called “immigrants,” technically a term reserved for those who travel to the USA with the intention to resettle here. Migrant workers and other nonimmigrants may move in and out of the USA while maintaining a home in their country of origin. However, occupational health studies and surveys do not always contain information on the circumstances of a worker’s employment, visa status, or residence in the USA. For that reason, immigrant and migrant and other foreign-born workers will, for the most part, be discussed together under the umbrella of “immigrant.”

Immigrants Hold Different Jobs

The occupational injury experience of immigrant workers in the USA is driven primarily by the occupations that they hold, but is also influenced by workers’ education and work history, language skills, and other important social factors that may increase or decrease their risk for injury on the job, compared with native workers. The employment profile of immigrants in the USA looks different than that of native workers. Immigrants are underrepresented in professional, management, and technical occupations, but are more likely than native-born workers to work in manual labor-intensive occupations. Typical work for immigrants includes construction, cleaning homes and offices, planting and harvesting crops, slaughtering animals and packing meat, operating machinery, and assembling consumer goods. In such occupations, the tasks performed, the tools and machinery used, the pace of work, and the workplace environment all present substantial risk for sustaining an injury.

In addition, the structure of jobs that are offered to immigrants, particularly undocumented immigrants, can affect their risk of occupational injury. Immigrants are often employed in contingent work such as day labor, securing daily work through temporary agencies. Day laborers are often unaware of who their actual employer is, what type of work they will be performing on any given day, and are often not given appropriate safety information or protective equipment. The lack of oversight over the employment and training of day laborers compounds the vulnerability of these workers to injury on the job.

Agriculture is an example of a hazardous industry with a large proportion of immigrants (note that many agricultural workers are *migrants* or *seasonal workers*) in its workforce. Immigrants account for a substantial proportion of the agriculture workforce across the USA with their highest representation in California, where approximately 95% of farmworkers are immigrants. Farmwork exposes these workers to extreme weather conditions (heat, cold, rain, sun), risk for falls from working on ladders, heavy burdensome work such as carrying crops, and ergonomic hazards such as stooping and extremely repetitive tasks, among other hazards. Farmworkers sustain injuries and illnesses from frequent exposure to pesticides and other chemicals. These same workers also experience poor general health and little access to quality health care, reflected in an average life expectancy among migrant and seasonal farmworkers of only 49 years, compared to a national average of 75 years.

The food manufacturing sector also relies heavily on immigrant labor. Recently, the experience of immigrant workers within processing plants, such as meatpacking and poultry facilities, have come to the attention of the general public through press coverage and popular books and films about the food industry (e.g., Fast Food Nation). In 2008, the *Charlotte Observer* ran a six-part investigative series, “The Cruelest Cuts,” focusing on the working conditions of immigrants in North Carolina’s poultry plants; poultry processing is among the industries with the highest rates of (nonfatal) injuries. The newspaper series reported the stories of workers with debilitating injuries, exposed the rate of safety violations within the plants, and found evidence of repeated underreporting of work-related injuries.

Immigrants are also overrepresented in occupations that involve extensive contact with the public, some linked to a high incidence of violence. In recent years, the leading cause of workplace fatality among immigrants has been workplace homicide. The disproportionate employment of immigrants, particularly Asian immigrants, in occupations characterized by unsafe conditions, is likely the main driver behind this statistic. Immigrants are more likely than US-born workers to work as convenience store and gas station clerks and taxi drivers – the occupations in which workers are most likely to be murdered on the job. These workers and their workplaces are often the targets of criminal activity, namely, armed robbery.

The federal Occupational Safety and Health Administration (OSHA) has released recommendations for protecting workers in these occupations, e.g., the use of bulletproof glass and other barriers, alarm systems, and drop safes. However, safety precautions have not been widely adopted. Immigrants working in non-secured work settings such as convenience stores continue to be murdered on the job. Surveys and studies also provide evidence that immigrants face a high incidence of violence, harassment including sexual harassment, and intimidation in many other work settings.

Not all foreign-born workers in the USA experience the same work-related injury rates; unskilled workers and workers with low education levels fill many of the most hazardous jobs. Among immigrants, undocumented immigrants fill many of the most hazardous jobs, while simultaneously facing economic pressures, language barriers, and other factors that inhibit them from seeking and obtaining safe work and from exercising their rights to a safe workplace. In 2008, an estimated eight million undocumented immigrants worked in the USA, comprising an estimated 5% of the total workforce.

Focus on Hispanic Workers

Recently, there has been a renewed focus on the occupational health and safety of Hispanic workers. In 2010, the National Action Summit for Latino Health and Safety (sponsored by OSHA and the National Institute for Occupational Safety and Health, in partnership with the National Institute for Environmental Health Sciences) was held to “develop a working agenda to prevent injury and death among Latino workers.” At this gathering of workers, trainers, unions, employers, researchers, and government officials, US Department of Labor Secretary Hilda Solis emphasized the rights of all workers to OSHA protections under the OSH Act of 1970, to include immigrant and undocumented workers.

In efforts to reduce injuries to immigrant workers, a focus on Hispanics is appropriate. Hispanics account for about half of the foreign-born working in the USA and also represent the largest proportion of low-wage immigrant workers. In addition, more than half of all undocumented immigrants in the USA are Hispanic, which implies that these workers will hold many of the most dangerous jobs. During the last decade, during a period when fatal workplace injuries among all workers declined, the rate of fatalities among Hispanic workers increased significantly. Although the data to describe the burden of *nonfatal* occupational injuries to immigrant workers are poor, foreign-born workers do appear to sustain more injuries in the workplace than native-born workers. Recent analyses also affirm that Hispanic construction workers are more likely to sustain a work-related injury than their non-Hispanic counterparts.

Risk Factors

It is clear that immigrants are more likely than native-born workers to hold jobs that present higher-than-average risk for occupational injury. In addition to riskier employment, occupational health researchers want to identify other root causes of injuries to immigrant workers. Identifying causes of disparities can point to policies and practices to reduce injuries among these workers.

Potentially important factors that may put a worker at risk of injury include language barriers and literacy (in the language of the destination country and/or native language), education level, skill and experience in the current occupation, perceptions of safety and willingness to take risks, and a worker's immigration status. Some of these risk factors can be recast as social, structural, or workplace factors. For example, many researchers suggest that that the fear of both losing income and being deported increase injury risk for undocumented immigrants, as workers are less likely to refuse unsafe work. Therefore, workplace health and safety practices and policies should also be examined. Likewise, while language barriers may be important, appropriate training and health and safety practices may allow immigrant workers to work safely alongside their English-speaking counterparts. More research is needed to distinguish contributing social risk factors from "cultural" or behavioral factors.

While the preceding paragraphs present a picture of increased risks and increased injuries to immigrant workers, it must be noted that we do not know enough about how work affects their health. The primary system that tracks work-related injuries and illnesses in the USA, the US Department of Labor's Annual Survey of Occupational Injuries and Illnesses, does not collect information on workers' birthplace. Therefore, injury rates for foreign-born workers cannot be obtained from this important source of data. Information on the occupational health of immigrant populations is often obtained from administrative datasets or special surveys and studies of immigrant populations.

The data that *are* available, however, do not tell the entire story. The reality of underreporting into injury and illness surveillance systems and of injuries going undocumented has become increasingly well appreciated. A 2008 report by the House Committee on Education and Labor entitled "Hidden Tragedy: Underreporting of Workplace Injuries and Illnesses" and a 2009 report from the US Government Accountability Office entitled "Workplace Health and Safety: Enhancing OSHA's Records Audit Process Could Improve the Accuracy of Worker Injury and Illness Data" detailed problems with injury reporting systems and the resulting data. Research suggests that the occupational injury experience of immigrants may be particularly poorly documented. Immigrants, both documented and undocumented, may be reluctant to report injuries, and may be discouraged by their employers from doing so. The House report concluded that immigrants are less likely to report injuries than native-born workers. Statistics on injuries to immigrants may also be biased because immigrant workers access health care and workers' compensation more seldom than native-born populations – two additional sources of data used to generate occupational injury statistics.

Workers' Rights

In any workplace covered by the Occupational Safety and Health Act of 1970 (almost all private sector workplaces), immigrants, regardless of their immigration status or documentation, are afforded the same rights as native-born workers. OSHA offices in each state can give workers information about their rights to a safe workplace and also offer technical assistance to employers. In many states, immigrant workers, with or without documentation, are eligible for workers' compensation benefits when injured or made ill on the job. Workers' compensation provides medical care, wage replacement, and death benefits for injuries that are deemed to be work-related, according to the state workers' compensation statute. Nonprofit organizations, workers' centers, and labor unions also assist workers faced with dangerous conditions in their workplaces.

Disclaimer

The findings and conclusions in this chapter are those of the author and do not necessarily represent the views of the National Institute for Occupational Safety and Health/Centers for Disease Control and Prevention.

Related Topics

- ▶ Access to care
- ▶ Back pain
- ▶ Barriers to care
- ▶ Border health
- ▶ Bracero program
- ▶ Chemical exposure
- ▶ Child labor
- ▶ Childhood injuries
- ▶ Discrimination
- ▶ Emigration
- ▶ Employment
- ▶ Falls
- ▶ Farmworkers
- ▶ Food industry
- ▶ Guest worker
- ▶ Hispanics
- ▶ Immigrant visa status
- ▶ Immigration in the global context
- ▶ Immigration processes and health in the U.S.: A brief history
- ▶ Injuries
- ▶ Job stress
- ▶ Labor migration
- ▶ Maternal employment
- ▶ Methodological issues in immigrant health research
- ▶ Migrant day laborers
- ▶ Migrant farmworkers
- ▶ Mortality and morbidity
- ▶ Occupational and environmental health
- ▶ Occupational health
- ▶ Sweatshop
- ▶ Undocumented

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Occupational Integration

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Occupational integration is a process by which immigrants enter and participate in the workforce of their new country. It is a key part of immigrants' adaptation process and it has a wide range of implications for the psychological social and economic dimensions of their lives. In addition to merely money, work provides many advantages, such as defining one's identity and purpose. For immigrants in particular, work allows for the building of relationships with others having similar interests in the new homeland. Not finding work may hence cause difficulty assimilating and decrease self-concept.

Occupational integration is often a long process and one of the most difficult problems that immigrants experience. In many countries, immigrants disproportionally represent unfavorable outcomes regarding unemployment, occupational status, and level of income. Barriers to successful occupational integration are numerous. Lack of competency in the local language and difficulty in getting their qualifications and work experiences from their original country recognized are common barriers. Lack of local work experience, local network, and knowledge in local work culture also make it difficult for immigrants to find a job or become an entrepreneur. In addition, prejudice and ignorance that employers, agencies, or corporations may have against immigrants severely impede integration.

Recent research has shown that unemployment increases risk of depression and the likelihood of poor adjustment. This is because unemployment deprives immigrants the benefits of work mentioned above. Results of unemployment are not only loss of income and financial strain, but loss of status and self-esteem, as well as constrained social contacts and network. Furthermore, the unemployed may be significantly stigmatized and have feeling of shame and guilt where full employment is a norm in the society. For refugees, stress, shame, and guilt may be even greater because some may feel a duty to provide not only for themselves and the family in the country of resettlement, but also for all those other family members and relatives left behind in the original country.

Underemployment is also a risk to poorer mental health. Skilled immigrants are underemployed when their job does not fully utilize their qualifications and skills gained in their original country. As a result, they find themselves in an occupation of lower socioeconomic status compared with the one in the original country. This drop in socioeconomic status and limited status mobility creates stress and is associated with poorer mental health. Underemployment is also an issue for the host country, as underutilization of skilled immigrants is a loss of a valuable resource.

Occupational integration requires a capacity for adaptation from both the immigrants and the host society. The host society and its members at different levels have a role to embrace diversity and eliminate discrimination. Individual immigrants have a responsibility to acquire competency in the language and in job skills. The host society also has a role to assist with this by improving access to language education and job training for immigrants. Pre-immigration training can provide information on the resources, work, and training opportunities in the host society and better equip immigrants to enter occupational integration process. Public education and support for cultural diversity and zero tolerance toward racism should be promoted in school, corporations, organizations, and media. Improvement in immigrants' occupational status will lead to an improvement in their mental health outcomes and will benefit the host society by ultimately saving health costs and by contributing to job creation and a diverse workforce.

Related Topics

- ► Late-in-life migration
- ► Psychological acculturation

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Oral Health

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The dental health status of immigrants is typically worse than that of native-born populations, and dental health care is often a major unmet health care need. Documented disparities exist in regards to dental caries ("cavities") in children, adolescents, and adults, and also in regards to periodontitis ("gum disease"). The major predictor of dental caries in immigrants, after taking into account socioeconomic status indicators, is time since immigration, with the more recent arrivals having worse disease. This association has been consistently noted in studies in the USA, Canada, Europe, and elsewhere in the world. The dental health of immigrant children is also typically better than of that of their adult caregivers.

In addition to recency of immigration, other predictors of dental health have been identified. In a cross-sectional study of dental health in adult immigrants from diverse geographic and cultural origins, Cruz et al. (2009) found that acculturation and certain immigration attributes play an independent, and perhaps more important, role than differences in socioeconomic characteristics such as education and income levels. Length of stay in the host country was inversely associated with need for treatment of dental caries, but not with any other indicator of dental disease. Factors such as country of birth and age at immigration were associated with variations in dental disease prevalence and need for dental health care, while language preference was not.

Immigrant dental health has generally been shown to be positively associated with acculturation, with greater acculturation associated with measures of fewer decayed teeth, less periodontal disease, and fewer missing teeth. While the process of acculturation may lead to adoption of habits deleterious to good dental health, such as a diet with a high content of refined carbohydrates, it may also lead to adoption of better preventive practices and enhanced access to professional dental health care services. In this regard, "acculturation" may serve as a proxy for cultural norms and behaviors that affect care-seeking and self-care behaviors and, ultimately, dental health outcomes.

In regards to children's dental health, it has been found that the dental health knowledge, opinions, and practices of their caregivers are significant predictors of the child's dental health. In particular, the "dental health literacy" of caregivers may be a critically important factor, independent of mother's education and family income. Culture plays an important role in determining dental health status, primarily through the effects on self-care dental hygiene practices, dietary patterns, and access to and utilization of professional dental health care services. Despite their disproportionate greater burden of dental disease, immigrants have lower utilization of dental services.

A major access barrier to dental care, for immigrants as well as for other population groups with dental health disparities, is the lack of dental insurance. Affordable dental care is typically beyond the reach of most uninsured persons. Work in Hispanic migrant farm worker families in the USA suggests that children's dental health and use of dental care is positively associated with being born in the USA. Children are also more likely to receive regular dental care and have better dental health than immigrant adults, who usually receive no care or only emergency care. The differences noted among family members suggest that access to services, and not lack of education, is the primary dental health care barrier facing farm worker families.

An important determinant of good dental health is access to affordable professional dental services, and a key prerequisite for such access is having dental insurance coverage. In the USA, over one-third of the population lacks dental insurance, which is approximately three times as many as those lacking medical insurance. Major effort has been devoted in US health care reform to extend access to dental services, and the Affordable Care Act of 2010 guarantees dental insurance for all children, to age 21. Efforts continue to extend dental insurance coverage to all adults.

Related Topics

- ► Access to care
- ► Acculturation
- ► Dental caries
- ► Health disparities
- ► Oral hygiene

Suggested Readings

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Oral Hygiene

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Dental health affects eating, speech, social function, and self-esteem and periodontal disease has been associated with diabetes, cardiovascular disease, chronic respiratory illness and obstetric problems such as preterm deliveries. Immigrants and refugees have particularly high rates of dental disease and unmet dental needs and should be regarded as at risk for oral health problems. Even individuals with optimal oral health can experience dramatic decline when under stressful conditions. Sadly, the high prevalence of neglected oral hygiene can be the result of low priority of oral health compared to the more immediate problems for example of resettlement.

The Need for Oral Hygiene in Immigrant Populations

Good oral hygiene is essential to keep the teeth and gums healthy and prevent tooth decay (caries) and periodontal (gum) disease. There is much evidence that certain immigrant groups demonstrate poorer oral hygiene compared to nonimmigrant groups and the reasons for this are likely to be multifactorial. Cohen studied an immigrant Ethiopian Jewish population in Israel and found that this population was in need of oral hygiene instruction, with almost 80% needing scaling. Angelillo and colleagues investigated the caries (cavity) prevalence, oral hygiene status, periodontal health, and treatment needs in immigrants and refugees in Catanzaro and Crotone, Italy and revealed poor oral hygiene and periodontal health as well as unmet needs for dental treatment in certain immigrant and refugee groups, in particular Moroccans and Yugoslavs. In a study of 298 children in Sweden, Wendt noted that immigrant children brushed their teeth less frequently, used less fluoride toothpaste, and had a higher prevalence of visible plaque at 1 year of age than native-born children.

Immigrant groups are often those who suffer the worst oral health and therefore optimal oral hygiene is highly desirable. Efforts to improve the uptake of dental care and improve oral hygiene should be directed toward all immigrant groups in order to improve oral health and decrease the need for extensive and often costly dental treatment. In children, early establishment of good oral hygiene habits and regular use of fluoride toothpaste are important for achieving good oral health.

Current Oral Hygiene Recommendations

Throughout history, many different measures have been used for teeth cleaning from chewing sticks to rubbing teeth with ash or wood charcoal. Dentists currently recommend careful tooth brushing with fluoride toothpaste and the use of dental floss or interdental cleaning aids to prevent the accumulation of plaque on the teeth. It is also advised to visit a dentist regularly, as professional cleaning including tooth scaling or debridement and tooth polishing may be required.

Teeth should be brushed at least twice a day for at least 2 minutes using a soft-tufted brush small enough to cover all areas of the mouth. It is important to pay particular attention to where the teeth meet the gums (gingival margin). The head of the toothbrush should be placed against the tooth and the bristles should be tilted to a 45° angle against the gum line and moved in circular movements several times on all the surfaces of every tooth. It is usual to brush the outer surfaces of each tooth, upper and lower, keeping the bristles angled against the gum line. This is repeated on the inside surfaces of the teeth and finally on the biting surfaces of the teeth. To clean the inside surfaces of the front teeth, the brush is tilted vertically and several small circular strokes are performed with the front part of the brush. Manual toothbrushes should be replaced every 3–4 months or sooner if the filaments become worn. Electric toothbrushes are sometimes used and may be more effective.

Interdental cleaning (cleaning between the teeth) is also important to remove the plaque and the decaying food remaining stuck between the teeth. Retained food debris and plaque cause irritation to the gums which can lead to periodontal disease and acid formation, which can cause demineralization, eventually causing cavities. Interdental cleaning commonly involves using dental floss at least once a day after brushing and preferably twice a day. The dental floss should be passed against either side of each tooth, going beneath the gum line by curving the floss around each tooth from the gum upward. A fresh piece of dental floss or tape should be used each time to clean the narrow spaces between the teeth which the toothbrush cannot access. The gums may bleed when flossing for the first time but this usually settles within a few days.

Many periodontologists often prefer the use of interdental brushes to dental floss; these are thought to be gentler to the gums and carry less risk for hard dental tissue damage.

Other Oral Hygiene Measures

Regular tooth brushing and interdental cleaning, along with regular dental checks, is usually sufficient although additional oral hygiene measures may be beneficial. An antiseptic mouthwash can help control plaque and reduce gingivitis, especially in people who are unable to use a toothbrush. As fluoride protects against dental cavities by making the surface of teeth more resistant to acids during the process of remineralization, fluoride mouthwash or topical fluoride applications can help prevent tooth decay. Some people also clean their tongues using a toothbrush or a special plastic tongue scraper after cleaning their teeth.

A well-balanced healthy diet is important, in particular, limiting the amount of sugary foods and drinks, which contribute to tooth decay. Interestingly, it is how often sugars are consumed (and not the amount) that is most important. It takes 40 minutes for the saliva in the mouth to neutralize acids caused by ingesting sugars or acidic drinks (such as colas) and it is therefore important to limit sugary foods and drinks to mealtimes. It is relevant to inquire into the dietary habits of immigrants as many may not be aware of the relatively high sugar content of prepared meals from supermarkets and fast food chains. Sugar-free chewing gum increases the flow of saliva, and its use after meals helps to “flush” the mouth and clear any remaining debris. Saliva contains buffer chemicals which help to stabilize the pH near to 7 (neutral) in the mouth and prevent acid attacks. Smoking is a major risk factor for developing gum disease and smoking cessation has many benefits for oral health.

Plaque and Calculus

Plaque is a sticky film of bacteria which forms on teeth and gums. Following eating food, bacteria in plaque release acids that attack tooth enamel: repeated attacks can weaken the enamel, eventually causing tooth decay. The bacteria are more active if frequent sugary and starchy snacks are ingested although plaque can easily be removed by a good oral hygiene regime.

If plaque accumulates through absence of daily brushing and cleaning between teeth, it can eventually harden into calculus or tartar which firmly stick to teeth and generally can only be removed with difficulty by a dentist or dental hygienist with special instruments.

Periodontal Disease in Immigrants

Plaque also produces substances that cause gum inflammation. These substances can make the gums red, tender, or bleed easily and may lead to periodontal (gum) disease. The gums may lose their attachment to the teeth and their supporting structures. Pockets may form which fill with more bacteria and in some cases pus. If left untreated, the bone around the teeth can be destroyed and the teeth may become loose. Periodontal disease is the main cause of tooth loss in adults.

Periodontal disease is a chronic infection or inflammation that affects the gingival, bone, and other tissues that surround the teeth. It is also a cause of bad breath (halitosis). Infection in these tissues can initiate inflammatory and immunologic changes commencing with gingivitis, which is inflammation of the gums and, in most cases, caused by plaque. If gingivitis progresses and worsens to involve the supporting tissues of the teeth (the periodontal membrane), it is called periodontitis, which may cause destruction of connective tissue and bone, leading to loss of teeth.

Immigrants are at risk of developing periodontal disease due to their interrupted lifestyles, lack of resources, and impaired access to dental care. In a study assessing dental health in adult refugees in Boston, 88% had some degree of gingival inflammation while 9% presented with acute periodontal infection requiring emergency dental referral. Gum diseases such as acute necrotizing ulcerative gingivitis (ANUG) and noma (or cancrum oris, an acute bacterial infection of the gingival and face) can still be prevalent among children in African countries and may be seen in immigrants.

Oral Health Assessment

This should include examination of the tissues of the head and neck; dentition; and soft tissues of the oral cavity, lips, and upper throat. It is important to detect and document signs of infection, oral cancer, manifestations of HIV/AIDS, injury or trauma and torture, as well as nutritional deficiencies such as scurvy (a nutritional deficiency caused by lack of Vitamin C). Pertaining to HIV, approximately 40–50% of seropositive individuals have evidence of oral fungal or bacterial infections in the early course of the illness and oral health providers can therefore contribute to diagnosis, prevention, and treatment of the condition. Kaposi’s sarcoma (a type of cancer), oral thrush, oral hairy leukoplakia (white patches caused by Epstein-Barr virus), herpes simplex infections, and oral ulceration are other common manifestations of HIV/AIDS that one should be vigilant for.

Particular care should be given to immigrants or refugees from countries with a high level of violence exposure and torture. Inadvertently, the healthcare practitioner can invoke “flashbacks” of previous violence or torture by examining the mouth, if for instance, oral rape or dental torture has occurred in the past. A simple question such as “Is there any reason why this examination could be difficult for you?” or “Did anything bad happen to your mouth in country X?” might be an opening sentence to explore this possibility.

Access to Dental Services

Most publicly funded national health services in the USA and UK do not provide any special or fast-track access to dental service for refugees. Hullah and colleagues, in a questionnaire-based study of 206 postnatal mothers in an inner city London hospital (of whom 74.2% were non-British born) noted that only a third visited their dentist during pregnancy (despite having free care) and at least half of these women required treatment. Interestingly, 26% of the women questioned did not know about the availability of free dental care during pregnancy and for 12 months afterward. Immigrants face many barriers when trying to access dental care such as language and low literacy rates. Many are unfamiliar with the health care system and are not able to navigate through the process of receiving dental care in their host country. Efforts must be made by advocates and community leaders to improve the uptake of dental care as periodontal disease has been shown to represent a significant risk factor for systemic diseases.

Cultural Beliefs and Oral Health Practices

Traditional oral hygiene practices vary widely throughout the world. Chewing sticks, which is quite effective in removing plaque, is a common practice in parts of Africa, the Middle East, and Asia, and many refugees prefer this as part of their daily oral hygiene regimen rather than using a toothbrush. Somalians use sticks from the "roomay" or "muswaki" trees and ashes and wood charcoal are often rubbed on the teeth to whiten them.

Members of the Dinka and Nuer tribes of Sudan often remove the lower anterior canine teeth of both male and female adolescents as a rite of passage to adulthood while uvulectomies (which leave a variety of anatomical soft palate changes) are often done traditionally on East African infants to prevent throat and tonsillar infections.

Conclusion

Accessing oral healthcare is challenging for immigrants due to financial constraints and issues of language, literacy, culture, and different care-seeking behavior. Maintenance of oral hygiene is important as periodontal disease has strong associations with systemic conditions such as diabetes, cardiovascular disease, and chronic respiratory illness. Medical and oral healthcare practitioners have to be culturally aware, and community leaders from immigrant societies can help encourage uptake of dental care within this group of individuals.

Related Topics

- ► Dental caries
- ► Human immunodeficiency virus
- ► Nutrient intake
- ► Nutrition
- ► Oral health
- ► Tobacco use

Suggested Readings

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Suggested Resources

American Dental Association. www.ada.org.uk
British Dental Health Foundation. www.dentalhealth.org.uk

Orphan

► Unaccompanied minors

Paan

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Paan is a chewing mixture popular in India and Southeast Asia. The mixture has different varieties (from bitter to sweet) and varies dependent on location. It is deep rooted in the culture of Asia as a social practice, but research is now arising about its addictiveness and negative effects to the human body.

Ancient Greek, Sanskrit, and Chinese texts dated back to 5000 B.C. have made references to this chewing mixture. Initially used by royalty, paan is now generally used in social gatherings, particularly after meals. Paan consists of a betel leaf smeared with lime paste (aqueous calcium hydroxide) then packed with boiled areca nut (see ► Betel nut) and spices, rolled into a quid or package and then chewed. Tobacco or sweet spices (e.g., cloves, cardamom, and peppermint) have also been used in its preparations. The package is chewed and sucked on for several hours while excess saliva is spit out. Paan chewers have a distinctive red discoloration to their lips and mouth.

The effects of paan are mainly due to the areca nut. Effects are described as those resembling a mild stimulant (increased heart rate, increased attention). The addictiveness of the chew is further increased with the addition of tobacco. Studies have now shown the direct link to paan chewing with cancer, even without the use of tobacco. Oral submucous fibrosis, a condition that leads to limited movements of the mouth, and precancerous and cancerous lesions of the mouth (in particular, squamous cell carcinoma) have a direct link to regular paan chewing.

Related Topics

► Asia
► Betel nut

Suggested Readings

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Suggested Resources

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Pacific Islanders

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Pacific Islanders

For thousands of years Pacific Islanders have explored the outer reaches of the Pacific Ocean due to population pressures, the need for resources, and in the pursuit of new opportunities. In recent history, Pacific Island migration has also been influenced by colonial expansion and ambition. Contemporary migration patterns continue to reflect traditional political alignments with larger colonial powers.

The migration history of Pacific Islanders is reflected in their distribution across many island nations and Western colonial territories. Pacific Islanders have become a heterogeneous mix of people with differences and similarities in cultural, social, and political structures. The effects of migration have thus often been beneficial and many Pacific Islanders

Sana Loue & Martha Sajatovic (eds.), *Encyclopedia of Immigrant Health*, DOI 10.1007/978-1-4419-5659-0,

continue to gain employment and academic opportunities abroad.

However, the process of migration can also result in acculturation stress and adversely affect an individual's health and well being. The following discussion therefore seeks to contextualize Pacific Island migration within an historical and contemporary framework in order to explore some of the specific health effects of immigration in these groups.

Geography

The Pacific Islands comprise some 10,000 islands in the Pacific Ocean south of the tropic of Cancer. They can be organized by archipelago or political unit but are commonly divided into Melanesia, Micronesia, and Polynesia.

Melanesia means *black islands* and is a reference to the dark skin pigmentation of their inhabitants. Comprised of mainly high volcanic islands with fertile soil, it is the most populous of the three regions. Melanesia includes New Guinea (which is divided into Papua New Guinea and the Indonesian provinces of Maluku, Papua, and West Papua), New Caledonia, Torres Strait Islands, Vanuatu, Fiji, and the Solomon Islands.

Micronesia means *small islands*. These include the Marianas, Guam, Wake Island, Palau, the Marshall Islands, Kiribati, Nauru, and the Federated States of Micronesia. Polynesia means *many islands* and is the largest of the three zones. It includes New Zealand, the Hawaiian Islands, Rotuma, the Midway Islands, Samoa, American Samoa, Tonga, Tuvalu, the Cook Islands, French Polynesia, and Easter Island. Micronesia and Polynesia are comprised of low islands formed by reefs or atolls which are relatively small and infertile.

Early Pacific Island Migration

The people of the Pacific Islands have a history of migration dating back some 50,000 years to the Pleistocene era. The first inhabitants of the greater Australian continent moved to settle the Bismarck Archipelago through a "voyaging corridor" that extended to the Solomon Islands. Beyond there, land masses were smaller and further apart and migrating settlement stopped until around 3500 BC.

The archeological record indicates that deep sea colonization began after 3500 and was probably associated with the Lapita culture. Evidence of this archeologically distinct group has been found on islands of Melanesia, Fiji, and West Polynesia dating to 1000 BC. Settlement moved across to Eastern Polynesia around A.D. 0. Cooler weather and more difficult sailing conditions likely delayed the migration south by the Maori to New Zealand until 1000 AD.

Colonization and Migration

The past three centuries have seen increasing contact between Pacific nations and colonial powers seeking to expand into the Pacific. The Dutch, French, Germans, English, Japanese, and Americans have all had an influence in the region over time. Although historical colonial contact and allegiances with the Pacific Islands continues to influence modern migration patterns, the legacy of these colonial histories is somewhat checkered.

The opportunity offered by these early colonial contacts was no doubt as tempting then as it is today. Many young Pacific Island men took the opportunity to work, see the world, or avoid the tyranny of their chiefs by signing to crew trade and whaling ships. However, with the demise of slavery, indentured labor became a new source of recruitment. Colonial contracts were primarily with China and India; however, initiatives were also explored in relation to Pacific Islanders.

The Polynesian Labourer's Act of 1868 and the Queensland Labor Trade were introduced in Australia during the same period that indentured Indian laborers were being brought to Fiji to work on sugar plantations. Tens of thousands of so-called kanakas were brought to Australia as migrant workers from Melanesia. In 1901 the Pacific Island Labourer's Act saw the end of the trade and indentured laborers were required to leave. Some, however, gained dispensation to stay and their descendents continue to seek compensation from the Australian Government for their mistreatment.

At best these initiatives acted as types of early labor exchange schemes; however, in reality it was little more than a civilized form of slavery. Nevertheless, more brutal forms of forced labor were to come under the occupation of Japanese Imperial forces during World War II. The role of the USA in defeating Japan and liberating occupied Pacific Islands has led to enduring and sanctioned opportunities for migration among Micronesian territories.

Later migrant labor schemes have continued to attract Pacific Island workers in both New Zealand and Australia. However these too have at times had negative consequences. In New Zealand, the 1970s saw the emergence of the so-called Dawn Raids, where so-called illegal overstayers were aggressively and sometimes traumatically deported leaving lasting memories in subsequent generations. Ironically, the late 1980s saw significant growth in migration from the Eastern Pacific due to more liberal immigration policies and visa-free experiments. The introduction of a new Immigration Act in 1987 and a swell of Indo-Fijian migrants in response to a series of coups in 1987 also contributed to growth.

Modern Pacific Island Populations

Population data from 2003 to 2004 estimated there were nearly nine million people living throughout the Pacific Islands. Of these 7.4 million were of Micronesian descent including over five million from Papua New Guinea and about 800,000 from Fiji. These totals eclipse the rest of the region where Micronesian people number just over half a million and Polynesians around 740,000 people. Often omitted from Pacific Island data are Maori who comprise the second largest ethnic group in New Zealand at around 565,000 people.

The indigenous population of Papua New Guinea is one of the most heterogeneous in the world and yet foreign residents account for just over 1% of the population. Papua New Guinea has several thousand separate communities, most with only a few hundred people, although a considerable urban drift has occurred in recent years.

In Fiji, indigenous Fijians account for 57.25% of the population with Indo-Fijians accounting for 37.64%. Europeans, other Pacific Islanders, and Chinese account for just over 5%. With the exception of Indo-Fijians, Polynesians and Micronesians tend to live outside their place of origin more often than Melanesians and are represented in higher numbers in migrant statistics.

Contemporary Immigration Patterns

Contemporary Pacific Island migration has tended to follow patterns of historical and political affiliations. Indigenous Melanesian people thus tend to move to Australia or Papua New Guinea rather than North America. Polynesians frequently migrate to New Zealand, America, and to a lesser degree Australia. Micronesians and Hawaiians tend to migrate primarily to the USA. Indo-Fijian people tend to disperse more widely to commonwealth countries and North America.

Of the destination countries, New Zealand provides the most comprehensive census data. In 2006, Pacific Island ethnic groups totaled 265,974 people representing 6.9% of the total New Zealand population. The Pacific Island population grew by over 30,000 (14.7%) from 2001until 2006, which reflected increases in immigration as well as the highest birth rate of all of the major ethnic groups, at 37.7%. Samoan, Cook Islands, Tongan, and Tokelau and Niuean people comprised the overwhelming majority. Although relatively smaller in numbers, Fijians migrants also grew by 40% to 9,864.

The 2001 Australian census found just over 2% of the population identified as Aboriginal or Torres Strait Islander, although the indigenous population has since increased by 11% (45,000 persons) to 455,031. Eighty-six per cent of the 2001 population were Australian citizens with England (4.3%) and New Zealand (2%) being the next highest groups. The largest Polynesian group that lives in Australia is the New Zealand Maori. Although other Polynesian communities do exist, particularly in New South Wales, they are relatively small.

In 2000 the US Census Bureau recorded over 800,000 Pacific Islanders living there. Most identified as Native Hawaiian. The rest were referred to as other Pacific Islanders and included Samoans, Tongans, Chamorros, and Guamanians.

Migration therefore continues to be prevalent throughout the Pacific exemplified by Samoa where the majority of ethnic Samoans now reside in other countries. In 2006 there were estimated to be 188,000 Samoans living in Samoa, in 115,000 New Zealand in New Zealand, 70,000 in the USA and some 40,000 in Australia.

Politics and Finance

Sovereign Pacific nation states include Australia, the Federated States of Micronesia, Fiji, Indonesia, Kiribati, Marshall Islands, Nauru, New Zealand, Palau, Papua New Guinea, Samoa, Solomon Islands, Tonga, Tuvalu, and Vanuatu.

Dependencies and other territories are administered by Australia (Christmas Island, Cocos Islands, Norfolk Island), Chile (Easter Island), Fiji (Rotuma), France (French Polynesia, New Caledonia, Wallis and Futuna), New Zealand (Cook Islands, Niue, Tokelau), the United Kingdom (Pitcairn Islands), and the USA (American Samoa, Guam, Hawaii, Northern Mariana Islands, US Minor Islands).

Smaller Pacific nations rely heavily for aid and development money from the larger states. Educational systems, currency, and health exchange schemes are often shared reflecting these relationships. In addition to foreign aid, remittances provide an indispensible source of foreign currency for small Pacific Island economies. Money and goods earned by family members in other countries are sent back to the Islands and can lead to increased development funding and better qualities of life for Island inhabitants.

Recent decades have seen the establishment of a number of regional trade, health and migration forums to collectively face the needs of the Pacific peoples. At a national level, New Zealand established a separate Ministry of Pacific Island Affairs in the 1980s. Australia has had an Ethnic Affairs Commission since 1977; however, it has no specific policies for different ethnic groups. These have served as initiative to improve communication between these countries and their Pacific neighbors.

Health and Welfare

There have been sporadic implementations of health programs through the Pacific Islands including immunization and sanitation. However, as different colonial powers have withdrawn their interests, these health systems have failed to be sustained. As a result, there are relatively impoverished health services in many of the Pacific Islands.

The major health problems among Pacific Islanders living in other countries are diseases of modernization and relate primarily to obesity. These include cardiovascular disease, diabetes mellitus (type II), and high cholesterol. This in large part relates to changes in diet, food production, and food distribution. Processed foods have for example now replaced tradition food gathering sources.

Pacific Island immigrants are also overrepresented in certain socioeconomic indices and mental health statistics. They have high rates of alcohol and drug problems and problem gambling is also increasing. They often experience poor housing conditions, unemployment, and domestic violence. Access to health and social resources can also be a barrier to receiving appropriate care and support. New Zealand in particular has made significant efforts to develop parallel cultural health and mental health services to meet this need.

It is thus encouraging that statistics suggest the children of Pacific Island migrants born and raised in their new culture do better in terms of qualifications and skilled jobs than their parents and grandparents.

Discussion

Migration has always played a key role in the development and formation of the social and cultural organization in the Pacific region. It has occurred for thousands of years in response to limited resources and population pressures. Strong kinship ties have, however, resulted in robust trading and political relationships between the Islands and provided a means of cultural cross-pollination.

Contemporary migration continues to be driven by the promise of better educational and employment opportunities abroad. To the extent that these promises are fulfilled, financial and cultural remittances continue to return to the extended family members who remain behind.

Looking to the future, one can only see rates of Pacific Island migration increasing. In a world moving toward globalization, there will be greater demand for the wealth and trappings of the Western lifestyle. Environmental change is also emerging as a new threat that could displace large numbers of Pacific Island people and dramatically change migration patterns. As birthrates of Pacific Islanders continue to increase nationally and internationally, it behooves the larger and more powerful Pacific partners to be responsive to the needs of these migrant groups.

The history of the Pacific Islands and its diverse peoples is nevertheless a common history and regional kinship and political ties remain strong. The future of the smaller and more vulnerable nations and the health of its people will therefore depend on the collective and coordinated responses and interventions of the wider Pacific region to ensure that current and future generations have access to international standards of education to compete on the global stage.

Related Topics

- ► Asia
- ► Australia

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Useful sources on Pacific development (literature and organizations). http://www.hawaii.edu/cpis/psi/anthro/pac_dev/Pac_Dev7.html.

Padrino

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Padrino, or compadre, are the Spanish terms for godfather; madrina, comadre, and padrina refer to a godmother. Compadrazgo, and the related comadrismo, designate Latin American kinship arrangements, duties, and expectations of godparents in a ritualized communal relationship that preserves and bolsters gender and familial structures, while also providing a socioeconomic mode of support beyond the extended family. Conventionally across the Americas, children baptized in the Catholic Church are given a madrina and padrino, the roles coming with mutual obligations and responsibilities to assist parents in raising the godchild, contributing funds to pay for baptisms, quinceañeras (15th birthday parties for girls), graduations, and weddings and, in the event of death of the parents, raising the children. Moreover, in Latin America, a padrino (or compe or compadre) may be an address of familiarity, like buck, pal, or mate. At times, a padrino can be the main force in fraternal relationships in a system that binds men in neighborhoods, communities, gangs, or enterprises in fictive kinship arrangements.

Given its place in a cultural system based on notions of mutual respect (respeto) and strong family values (familismo), the padrino role has many implications for health and medical policy, work, treatment, and support involving Latin Americans, and Latinos and Latin American immigrants in countries such as the USA and Canada, particularly when families are distanced from their home communities. Throughout Latin America, relations with medical authorities are often a collective or communal affair involving direct and extended family members, padrinos and comadres, and other family associates. Many children may have more than one padrino and comadre, with different roles. Health practitioners in the Spanish-speaking Americas may be aware of, and thus account for, these arrangements due to cultural familiarity.

The padrino is a particularly crucial support role when parents are away from direct family. He may take a leading role both supporting and liaising with absent parents, and in making or being involved in key family decisions about the medical care given to godchildren, including their access to health services, their general treatment and welfare, prognoses of survival in instances of serious illness or accidents, and procedures with regards to dying or deceased patients. As with the traditional father, the padrino figure also plays a role in upholding family honor, a duty that may involve being a provider for the family, for instance, if the family male head is ill or incapacitated. Circumstances such as these ones, often oblige the padrino to make considerable sacrifices of money and offer additional support to godchildren and their parents, including paying for medical treatments and other costs. Even when physically absent, the padrino may be involved in medical discussions via technologies such as the Internet and cellular phones.

Godparenting among Latinos and Latin American migrants may not be understood by medical practitioners in the USA, or in Canada. Such practitioners may need to adjust their conventional thinking that only closely related family members are entitled to be involved in discussions about medical issues involving non-related people. Medical practitioners also need to be aware that in many countries, including the USA, the issue of undocumented immigration can present numerous obstacles to medical systems attempting to deal with patients who may be classified as “illegal” by legal authorities. Godparents, rather than direct family, may in such instances be more willing to liaise with medical authorities and deal with health care systems as a means of protecting the parents or children involved if designated “illegal” and thus potentially subject to deportation.

Related Topics

- ► Compadrazgo
- ► Familismo
- ► Family
- ► Hispanics
- ► Illegal immigration
- ► Immigrant health disparities
- ► Immigration status
- ► Latinos
- ► Machismo/Macho
- ► Respeto

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Pain

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Pain is a symptom that has wide ranging causes, origins, and widely differing experiences in all populations, including immigrant populations. The causes, diagnosis, treatment, and management of pain in immigrant populations have some special characteristics for practitioners to consider.

Causes of Pain

Pain can be caused by physical and psychological experiences, and is often a mix of both. Immigrant populations frequently experience enormous stress as a result of the reasons underlying their departure from their country of origin, the stress of living in a new culture where they may or may not be fluent in the language and customs, and the limited employment opportunities immigrants often have, which are often jobs that involve a lot of physical and emotional stress, and little leisure. Undocumented immigrants experience all of these stressors more acutely as their concern over state interference in their lives can have even more dire consequences. Leaving a country of origin because of oppressive circumstances can lead to extraordinary pain not only in the form of headache, but also in the form of physical pain, including conditions like fibromyalgia, chronic back pain, and other forms of muscle and skeletal pain. In addition, the stress of living in a new culture – negotiating systems of health care, state registrations, and the immigration system in general can be an additional stress, leading to conditions such as high blood pressure, headache and migraine, and physical pain. In addition, immigrants may perceive state authority as suspicious, and be reluctant to reach out for assistance with pain. Additionally, if immigrant populations are not from countries where chronic pain is regularly treated, they may not seek out treatment for chronic pain, potentially leading to worse pain by the time they access a health care provider. Immigrants that do not speak the language of their new country of residence may be limited to employment that is taxing to the body – such as day labor, nail salon work, garment work, or other forms of physically taxing and potentially physically dangerous work that can lead to muscle strain, broken bones, burns, and other forms of injury. These risks are greater in undocumented immigrant populations, who may not have a choice in their work, and who may not feel that violations of their rights will be taken seriously by reporting authorities. Additionally, undocumented immigrants may be suspicious of the interaction between health care systems and immigration authorities, so may be unwilling to seek care except for in the most extreme circumstances – this can lead to problems with pain becoming worse for lack of treatment. In addition, living with chronic pain or injury is psychologically taxing, and thus immigrant patients with chronic pain may have their conditioned worsened by the toll that chronic pain can take on a person.

Diagnosis of Pain

The International Association for the Study of Pain (IASP) established a committee in the 1980s to attempt the arduous task of a chronic pain classification. They defined pain as “an unpleasant sensory and emotional experience,” and devised a scheme that codes pain disorders along the following six categories: region involved, systems involved, temporal characteristics, degree of intensity, time since onset, and etiology (origin).

Pain is diagnosed by patient reports, physical exam, and by diagnostic testing, including x-ray, MRI, and CT scan. Pain is often classified as acute or chronic pain. Acute pain is often from injury, accidents, movement, or rupture. Chronic pain can happen in many conditions, including cancer, neurological conditions, rheumatic conditions, and from unknown sources. Patient reports are often inaccurate in immigrant populations as nonnative speakers of a language may be unfamiliar with the typical terms used to describe pain states, and thus interviews can lead to miscommunication. In addition, people from different cultures can have different explanations for the causes and experiences of pain, so immigrants may have difficulty expressing themselves in ways that health care providers in their country of residence understand, and this may lead to mismanagement of pain. If health care provider and immigrant do not speak the same language, this leads to further difficulty, and often under-treatment of the pain the patient is experiencing. Physical exams are also used to diagnose pain – in these, the health care provider attempts to move the patient’s body (or have the patient move their body) in ways that can convey the nature of an injury. If a physical exam is inconclusive, or the patient is having difficulty expressing the impact of the physical exam on his or her body, the physician may decide that the patient is “drug seeking” or not really in pain. This is another reason why the pain of immigrants may go untreated. Various forms of imaging (x-ray, magnetic resonance imaging, and computerized tomography) are used to diagnose the exact origins of pain, but these examinations are often expensive, so depending on the resources of the health care system and the country in which the patient is located, it may or may not be done. In addition, the source of chronic pain is often not seen on any of these kinds of scans, and thus patients may have a difficult time being treated for pain that they are experiencing.

Treatment and Management of Pain

Immigrants may wish to manage their pain with traditional medicine from their cultures of origin and may not disclose to hospitals and other parts of the health care system that they are utilizing these strategies. Additionally, health care providers in the host country may be unfamiliar with the traditional practices in the culture of origin of their patients, so they may not ask questions that would lead a patient to answer about traditional medical practices. This can cause problems as all medicines can have both side effects and interactions, and so this miscommunication can lead to poor health outcomes in patients.

Many medications are used to treat pain, including nonsteroidal anti-inflammatory drugs (NSAIDs) such as aspirin, ibuprofen, and acetaminophen. Additionally, opiate drugs like codeine, morphine, fentanyl, and hydromorphone are used to treat more severe pain. There are also "non-opiate" painkillers such as tramadol, which have similar strength to opiate drugs, but have fewer of the side effects of opiate drugs. Each of these drugs has side effects – the most notable from NSAIDs being bleeding in the digestive tract, and the most notable for opiates being drug addiction. The issue of drug addiction to pain medication is believed to be one of the reasons for so-called "pain disparities," which are the differences in pain treatment based on race, class, or sex of individuals suffering from pain conditions. These pain disparities also affect immigrants, who face cultural and language differences in pain treatment, and thus may receive inappropriate or incomplete care from practitioners.

Though the prevalence of pain and pain disorders is high in immigrant populations due to work conditions, psychological factors, and lack of access to health care, its diagnosis and treatment do not adequately address this need. Persons working with immigrants should ask regular and culturally appropriate questions regarding pain, and help immigrant persons advocate for effective treatments for their pain conditions.

Related Topics

- ► Addiction and substance abuse
- ► Alternative and complementary medicine
- ► Back pain
- ► Chronic pain
- ► Prescription drug use
- ► Substance use

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Pakistan

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Background Information

Pakistan is located in southern Asia. Its immediate neighbors are India to the East, Iran and Afghanistan to the West, and a small common border with China in the Northeast. In the south, it is bordered by the Arabian Sea. It covers 307,374 mi^2. Though there has not been an official census since 1998, the estimated population in 2010 is 169,000,000. Pakistan is divided into four provinces – Sindh, Punjab, Balochistan, and Khyber-Pukhtoonkhwa (formerly called the North West Frontier Province). Also, it controls what is called Pakistan-Administered Kashmir of the disputed region of Kashmir. There are Federally Administered Tribal Areas (FATA) as well as Provinicially Administered Tribal areas (PATA) also, where, traditionally, the government exercises little control, and the local tribes run themselves fairly autonomously.

Nation's History

Pakistan achieved its formal independence on the August 14, 1947, when Britain divided the Indian subcontinent into Hindu-majority India and Muslim-majority Pakistan. Referred to as Partition, this has been considered the greatest exchange of populations in history, as many Muslims left the territory that was to become India; and, similarly, many Hindus left the territory that was to be Pakistan. Over 1,000,000 people are presumed to have lost their lives in this process as mobs attacked the vacating populations. Pakistan was initially composed of two wings, West Pakistan and East Pakistan – however, following a civil war in December 1971, East Pakistan became Bangladesh and West Pakistan was known simply as Pakistan.

Culture and Language

Ninety-five percent of Pakistan's population are practicing Muslims; after Indonesia, Pakistan is the second most populous Muslim-majority country in the world.

The remaining 5% of the populace are mainly Hindu and Christian, with smaller numbers of other religions such as Sikhs and Parsees. The majority of Pakistanis are Sunni Muslims. The capital of Pakistan is Islamabad, and the largest city and major port is the city of Karachi in the south – in the province of Sindh. Karachi's population is estimated to be 20 million. The city of Lahore in the Punjab is acknowledged generally as the cultural center of Pakistan.

The national language of Pakistan is Urdu, which is written in Arabic script. Urdu and Hindi, used in India, are very similar spoken languages, except that the latter is written in Sanskrit script and that there are differences in formal vocabulary. An Urdu speaker and a Hindi speaker, however, should be able to communicate without too much difficulty. English remains the major language of government and business. In addition, each province has its own regional language with numerous regional dialects.

Political History

Pakistan's history has remained tumultuous and violent. It includes several wars with India, a civil war in 1971, being a frontline state against the Soviet Union and its Afghan proxies in the cold war, and three bloodless military coups. It is formally a parliamentary democracy, with the President as Head of State and the Prime Minister as the Head of Government. However, there have been many times when the Prime Minister was more ceremonial, with the President wielding the true powers of government.

At this time, Pakistan is fighting several groups of militants led by Islamic extremists in the tribal regions; this has led to large numbers of internally displaced refugees fleeing the fighting. Pakistan continues to host close to 2,000,000 refugees from Afghanistan who fled the Soviet invasion in the 1980s. At one time, this number peaked at nearly 5,000,000 refugees.

Economy

Historically, Pakistan's economy has been agriculture based with its major exports being textiles and leather products and agricultural produce; however, official statistics suggest that the service sector, which includes transportation, retail trade, communications, and financial services, made up 53% of the economy.

Emigration

Pakistanis have migrated to many parts of the world. In the 2005 US Census, it was estimated that there were 210,000 Pakistanis in the USA. In 2009, the Institute of Developing Economies reported that there were around 4,000,000 overseas Pakistanis – about one half were in the Middle East, with 800,000 in the UK; 600,000 in the USA; and 250,000 in Canada. Pakistani emigration was mainly to the UK until the 1960s, after which the USA became a preferred destination. The majority of immigrants to the Middle East and the UK were of lower socioeconomic status; this is true especially of immigrants to the Middle East who settled and found manual labor jobs. Conversely, initial emigration to the USA was mainly of professionals such as doctors and engineers, although a wave of blue-collar workers followed in the 1980s and 1990s. The majority of Pakistani immigrants to the USA are based in the New York – New Jersey metropolitan area. The numbers of immigrants from Pakistan to the USA has dropped markedly after the September 11, 2001 attacks.

Emigrants and the Pakistani Economy

Pakistani expatriates have played an important role in Pakistan's development, thanks to remittances they have sent back. Undoubtedly a significant source of motivation for the laborers who immigrated to the Middle East and were met frequently with deplorable working conditions, the money sent back to Pakistan allowed many families to improve their economic standing. Many Pakistani expatriates used the informal banking sector to send money back. However, due to crackdowns after the attack on the World Trade Centers on September 11, 2001, more people have begun using authorized banking routes, which has further benefited the general economy.

Health Statistics

Pakistan's major burden of disease remains communicable illnesses. The most common cause of death is lower respiratory infections, pneumonias, followed by ischemic heart disease and diarrheal-related illness. Life expectancy is 62 years for men and 63 years for women, while the mortality rate for those under 5 is 89 per 1,000 live births. Chiefly contributing to the mortality rate in those under 5 is neonatal causes, of which, neonatal infection is the highest subgroup. Although polio has not been eradicated from Pakistan, the reported number of cases has dropped from 1,100 in 1997 to 118 in 2008.

It remains difficult to properly assess burdens of disease in Pakistan as much research is lacking or out of date. An estimate of the prevalence of diabetes done in the 1990s suggested that 12% of the population older than 25 had diabetes and another 10% had impaired glucose tolerance, while central obesity was the most common risk factor, with Type 1 diabetes being relatively rare. The World Health Organization (WHO) lists Pakistan in the top-ten countries with diabetes.

Further information on the health statistics of Pakistanis yields information on cigarette smoking, HIV, and the use of alternative medicine. The prevalence of cigarette smoking is estimated at 19.4% in adults over the age of 15. HIV is concentrated among IV drug users and male sex workers. Actual surveillance data suggests that there may be 40,000–45,000 HIV cases in Pakistan, though other estimates have gone as high as 80,000.

There is a notably high use of alternative medicine as 70–80% of Pakistanis use it to some degree. Often these healers are the first to be sought in cases of sexual dysfunction, epilepsy, psychiatric issues, chest and stomach disorders. There is a prevalent use of medicinal plants in what is referred to as the "Unani" (Grecian) tradition. Due to a combination of affordability, accessibility, and societal preferences, traditional healers often are the major source of medical care in the rural community. Faith healers are also often sought, especially as a treatment for mental illness. They provide prayers and talismans against possession and magical practices such as the "evil eye." Despite the generally religiously conservative beliefs of people, shrines of saints are also popular places where people go to pray for relief from medical problems, as well as for other issues.

Cultural Issues

In terms of culture, Pakistanis tend to be conservative, and many first- or second-generation immigrants will try to maintain the cultural mores to which they were accustomed. Concerning health care, female patients may be reluctant to be examined by male physicians, and, in some cases, they may be forbidden by their male family members to be seen by a male doctor. Similarly, male patients may be reluctant to be evaluated by a female doctor.

Religion is very important for most Pakistanis. Often they feel a deep affinity for Islam and Muslims around the world. Consequently, frequently they will have strong feelings toward perceived injustices against Muslims.

Related Topics

- ► Bangladesh
- ► Cultural background
- ► India
- ► Islam
- ► Mental health
- ► Muslim
- ► War-affected children

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Palestine

- ► Islam
- ► Muslim

Pandemic

- ▶ Infectious diseases
- ▶ International Health Regulations
- ▶ Quarantine

Panel Physician

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The US Immigration and Nationality Act (INA) mandates that all immigrants and refugees migrating to the USA undergo an overseas medical screening examination. A panel physician is a medically trained, licensed, and experienced physician practicing overseas, who is appointed by the local visa-issuing US Embassy or Consulate to conduct these examinations. Worldwide, over 675 panel physicians perform the overseas medical examinations required for US-bound immigrants and refugees. The US Centers for Disease Control and Prevention (CDC) is responsible for providing the medical screening guidelines (referred to as technical instructions) to the panel physicians in performing the overseas medical screening examination. Through its Quality Assessment Program, CDC also monitors the quality of the overseas medical examination process.

The mandated medical examination focuses primarily on determining any inadmissible condition for the purposes of visa eligibility and of preventing the importation of a "communicable disease of public health importance." These medical conditions include infectious diseases such as tuberculosis (TB), syphilis, chancroid, gonorrhea, granuloma inguinale, lymphogranuloma venereum, and Hansen's disease (leprosy); mental disorders associated with harmful behavior; and substance abuse or addiction. On October 6, 2008, CDC amended the regulations that govern the required overseas medical examination for immigrants and refugees to include the following additional disease categories: (1) diseases subject to federal quarantine authority, as designated by Presidential Executive Order and (2) diseases that meet the criteria of a public health emergency of international concern, which requires notification to the World Health Organization under the revised International Health Regulations of 2005. CDC also amended the provisions that describe the scope of the medical examination by incorporating a more flexible, risk-based approach based on medical and epidemiologic factors. This approach will determine which diseases are included in the medical screening and testing of immigrants and refugees in areas of the world that are experiencing outbreaks of specific diseases.

Panel physicians must follow specific identification procedures to ensure that the person appearing for the medical examination is the person who is actually applying for the visa. The panel physician makes local arrangements for any radiologic and laboratory examinations required as part of the medical examination. The panel physician is responsible for the entire examination and also for reporting the results of all required tests and consultations on the US Department of State forms and for ensuring that the completed medical report forms are sent directly to the consular officer. The US Department of State sponsors refugees, but immigrants pay for their own medical examinations.

For the purposes of determining the inadmissibility of an applicant, medical conditions are categorized as Class A or B. Class A conditions are defined as those that preclude an immigrant or refugee from entering the USA. Class B conditions are defined as physical or mental abnormalities, diseases, or disabilities serious enough or permanent in nature, as to amount to a substantial departure from normal well-being. If an immigrant or refugee is found to have a Class A condition, a visa may still be issued after the illness has been adequately treated or after a waiver of the visa ineligibility has been approved by the US Citizenship and Immigration Service. Immigrants and refugees found to have a class B condition are not precluded from entering the USA.

Through the web-based Electronic Disease Notification (EDN) system, CDC electronically notifies the receiving health departments of all arriving refugees and of immigrants with Class A conditions (with waiver) or Class B TB conditions who are resettling in their jurisdiction and need follow-up evaluation and possible treatment. Health department physicians are asked to conduct post-arrival follow-up evaluation of newly arrived immigrants and refugees with Class A TB conditions (with waiver) or Class B TB conditions and report the results to CDC.

Canada, the United Kingdom, Australia, and many other countries also require immigrants and refugees to undergo medical examinations before their arrival. Like the USA, many of these countries appoint local licensed physicians to perform the examinations.

Related Topics

► Acquired immune deficiency syndrome
► Communicable disease of public health significance
► Immigrant visa status
► Immigration processes and health in the U.S.: A brief history
► Medical examination (for immigration)
► Sexually transmitted diseases
► Syphilis
► Tuberculosis

Suggested Readings

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Pap Test

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Cervical cancer is defined by the National Cancer Institute (NCI) as a disease in which cancer cells develop slowly over time in the cervix, becoming more abnormal by a process called dysplasia. The degree of cellular abnormality determines the need for treatment. In the absence of appropriate treatment, dysplasia will progress to cervical cancer over several years. The most common cause of cervical cancer is infection of the cervix with the human papillomavirus (HPV). There are more than 80 types of HPV, with 30 types that can infect the cervix, half of which have been linked to cervical cancer, and are mostly spread through sexual contact. The Pap test has been shown to detect human papillomavirus, abnormal or precancerous cells, as well as cervical cancer lesions.

Among the risk factors for cervical cancer are: HPV infection, smoking, high number of full-term pregnancies, and long-term use of oral contraceptives. Women who are sexually active at a young age or have many sexual partners are at a higher risk of developing HPV, which can progress to cervical cancer. In women who are infected with HPV, dysplasia and invasive cancer occurs two or three times more often in current and former smokers than nonsmokers. Women who have had seven or more full-term pregnancies may have an increased risk of cervical cancer. Finally, women who have used oral contraceptives for 5 years or more have a higher risk of developing cervical cancer compared to women who have never used oral contraceptives with the risk increasing after 10 years of use.

According to the NCI's recent guidelines, cervical cancer screening is not beneficial for women younger than 21 years of age, women who do not have a cervix as a result of a hysterectomy for a benign condition, and for women who are older than 60 years of age with a history of recent negative tests. As cervical cancer is slow growing, women with a consistently negative screen, require testing once every 3 years. Yearly screenings are still the recommendation for women with a history of positive Pap tests.

Epidemiology

The US age-adjusted death rate between 2002 and 2006 was 2.5 per 100,000 women. Approximately 1 in 145 women will be diagnosed with cervical cancer in their lifetime. The greatest burden of cervical cancer is found among underserved, resource-poor populations as 80% of all new diagnoses and related mortality occur in this population. The National Institutes of Health (NIH) estimates that half of the women who receive a cervical cancer diagnosis have never been screened for cervical cancer. An additional 10% had not been screened in the previous 5 years.

More than half of cervical cancer deaths in the USA have been reported to occur in foreign-born women. These groups represent vastly diverse national, linguistic, racial, cultural, and religious backgrounds, and are more likely to lack health insurance, have less timely contact with the health care system, and have a host of socio-demographic and health access barriers to healthcare. Based on the NCI's Surveillance Epidemiology and End Results (SEER) cancer statistics, the age-adjusted incidence rate for cervical cancer was 8.2 per 100,000 women per year between 2002 and 2006. The median age for diagnosis of cervical cancer in the same period was 48 years. Approximately, 0.2% of the cases were diagnosed in women under the age of 20, while 14.9% were diagnosed between the ages of 20 and 34. The highest cervical cancer incidence was 26.2% between the ages of 35 and 44, and 23.5% between 45 and 54. The incidence of cervical cancer during this period decreased with advancing age with the rate dropping to 15.8% between age 55 and 64; 10.4% between 65 and 74; 6.6% between 75 and 84; and 2.5% in women 85 years of age and older. The incidence rates by ethnicity in the same period demonstrated that Hispanic women had the highest incidence at 12.7 per 100,000 women, followed by Blacks at 10.4 per 100,000 women. The rate for White women was 8.1 per 100,000 women, while 7.6 per 100,000 women among Asian/Pacific Islanders. American Indian/Alaskan Native women had the lowest rate at 7.2 per 100,000 women.

Worldwide, cervical cancer accounts for approximately 10% of all cancers, and is one of the three main female cancers, accounting for over 370,000 new cases of cancer each year. In mainland China, invasive cervical cancer is the second leading cause of cancer death with Chinese immigrant women in the USA demonstrating a higher rate (12.3 per 100,000 cases) of cervical cancer compared with 7.2 per 100,000 for non-Hispanic White women.

Barriers to Cervical Cancer Screening

Regular pelvic exams and Pap tests can detect abnormal cells in the cervix before cancer can develop. However, among immigrants and ethnic minorities, there are barriers to screening that result in a higher incidence of cervical cancer morbidity and mortality in these populations.

Barriers to Pap Screening Among Hispanic Immigrants

Among Hispanic women, perceived barriers to Pap testing in the USA includes: threatened virginity, embarrassment, fatalism, distrust of health system, fear of pain, fear of diagnosis, lack of physician referral, presence of male health care provider, and difficulty finding qualified interpreters. Other barriers include: lack of general knowledge about cervical cancer and Pap testing; as well as the perception that Pap tests are unnecessary unless when one is ill.

Inadequate functional health literacy in Spanish is another barrier to screening among Hispanic women as nearly half of a study population would experience difficulty interpreting written materials even in Spanish. When compared with those with adequate and marginal literacy, Hispanic women with inadequate functional literacy in Spanish were significantly less likely to have ever had a Pap test even when controlled for other socio-demographic factors.

Barriers to Pap Screening Among Asian Immigrants

Among Asian immigrant women, similar barriers to cervical cancer screening were found as in other immigrant groups. Sociocultural beliefs, lack of knowledge about the disease process and Pap testing, language barriers, low acculturation levels, and lack of physician referrals were found to be barriers to screening. The stigma of cancer, lack of familiarity with Western medicine, and use of traditional health practices are also concerns. A study among Asian Canadian immigrant and nonimmigrant women demonstrated that Asian immigrant women had a significantly lower rate of Pap testing (52%) compared to the nonimmigrant population (72%). The barriers to screening were a lack of time and lack of necessity of testing.

Barriers to Pap Screening Among African and Caribbean Immigrants

There is a dearth of available literature on Pap testing and cervical cancer among African and Caribbean immigrant women. One reason for the lack of representation among these groups is the failure to distinguish the various ethnic groups that comprise the general umbrella of the term African-American. Administrative barriers to screening such as long wait times, scheduling delays, limited availability of physicians, as well as poor patient communication skills, perceptions of racism, and lack of family/community support, have been noted among African-American as well as Caribbean immigrant women.

Implications

Although there are general similarities in the challenges and barriers to Pap testing across immigrant and ethnic minorities, there also exist many unique factors within each group that prevent them from accessing appropriate cervical cancer screening. For any intervention to be effective in raising awareness and access to screening, it must first take into consideration the unique needs of each group. It is evident that the education and health promotion strategies common in Western constructs of care may not be adequate in these populations. Programs that have been shown to have the greatest effectiveness are those that incorporate the sociocultural context and other unique characteristics of each of these groups in their practice models.

Language barriers, lack of knowledge of the health care system, and lack of provider/physician recommendation are common across immigrant groups. Health care policy makers must formulate policies to improve cervical cancer screening that reflect an attention to reducing these barriers. Likewise, health care providers caring for immigrants and ethnic minorities should reinforce their recommendations for screening and Pap smear referrals among their patients as well as take a partnered approach in engaging directly with communities in further outreach and education.

Future Directions

Targeting immigrant and ethnic minority women with population-based programs has been shown to increase overall cervical cancer screening rates. Access to screening can be improved by eliminating or reducing out-of-pocket payments and removing geographical barriers. The best strategies to improve adherence in populations where it has previously been low are: to have organized programs where free tests are available, facilitate appointments, arrange transportation, and as much is feasible, tailor each program to the specific cultural/ethnic identity of the target population(s).

HPV vaccines have been shown to not only prevent infections with the virus, but it also reduces cervical malignancies. Policymakers should consider parental acceptability of HPV vaccines when strategizing improved vaccination campaigns. Parental acceptability and attitude toward HPV vaccination has more to do with parental beliefs and general discomfort about the vaccines rather than lack of knowledge about the vaccines. Another factor that affects parental acceptability is the age of the child, as the greater the proposed vaccination age, the greater the parental acceptability. Further research is needed to address barriers to screening in African and Caribbean immigrant communities as these communities continue to increase in the USA due to the recent influx of immigrants and refugees from war-torn regions of the world. In addition, interventional programs should utilize the available research among Hispanic and Asian communities to design programs that target the eradication of barriers to screening and increase access to Pap testing among these groups.

Related Topics

- ▶ Cancer health disparities
- ▶ Cancer incidence
- ▶ Cancer mortality
- ▶ Cancer prevention
- ▶ Cancer screening

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Parasitic Infections

- ▶ Intestinal parasites

Patient Satisfaction

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Patients' perspectives regarding the quality of healthcare provided have been considered an important indicator for health service quality, including patient satisfaction.

Avedis Donabedian, a pioneer in public health and proponent of quality assessment, believed quality of care could be evaluated based on three criteria: structure, process, and outcomes. Namely, researchers should focus on environmental attributes (i.e., material and human resources), how and what things are done (i.e., diagnoses and treatments), and the effects on patient satisfaction and health status to determine quality (i.e., health status and patient satisfaction). Structure tends to be the major cause of quality of care, while a process provides judgments about the relationship between process and outcome. Finally, outcome is considered because, according to physicians, patients' health and well-being are the most desired outcome. However, outcome has the advantage of showing the quality of the patient's treatment as well as the skill with which the care was given. Also, patients are able to evaluate many outcomes, allowing them to evaluate the quality of care they have received.

He also noted that patient care has technical and interpersonal factors. In particular, quality services are the degree to which patient care increases the likelihood of desirable outcomes and reduces the likelihood of undesirable outcomes.

Patient satisfaction often is measured to improve service efforts, fulfill accreditation requirements of health plans, receive reimbursement from the government agencies, and calculate financial bonuses for doctors. For example, surveys may be used to identify areas of weakness and to make necessary changes, such as adjusting patient appointment patterns for more effective scheduling and developing new policies. Physicians also may use this information to help negotiate third-party contracts, measure specific initiatives, train staff, and increase employee morale. In a competitive healthcare environment, marketing surveys help provide insight into patient expectations and the demands for services. Organizations and providers, who utilize these results to improve care, maintain a competitive position in the marketplace. Differences in measurement tools, however, are a barrier in making patient satisfaction a reliable benchmark. Patient satisfaction data typically is collected by various organizations, for different purposes, and at different levels in the healthcare system. With the recent launch of the hospital report card initiative by the Department of Health and Human Services, efforts have begun to bring consistency to measuring patient satisfaction at healthcare centers.

Patient satisfaction also is an important index because patients use services continuously, recommend healthcare services to others, and comply much more readily with physicians' recommendations. Low patient satisfaction is associated with lower trust in caregivers and greater chance of a change of health providers, resulting in less continuity of care. Furthermore, low patient satisfaction also is associated with a greater number of patient complaints and malpractice lawsuits.

Satisfaction is related to the overall effectiveness of communication between physicians and patients. Studies have indicated that empathy and patient-centeredness during consultations, for example, increased patient satisfaction and better compliance with healthcare provider recommendations. Noncompliance toward healthcare services is attributed to a lack of intimate and effective communication between the patients and physicians. Therefore, teaching and assessing communication skills are critical components in health professionals education designed to improve the communication knowledge and skills of health providers. .

Complaints in healthcare settings are two times more likely to be related to communication problems than to medical techniques. Additionally, higher patient trust and satisfaction occurs when a healthcare receiver is more involved in his or her treatment.

Further, an increased focus on enhancing relationships with patients also can result in a reduction in medical errors because patients are more comfortable asking about their medications and treatment.

Immigrants have specific needs that influence their perception of a satisfactory experience. Availability of translators, providers who understand their culture and language, systems that account for their family members, food preferences and health beliefs may be central to them having a satisfactory experience. Immigrants may be reluctant to respond to efforts to assess their satisfaction if they perceive a language barrier or fear consequences (such as deportation or discrimination) to their responses. Therefore, determination of patient satisfaction in immigrant populations must include culturally sensitive queries and appropriate quality benchmarks.

Related Topics

- ► Access to care
- ► Communication barriers
- ► Health care
- ► Hospitalization
- ► Physician–patient communication

Suggested Readings

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Pediatrics

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Children of all ages migrate across the globe. Exact numbers are unknown, but there are estimated to be at least 20 million migrant children worldwide. The United States is the top destination country for all immigrants. This encyclopedic entry will address the issues pertaining to child migrants around the world and focus specifically on those children entering the United States. It will include children migrating with their families, refugees, international adoptees, and children and adolescents traveling alone. In this entry, migrant children in the United State will include U.S.-born children living in families with immigrant and undocumented parents. These children face many of the same issues as non-US-born children.

Demographics

Seventy million children live in the United States today; 2.3 million were born outside of the United States to foreign-born parents, and 13.9 million were born in the United States to foreign-born parents. One in five children in the United States lives in a family in which at least one parent is an immigrant. Today, the majority of immigrants to the United States come from Latin America and Asia. In addition, each year, US families adopt more than 20,000 children internationally. Very few statistics regarding child immigration in countries outside the United States are available. However, one study conducted by UNICEF in the UK reports 4,285 unaccompanied children entered that country in the year 2008 alone.

Children migrate both with their families and independently. Children under the age of 18 years migrate without their parents for a variety of reasons, including fleeing their own families, fleeing war or political upheaval, natural disasters, extreme poverty, and escape from forced labor. Many are victims of human trafficking. Still others are sent by their families to initiate networks for other arrivals, to be cared for by other families, or to receive education. Several thousand adolescents immigrate to the United States unaccompanied each year. In 2008, over 8,000 unaccompanied immigrant children were taken into custody by United States immigration authorities.

Although not technically immigrants, over three million children come to the United States each year as temporary visitors, usually accompanying their parents who may be temporary workers, diplomats, or students. A portion of these children are exchange students traveling alone. A small segment of US immigrant families with children are educated, financially stable, and coming from a market economy. This group of children typically has very few health problems on arrival to their new country. However, some of these children may have medical issues similar to those of immigrants. Several thousand children travel each year to the United States through various humanitarian organizations in order to receive medical care for various congenital defects, cancer treatment, and rehabilitation. Some stay with foster families for several years while receiving care.

Civil Rights

Migrant children around the world are at a high risk of being abused and being denied basic rights. They are forced into child labor and early marriage. They may become victims of violence, neglect, and exploitation. While the United States grants automatic citizenship to anyone born on its soil, this is not the case around the world. Depending on the country's laws and particular circumstances of the parents' citizenship and nationality, it is possible for a child to be born and there be no official registration of birth and the child to be without citizenship anywhere. These children are essentially "stateless" and cannot claim the rights or protections that come with citizenship.

The number of unaccompanied minors immigrating to Europe rose 40% from 2007 to 2008. In 2008, unaccompanied minors in 22 European states filed 11,000 requests for asylum. European Union law allows for the detention of "irregular migrants" and asylum seekers for up to 18 months. Depending on the laws of the country they have entered, children may be detained in harsh conditions for extended periods of time. Often times, children are housed with adults which increases their risk of abuse. Research in Europe has found that the immigration detention centers are poorly equipped for children. Children in these centers experience violence, abuse, overcrowding, and do not receive schooling. They often are kept from family members and access to service providers for long periods of time. Additionally, staff members of the centers are not trained in the needs of children and reports of suicide have been noted.

Human Trafficking

Every year, thousands of foreign-born children arrive in the United States unaccompanied. Among those taken into federal custody to undergo immigration processing, many have been trafficked, persecuted in their home countries, or subjected to domestic violence, abuse, and neglect. On December 23, 2008, the William Wilberforce Trafficking Victims was passed in the United States. Among other things, it provides a 90-day interim of assistance to child victims of trafficking, it determines the eligibility for long-term assistance, and provides a program to protect and repatriate alien children and ensures that they receive critical services.

Health Screening

Health-screening strategies for newly arrived immigrants can be found in the U.S. government Centers for Disease Control and Prevention's (CDC) *History and Physical Guidelines* and The American Academy of Pediatrics' *Policy Statement on Providing Care for Immigrant, Homeless and Migrant Children.* Several points from their published guidelines are particularly salient.

- Children should be screened within 3 weeks of arrival to the United States or sooner if medically indicated. All internationally adopted children are required to have a medical exam performed by a physician designated by the US State Department in their country of origin (panel physician). It is not a comprehensive exam of the child's health but screens for certain communicable diseases and serious physical or mental defects that would prevent the issue of a permanent residency visa.
- Child refugees may have been residing in refugee processing camps and will have had access to basic medical care and treatment but not a comprehensive assessment. Growth and development measures should be plotted on standardized growth charts. Children who were previously in refugee camps may have growth charts from the camp.
- Children born outside the United States often suffer from malnourishment, which can lead to growth stunting and poor weight gain or even weight loss. Immigrant children frequently do not meet established height for weight, weight for age, or head circumference standards. Many will experience catch-up growth over the first year of their arrival but should be monitored.
- Internationally adopted children have high rates of developmental delays, and screening for developmental delay should be included in their initial well-child assessment.
- Although in the United States there are standardized newborn screens performed at birth, this is often not the case for foreign-born children and diseases such as congenital syphilis, hemoglobinopathies, and inborn errors of metabolism must be considered. Congenital cardiac disease is often undiagnosed in immigrant children and should also be considered.
- A thorough dental assessment of children is very important. Dental problems and disease are among the most common complaints of children entering the United States. In elementary school, immigrant children have been found to have twice the number of cavities in primary teeth as compared to their US-born counterparts.
- Hearing and vision assessments should also be performed.
- A medication history should be taken, and caregivers should ask about traditional and herbal medicines, home remedies, and traditional therapies unique to their culture. Many of these substances can have potentially serious interactions as well as contain contaminates if purchased outside the United States (e.g., lead and other toxins).

Vaccines and Disease

A review of an immigrant child's vaccination status is important but often impossible to obtain. Frequently, records do not exist, are incomplete, or get lost during migration.

The *American Academy of Pediatrics Redbook* provides detailed vaccine guidance. People immigrating to the United States after 1996 must show proof of at least the first doses of all the recommended vaccines in the current immunization series. This applies to almost all children entering the United States. There are several exceptions: (1) A vaccine is not required if it is not available in their country of origin. (2) Children under the age of 10 years who are being internationally adopted by US parents are exempt from the requirement as long as the adoptive parents sign a waiver that states they intend to comply with the ACIP immunization requirements after the child arrives in the United States. (3) Refugees are not required to comply at the time of entry but must show proof of immunization when they apply for permanent residency.

Children who were living in refugee camps prior to entering the United States may have received some immunizations in the camp but rarely have documentation demonstrating completion of the required immunizations. Either a new record may be established or measurement of antibody concentrations may be performed. Vaccines for Children (VFC) is a US governmental program that provides free vaccines for providers that can be administered to children without insurance. Immigrants are not excluded.

Antibody concentrations to the following may be tested if deemed necessary to determine whether a child needs additional immunizations: diphtheria, tetanus, measles, mumps, rubella, varicella, poliovirus (each serotype), and anti-HBs. If the child is from a Hepatitis B endemic area, then HBsAg and anti-HBc are also required.

Although wild-type polio has been eradicated from the Western Hemisphere, it is still found in at least six countries: Afghanistan, India, Pakistan, Nigeria, Niger, and Egypt. Importation of measles is a significant source of measles cases in the United States. Measles antibody can be measured, but it is often not necessary because many children will need a dose of mumps and rubella vaccines since these are not routinely given in developing countries, and measles, mumps, and rubella are combined in one vaccine, the MMR.

Clinical histories of rubella and varicella are not considered acceptable evidence of immunity, and the children should have antibody testing performed.

Immigrant children often have diseases that are infrequent in the United States, including malaria, amoebiasis, and schistosomiasis. Immigrant children are considered to be 100 times or more at risk of contracting tuberculosis than US-born children. In comparison to adults, children who have been infected with mycobacterium tuberculosis are at an increased risk of going on to develop active disease. Infants are up to 40 times more likely to develop active disease if untreated. More information regarding vaccination and screening for specific diseases is available both in the *Redbook* and through the Centers for Disease Control and Prevention.

Migrant Workers

It is currently estimated that between three and five million migrant farm workers and their dependents live in the United States. Most are Spanish speaking.

Children of migrant workers experience unmet medical needs at a proportion 24 times that of US children overall. One study found that 80% of migrant workers' children had never had a dental exam. Preschool age migrant children were at a significantly higher risk of having unmet medical needs. Reasons for the lack of care included lack of transportation, lack of knowledge of where to go for care, and an inability to leave work for a child's medical care for fear of losing their job.

Children of migrant farm workers of all ages are at increased risk of respiratory and ear infections, bacterial and viral gastroenteritis, intestinal parasites, and dental problems.

Furthermore, migrant children are at risk of lead and pesticide exposure, unintentional and intentional injuries, occupational injuries, and substance abuse. In addition to screening all immigrant children for lead after arrival, consideration should be given to screening the children again in the future because immigrants are more likely to live in poor housing on arrival to the United States and are at a new risk for lead exposure.

Parents and older children should be asked regarding their work history in order to determine possible environmental and chemical exposures.

Adolescents

Childhood and adolescence are the time when activities that promote health and prevent illness produce maximum results. Interventions can significantly affect risk-taking behavior, such as smoking, substance abuse, and high-risk sexual activity.

In addition to questions regarding alcohol and tobacco use, questions should be asked regarding the use of other substances that are common in the immigrant's country. Important examples include: betel nut, "khat" or "qat, "and "hookah." Hookah, also known as sheesha or argileh, is a form of tobacco smoking using a water pipe that many erroneously think is safer than cigarette smoking, when in fact smoking an argileh for a typical session of 40–60 min is comparable to smoking 100–200 cigarettes in terms of the amount of smoke and nicotine that is inhaled. Argileh smoke contains tar, nicotine, and heavy metals. Children exposed to secondhand smoke are at risk for SIDS (sudden infant death syndrome), asthma, ear and throat infections, and permanent loss of lung function. Hookah is popular throughout the Middle East, Asia, Philippines, Southeast Asia, and South Africa.

Psychological Impact

Immigrant children are at risk for psychological distress and may go on to develop mental illnesses resulting from their exposure to traumatic events, war-related violence, and the upheaval and displacement of the migration process itself. Immigrant children may display symptoms of depression, grief, anxiety, posttraumatic stress disorder (PTSD), and conduct disorders. Psychological symptoms in children exposed to violent conflicts include regression, withdrawal, nightmares, and anxiety.

Some studies have shown that children who witness traumatic events, including mass murders, bombings, and abuses frequently develop PTSD, anxiety, and depression. Moreover, if the experience affects their nuclear family or they experience personal loss or harm (e.g., the loss of a parent or witnessing a family member's murder), they are particularly at risk for psychological trauma.

Other studies have shown that a child's culture and region of origin affects their symptoms and expression of emotional distress. For instance, in 1996, a report by McCloskey and Southwick stated that Latin American refugee children present with many of the same problems as children from Southeast Asia; however, the Latin American children have more prevalent academic and conduct problems, while the Southeast Asian youth were more likely to display withdrawal.

US-born citizen children whose parents have been deported have been reported to have an array of changes in their behavior, including increased crying, withdrawal, aggression, and changes in their sleeping and eating habits. Children who witnessed their parents' arrest seemed to be the most affected.

Undocumented Immigrants

According to the Urban Institute, there are 5.5 million children currently living in the United States with one or more undocumented parents. It is estimated that two-thirds of these children are US-born citizens themselves. Approximately 37% of these children are 5 years old and under.

While the majority of their U.S.-born children are under 10 years of age, immigrant parents' adolescent children are most often foreign-born and not citizens. This has wide implications. The Urban Institute has published studies regarding the affects of parental deportation on the children left behind. When parents are arrested or detained, young children are often left stranded without care. Many times, parents do not report to authorities that they have children for fear of losing them to child welfare services. Long-term detention without access to telephones or in remote facilities is particularly hard on families with small children. Frequently, other family members and friends go into hiding quickly after a workplace raid or when family and friends have been detained and do not want to be discovered for fear of deportation. It then becomes very difficult for attorneys and social workers to make contact with them or to arrange care for the children left behind. This further disrupts the children's already unstable lives. Sometimes, other immigrant family or friends will take the children into their homes, which often forces the children into more crowded and poorer living conditions, putting them at risk of food insecurity and general hardship. While the parents are in detainment (detention) centers, they are unable to work and earn money and when parents are released, they are often not permitted to work for several months while their cases are pending worsening their economic position.

Government Assistance

It is difficult for both immigrant and U.S.-born children of immigrant parents to obtain public benefits and medical assistance, including health insurance. Children of immigrants live in lower income families than children of natives. One study found in 2003 that 54% of children of immigrants versus 36% of children of native-born parents had family incomes below twice the federal poverty level. Lower incomes are associated with food insecurity, crowded housing, poorer health, and lower rates of health insurance coverage in immigrant families. Yet young, low-income children of immigrants are significantly less likely to receive federal assistance than low-income children in nonimmigrant families.

In the United States, both the federal and individual state governments have medical assistance programs for immigrants. There are differences in eligibility requirements between the federal and state programs, as well as differences between individual. The terminology and requirements are complex and can be difficult for an English-speaking U.S. native and much less for an immigrant parent to understand. Until very recently, federally funded Medicaid and CHIP (Children's Health Insurance Program) were available only to "qualified" immigrants who have held the "qualified status" for at least 5 years. The definition of a "qualified" immigrant is available at the National Immigration Law Center. Certain refugees and other "humanitarian" immigrants were able to get Medicaid or CHIP without a 5-year waiting period. Some states denied federal Medicaid to most "qualified" immigrants who entered the United Sates on or after August 22, 1996, even after they completed the federal 5-year bar. In 2009, Congress passed the Children's Health Insurance Program Reauthorization Act (CHIPRA), giving states an opportunity to provide health coverage through Medicaid and CHIP for "lawful" immigrants without having to wait 5 years. Undocumented immigrants remain ineligible for nonemergency Medicaid and CHIP. States have the opportunity to choose whether to adopt the new CHIPRA option, which may mean there will continue to be a wide variation in health coverage for children across the United States.

Many of the current U.S. child and family government assistance policies to aid low-income families were enacted in the 1960s. However, the characteristics of "low income families" today are very different compared to when the programs were first designed. The number of U.S. immigrants has tripled in the last 35 years, and a large and growing share of low-income children in the United States live in immigrant families. The vast majority of U.S. immigrant families are Latino. Today, 22% of all U.S. children are Latino, and the number of school age children who speak Spanish number over seven million. This shift in demographics affects the governmental programs and institutions that assist children, including schools, health providers, and social service agencies. Additionally, the number of children of immigrants who are considered low-income and in need of government assistance is continually increasing due to the rising numbers of immigrant parents with little education, limited English, and worsening poverty.

According to the Pew Hispanic Center, the number of US-born children with an unauthorized parent has increased 48% since 2003. Although the majority of children in immigrant families are US citizens and fully eligible for public assistance and social service programs, their immigrant parents may be ineligible for these programs if they are undocumented or not legal permanent residents.

Many parents do not participate in or even apply for public benefit programs such as TANF (Temporary Assistance for Needy Families), food stamps, public housing, EITC (Earned Income Tax Credit), or Medicaid. A number of factors contribute to their lack of obtaining services. Some avoid any contact with governmental agencies. Parents fear discovery or deportation either for themselves or for other relatives or friends.

Some parents worry that accepting government assistance or public funds could impede their path toward citizenship or legalization. Further, parents do not understand that if their children were born in the United States, those children are eligible for SCHIP and Medicaid. Lastly, immigrant children's access to care can be significantly hindered if their parents have limited English skills, cannot read English, and do not understand the applications required to obtain aid. Not many states have the resources such as bilingual teachers or health interpreters to help immigrant families or their children. Immigrants need literacy skills in order to obtain and understand basic health information and services needed. In addition, they need literacy skills to interact with other social systems such as schools, social welfare, and the legal system that affect their children's well being.

There are estimated to be millions of child immigrants across the globe. Yet data regarding their numbers are lacking. More research is needed to quantify their numbers and circumstances in order to address their unique health and social needs as well as protect their basic rights.

Related Topics

- ▶ Immigration status
- ▶ Irregular immigration
- ▶ Labor migration
- ▶ Medical examination (for immigration)
- ▶ Nutrition
- ▶ Oral health
- ▶ Posttraumatic stress disorder
- ▶ Refugee
- ▶ Refugee camp
- ▶ Refugee status
- ▶ Refugee youth
- ▶ Trafficking
- ▶ Trauma exposure

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Peer Education

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Peer education is an approach to health promotion. It is a tool or strategy used by people who share similar ages, backgrounds, or interests to communicate messages, raise awareness, and provide accurate information. Peers are traditional providers of information and talk to each other about sensitive issues they may not feel comfortable discussing with an authority figure. Peer education is provided in a multitude of venues including health clinics, churches, parks, recreational centers, homes, schools, and places where youth congregate.

Peer education is one of the most widely used strategies to address the HIV/AIDS pandemic; it has also been commonly used with other issues such as tobacco, alcohol, and other drug use; STI (sexually transmitted infections) and pregnancy prevention; and reproductive health. The purpose of peer education is to effect change at the individual level with the goal of modifying a person's knowledge, attitudes, beliefs, and behaviors.

Peer education has been viewed as a relatively inexpensive program strategy; however, there is an ongoing need for funds in order to adequately train, support, and supervise peer educators. Compensation of some kind is also critical for peer educators. This can come in several forms, for example, items that identify the program including bicycles, key rings, tee shirts, baseball caps, pens, and backpacks. Other incentives can include stipends, gift certificates, transportation support, community service credit, and the opportunity for personal and professional development.

Peer educators convey health promotion messages and information by leading group discussions and participating in individual conversations with peers; role playing; offering counseling, support, and referral services; and linking participants to health care services in the community. Peer educators are also able to access hard-to-reach populations, such as homeless youth and immigrant communities with language barriers, who otherwise may not seek out services or information.

Related Topics

- ► Community health workers
- ► Health education
- ► Health promotion
- ► Promotora
- ► Refugee
- ► Youth

Suggested Resources

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Peers

- ► Social networking

Percent Body Fat

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Percent body fat is a measure of body fat in relation to body weight and is calculated as the total weight of a person's body fat divided by the person's body weight. There are several techniques of measuring body fat, including anthropometry (e.g., skinfolds and waist circumferences), density (e.g., underwater weighing), and conductivity (e.g., bioelectrical impedance). Sophisticated radiographic (X-ray) techniques such as the duel energy X-ray absorptiometry (DEXA) also exist and are used mostly in clinical and research settings. DEXA employs two beams of X-rays that pass through body harmlessly and could differentiate muscle tissue, fat tissue, and bone tissue. It provides high-quality assessments of total body fatness and fat distribution.

Due to its direct measure of body composition, percent body fatness obtained through techniques such as DEXA is considered a more precise measurement of an individual's fatness level compared with the body mass index (BMI), a widely used measure that estimates body fatness through a formula using a person's weight and height (BMI=weight in [kg]/height in [m^2]).

Ideal percent body fat varies depending primarily on gender and age. It has been recommended that a healthy range for men is between 12% and 20%, and for women it is between 20% and 30%. As for indications of excessive body fat, data have suggested the following cutoffs: a body fat percentage at or above 22% for men and 32% for women age 40 and younger, whereas a body fat percentage at or above 25% for men and 35% for women over age 40. However, these cutoffs are not the same for all individuals. Other factors such as lifestyle or stage of life may also influence the required fatness. For example, elite marathon runners often have a lower body fat level compared with the general population. On the contrary, pregnant women may need additional fat to ensure proper fetal growth. It has been estimated that the increase in the percentage of body fat during pregnancy ranges from 2.6% to 8%.

A high level of body fat is often associated with a greater risk of diseases and consequent mortalities. For example, using BMI as a proxy for body fatness, prior research has shown that people with a higher BMI level (presumably a higher level of body fatness) have higher risks for developing cardiovascular disease, diabetes, hypertension, and certain types of cancer. Certain immigrant and/or minority populations, including Hispanics and African Americans, have higher BMIs compared with White Americans. Asians, on the other hand, generally have a lower BMI compared with other race/ethnic groups.

However, recent research seems to question the validity of using BMI as a proxy for body fatness. The discrepancy between BMI and percent body fat is especially profound among Asians. That is, for a given BMI, Asians have higher percent body fat than Whites. According to a recent literature review, Asians (Indonesians, Singaporean Chinese, Malays and Indians, and Hong Kong Chinese) had a higher percent body fat at a lower BMI compared to Whites. The research findings show that for the same BMI Asians' percent body fat was 3–5% points higher compared to Whites. For the same percent body fat, their BMI was 3–4 units lower compared to Whites.

These findings also apply to children. Using a sample of multiethnic children from New York City as well as children from China, researchers have found that, for the same BMI, Asian children have significantly higher percent body fat compared with African American and White children. In addition, girls are found to have higher percent body fat than boys.

The above findings seem to indicate that the relationship between percent body fat and BMI is ethnic specific and that the BMI threshold for defining obesity in Asians should be lower than the threshold for other ethnic groups. With obesity and its associated comorbidities on the rise rapidly, caution is warranted when applying universal BMI cutoffs across sex and ethnic groups. Percent body fat that measures body fatness directly should be an important measurement in assessing the risk of obesity and chronic diseases, especially among immigrant and/or minority populations.

Related Topics

- ► Body mass index
- ► Cardiovascular risk factors
- ► Obesity

Suggested Readings

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Personality

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Personality, a term derived from *persona*, the Latin word for mask, refers to the organization of behavioral and emotional attributes that characterize a unique individual. A broad definition of personality typically includes dimensions of stability, determinism, and uniqueness; that is, personality changes little over time, is determined by both internal processes and external factors, and reflects an individual's distinctive qualities. Conceptualizations of personality date back at least 2,000 years to the work of Hippocrates, who described four basic human temperaments. Hippocrates thought temperament was related to a person's prominent bodily fluids, or *humors*: blood (*sanguine*), yellow bile (*choleric*), black bile (*melancholic*), and phlegm (*phlegmatic*). For example, a person with a kind, cheerful temperament would be described as sanguine, meaning his or her prominent bodily fluid was blood.

The nineteenth century marked several important advances in the understanding of personality. Franz Gall wrote about *phrenology*, the idea that a person's skull shape can reveal personality traits. The link between brain and personality was established when Phineas Gage experienced personality changes after an iron rod accidentally pierced his skull. Sigmund Freud began his career in psychiatry and neuroscience, and Auguste Comte described *la morale*, a science dedicated to the examination of the individual person as both "a cause and consequence of society."

In the early twentieth century, personality became a popular concept in the United States as Americans feared depersonalization, while they experienced rapid societal changes associated with industrialization, immigration, and urbanization. By the 1930s, personality psychology emerged as a scientific discipline, marked by the publication of Gordon Allport's monograph. Allport defined personality as "…the dynamic organization within the individual of those psychophysical systems that determine his unique adjustments to his environment".

There are several theoretical perspectives on personality and its development. Most can be grouped into one of the following classes: behavioral-genetic, social-cognitive, cultural, psychoanalytic, and humanistic. Trait theory, a behavioral-genetic approach that attempts to identify basic personality traits and their organizational structure, is probably the most fundamental perspective in personality psychology. As defined by the American Psychiatric Association's *Diagnostic and Statistical Manual* (DSM), personality traits are "prominent aspects of personality that are exhibited in a wide range of important social and personal contexts." Thus, according to trait theorists, a friendly person is likely to act friendly in any situation because of relatively stable personality traits. The *Five-Factor Model*, which organizes 30 common traits into five broad dimensions, is the most widely used structural model in personality psychology. The five dimensions are neuroticism, extroversion, openness, agreeableness, and conscientiousness. Neuroticism refers to a person's tendency to experience negative feelings, extroversion is measured by one's level of engagement with the external world, openness refers to imagination and curiosity, agreeableness reflects one's tendency to cooperate, and conscientiousness concerns impulse control.

While trait theory implies that personality and behavior are relatively stable in a given individual, it is evident that situational influences also affect the way a person thinks, acts, and feels. There has been considerable debate among psychologists regarding behavioral consistency, and from this emerged the "person–situation debate" of personality. Most contemporary behavioral-genetic perspectives acknowledge the fact that behavior results from an interaction between personality and situational forces and are thus "interactionist" in nature. Behavioral-genetic data from twin and adoption studies show that the heritability of many adult personality traits is between 0.40 to 0.60, with the remaining variability accounted for by a person's unique environment and experiences. In the late twentieth century, neuroscience advanced the study of personality psychology by introducing more objective tools for brain analysis such as positron emission tomography (PET) and functional magnetic resonance imaging (fMRI).

Social-cognitive theories emphasize the complex relationship between a person's environment, cognitions (thoughts), and behavior. The term "reciprocal determinism" is used to describe how this complex relationship shapes one's distinctive personality. An important concept in social-cognitive theory is "locus of control," which is the degree to which people believe they have control over their lives. People with an "internal" locus of control believe they are responsible for what happens in their lives while those with an "external" locus attribute life circumstances to fate, luck, or influential others. Locus of control is one example of a cognition that is likely to influence behavior.

Cultural theory holds that many qualities treated like personality traits are actually influenced by one's culture. Cultural psychologists view culture and personality as interdependent, since the very concept of the person is seen as socially constructed and variable across cultures. Proponents of this perspective prefer "constructionist" assessment methods, which emphasize the construction of meaning by cultural groups, rather than researchers. In constructionist assessment, an individual's dimensions or narratives of self and others are generated in his or her own terms. Many of the personality inventories developed around the world do not appear culture-specific, despite their local origins, because they are based on constructs imported from Western psychology.

Psychoanalytic theories, based on the work of Freud, explain human behavior in terms of interaction between the various components of personality. According to Freud, personality is shaped by the interaction of three components: the ego, superego, and id. Psychoanalysis emphasizes unconscious motivations and the conflicts between primal urges (id) and learned social mores (superego), stressing the importance of early childhood experiences in determining mature personality.

Humanistic theories emphasize that people have free will and play an active role in behavior. This approach places less emphasis on genes, past learning, and psychological conflicts, and instead explores the strengths and inner potential of each human being. Both psychoanalytic and humanistic perspectives regard the objective measurement of traits as too fragmented to fully capture personality development.

Several personality tests have emerged from the various theories of personality. These tests, commonly administered by psychologists, aim to assess aspects of a person's character that remain stable across a variety of situations. Some involve self-assessment questionnaires in which subjects rate themselves on a series of attitudes. The widely used Minnesota Multiphasic Personality Inventory (MMPI) uses a true–false questionnaire to delineate normal personality types from variants. Others, called projective tests, involve the evaluation of a person's responses to ambiguous pictures. The Rorschach inkblot test and the Thematic Apperception Test are examples of projective tests.

When personality traits are maladaptive and cause significant functional impairment or subjective distress, they may result in a personality disorder, as defined by the DSM. The DSM describes ten personality disorders: paranoid, schizoid, schizotypal, antisocial, borderline, histrionic, narcissistic, avoidant, dependent, and obsessive-compulsive. Many of these correspond to extreme variants of the "five factors" of personality. For example, paranoid personality disorder may be related to extremely low agreeableness, reflecting a wariness and mistrust of others.

In summary, personality is a complex and evolving area of study. Each individual has a unique combination of inherent abilities and preferences as well as learned responses. As a single model of personality is unlikely to account for all of its complexities, it may be most useful to integrate diverse perspectives, in recognition that personality is truly multidimensional.

Related Topics

- ► Emotions
- ► Mood disorders

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The Personality Project. Department of Psychology, Northwestern University. http://personality-project.org

Pesticides

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Introduction

Pesticides are widely used in agricultural and residential settings and public places. According to the US Environmental Protection Agency (EPA), 213 million pounds of active ingredient (a.i.) are used in the nonagricultural sector compared to 675 million pounds a.i. in the agricultural sector. In an effort to safeguard the safe use and handling of pesticides, the US EPA is mandated under the federal insecticide, fungicide and Rodenticicide Act (FIFRA) to ensure the safe use and management of pesticides, and defines pesticides as "any substance or mixture of substances developed to prevent, destroy, repel or mitigate insects (i.e., insecticides), rodents (rodenticides), fungi (fungicides), or weeds (herbicides)."

Under FIFRA, EPA evaluates the risks posed by these substances prior to registration, and also reevaluates older pesticides already on the market. There are currently more than 1055 active ingredients registered as pesticides which are formulated into thousands of pesticide products that are sold in the USA.

Chemical pesticides compared to other forms of pest control, for example, biopesticides, antimicrobials, and other pest control devices, have traditionally been the pest control of choice in many households. They consist of several classes of pesticides, which generally exert their toxic effect on the nervous system (neurotoxins). Some examples are organophosphate pesticides, which exert toxicological health effects through the disruption of the enzyme, acetycholine esterase, an enzyme that is responsible for regulating the neurotransmitter, acetycholine at the cholinergic junctions of the nervous system; carbamate pesticides also inhibit the actions of acetylcholinesterase, however, the hydrolysis of carbamates occurs more rapidly than organophosphate and the toxic effect is reversible; organochlorines exert their toxic effect through the disturbance of the neuronal membrane which results in hyperexcitability of the nervous system. The pyrethroids are synthesized from the naturally occurring pesticide, pyrethrin found in the chrysanthemum plant. Pyrethroids exert their toxic effect by inhibiting ion movements across the nerve cell membrane.

Exposure to chemical pesticides occurs via three major pathways of exposure, that is, inhalation, ingestion (dietary and non-dietary), and dermal. Health response varies among individuals and is largely dependent on the health condition, age, and characteristics of exposed individuals, typically with more deleterious effects in individuals with compromised health, small children, and the elderly. These sensitive populations are especially vulnerable when frequency and duration of exposures to pesticides are extensive.

Below are some examples of studies of the workplace or the home, and information examining the relationship between adverse health effects and pesticide exposures, often in immigrant populations.

Examples of Research Conducted During the Period of 2000 and 2010 in Various Settings

Residential Setting

It is reported that in the USA, individuals spend more than 90% of their time indoors, and approximately 74% of households use pesticides. It is therefore logical to assume that indoor residential exposures can potentially be a significant exposure pathway for many individuals, especially occupants of urban multiunit dwellings with severe pest infestation, which may result in high prevalence of pesticide. This situation is especially true in older, poorly maintained housing stock where pesticide usage oftentimes includes the use of prohibited or restricted-use pesticides that are sometimes influenced by social networks.

A study conducted by Whyatt et al. with a cohort of African American and immigrant women of Dominican descent between the ages of 18–35 years found that there was a statistically significant association between birth weight and length and cord plasma chlorpyrifos and diazinon. Whyatt et al. concluded that the deficit in fetal growth among this cohort was associated with the prenatal exposure to diazinon and chlorpyrifos. However, these two pesticides were phasing out several years later due to the potential to cause adverse health effects to occupants, especially children. Whyatt and colleagues were able to also demonstrate that this association was no longer significant for babies born subsequent to the phase out.

In another study known as the Healthy Public Housing Initiative (HPHI), Julien and colleagues investigated the magnitude and distribution of pyrethroid and organophosphate pesticide loadings within public housing dwellings in Boston, Massachusetts. They collected dust samples from 42 households of which more than two-thirds were immigrants with Hispanic heritage. The dust samples were tested for 11 pyrethoids (e.g., permethrin and cyfluthrin) and two organophosphates (chlorpyrifos and diazinon) in house dust. Permethrin and chlorpyrifos were detected in kitchen floor wipes in all homes, followed in frequency of detects by diazinon (98%), cypermethrin (90%), and cyfluthrin (71%). The majority of homes had at least six pesticides and in some homes, banned or restricted use pesticides were also detected, which underscored the need for alternative pest management strategies that embrace the safe and judicious use of pest control products.

Other Settings

Agricultural

Studies have shown that children living in an agricultural community may experience higher levels of pesticides compared to children from nonagricultural community. Sources of exposures contributing to the elevated levels in children in agricultural communities are multifaceted and include exposures from pesticides being tracked into the home due to living in close proximity to a farm and from breast milk during lactation.

One of the many studies conducted under the auspices of the Center for the Health Assessment of Mothers and Children of Salinas (CHAMACOS) looked at the relationship between exposures to pesticides in utero and early post natal exposures to organophosphates and neonatal neurobehavior in humans. Study participants were largely Mexican immigrants who worked in the Salina Valley, an agricultural region in California. Cluster measurements were taken for "habituation, orientation, motor performance, range of state, regulation of state, autonomic stability, and reflex," were conducted using the Brazelton Neonatal Behavioral Assessment Scale (BNBAS). Young and colleagues examined this relationship in a cohort of 381 infants, 2 months old who were born to women attending the CHAMACOS center. The results from this longitudinal, birth cohort study found a significant association between OP exposure and an increase in the number of abnormal reflexes.

Another study that was conducted by Arcury and colleagues analyzed biological samples from 60 farmworker children, ages 1–6 years of age. These children were from an immigrant population of Hispanic heritage. Study results which showed metabolites of organophosphate pesticides, for example, parathion/methyl parathion detected in 90% of the children including the range of pesticide metabolites detected (0–7) were all indicative of an environment where multiple exposures to pesticides occurs. Because some of these pesticides are known to be persistent in the indoor environment, Arcury et al. concluded that more needs to be done to quantify and address these exposures.

Daycare

Wilson et al. conducted a study which monitored pesticide concentration in 10 day care centers. They focused on young children because of their rapidly developing bodies and immature immune systems and activity patterns that collectively increased their exposures to pesticides indoors. Wilson and colleagues monitored for select pesticides and other persistent pollutants, for example, organophosphate pesticides (diazinon, chlorpyrifos), organochlorine (DDT, chlordane), and lawn herbicide 2,4-dichlorophenoxyaceti because of their persistence in the indoor environment. Using the monitoring results, the researchers selected the centers with the lowest and highest levels of pesticide residues and obtained environmental and biological data from nine preschool children (including

Hispanic children from immigrant households) ages 2 to 5 years. Target pesticides, including persistent organic pesticides, were collected in several media (e.g., indoor floor dust, outdoor soil, solid and liquid food, hand wipes, and urine). Researchers found that the children's diet did contribute to their exposures to target substances but found no difference between their exposures at home when compared to the daycare.

Conclusion

These examples are studies that were conducted to expand on the body of literature around pesticide exposure and human health effects. It is by no means representative of all the studies and investigations that have been conducted to date in these settings. However, it is the hope that they provide some measure of insight into the type of research that has been conducted in order to shed some light on pesticides, pesticide prevalence, and the possible associations between pesticides and human health effects.

Disclaimer

This entry does not necessarily reflect the position of the US Environmental Protection Agency and the Harvard Extension School. No official endorsement by the US EPA and the Harvard Extension School is intended or inferred.

Related Topics

- ► Access to care
- ► Allergies
- ► Asthma
- ► Border health
- ► Cancer
- ► Cancer health disparities
- ► Cancer incidence
- ► Cancer mortality
- ► Chemical exposure
- ► Community-based participatory research
- ► Cultural background
- ► Environmental exposure
- ► Environmental health
- ► Environmental justice
- ► Food industry
- ► Health barriers
- ► Health care
- ► Hispanics
- ► Infant mortality
- ► Low literacy level
- ► Migrant farmworkers
- ► Occupational and environmental health
- ► Peer education
- ► Reproductive health
- ► Research ethics
- ► Risk perception
- ► Vulnerable populations

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Peyote

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Peyote (*Lophophora williamsii*) is a small, spineless cactus native to southwestern Texas and northern and central Mexico. In Mexico, peyote grows in the states of Chihuahua, Coahuila, Nuevo León, Tamaulipas, San Luis Potosi, and Zacatecas, while it is only found in a few counties in Texas bordering the Rio Grande River. Growing on or near desert scrub limestone hills, the cactus flowers sporadically, producing small edible pink fruit. The largest part of the cactus is located underground in a long, carrot-like root, while the aboveground portion of the cactus is the crown, which develops disc-shaped buttons no larger than 12 cm diameter that are cut, dried, and consumed.

History

Consumption and use of peyote by humans has been documented as far back as the middle Archaic period (8000–1000 BCE). The first, historically documented reports of peyote use by indigenous peoples of North America come from early Spanish missionary records, dating to the 1600s and early 1700s, and indicate that its use was sporadic but widespread across much of northern Mexico. In the 1800s, the use of peyote is believed to have increased among indigenous peoples, especially those living in the southern Plains of North America as a response to colonial and missionary pressures. Indigenous peoples in the southern Plains and northeastern Mexico began to incorporate certain indigenous peyote rituals into the newly imposed and supported Christian teachings, resulting in the formation of a syncretic set of practices and beliefs. Today, the use of peyote continues in the United States by Native Americans under the auspices of the Native American Church. In Mexico, indigenous and Mexican communities continue to use peyote for spiritual and medicinal purposes. Outside of these two population groups, consumption and use of peyote is very limited; however, development and traffic from immigrants crossing through Chihuahua and Coahuila into the United States has caused the cactus to become scarcer.

Consumption

The peyote cactus contains more than 55 alkaloids and related compounds, many of which have direct affects on human physiology and brain neurochemistry, but only lophophorine, anhalodine, anhalonidine, hordenine, pellotine, and mescaline have been studied. Although each peyote cactus contains all of these alkaloids, no two plants contain the exact same ratio of alkaloids and, therefore, there is no standard effective dose size. Anecdotal evidence suggests that four or more buttons, the dried tops of the peyote cactus, are required for any psychological effects to take place on a human individual.

Mescaline is considered by many pharmacologists to be the main psychologically active alkaloid in peyote, and it has been extensively studied compared to the other alkaloids. Mescaline is believed to affect the action of serotonin, one of the main neurotransmitters within the central nervous system. This hypothesis accommodates the wide array of physiological effects that mescaline has been reported to produce, including an increase in blood pressure, pulse rate, perspiration, breathing, motor activities, and body temperature.

The direct psychological actions of mescaline, unlike the physiological effects, have only recently begun to be understood. For example, research indicates that mescaline inhibits cholinergic neuromuscular transmission by blocking the release of the neurotransmitter acetylcholine at the neuron sites, affecting the storage of memories and the binding of information in the brain.

Likewise, mescaline has neurophysiological affects on the release and reuptake of the neurotransmitter serotonin and dopamine. It also appears to have access mediating effects on the flow of information to the cerebral cortex. Finally, mescaline has hemispheric-specific activation in the brain. That is, mescaline has activation-specific effects on the right hemisphere that may account for the reported effects of increased creativity, understanding, and visualization during ingestion.

Legal Status

Peyote is currently classified as a Schedule-I controlled substance under the Comprehensive Drug Abuse Prevention and Control Act of 1970. It is illegal for anyone to grow, import, possess, use, or distribute peyote. However, use of peyote by Native Americans is legal under 21 CFR 1307.31. Furthermore, the American Indian Religious Freedom Act of 1978 (AIRFA), which was subsequently reenacted by Congress in 1991, supports the use of peyote by members of the Native American Church (NAC). As such, AIRFA preserves the sacramental use of peyote, while 21 CFR preserves the legal use by Native American Church practitioners.

In Mexico, peyote is classified as a Schedule-I controlled substance, and it is illegal for anyone to grow, import, possess, use, or distribute peyote.

Related Topics

- ▸ Drug use
- ▸ Nativism
- ▸ Religion, religiosity, and spirituality

Suggested Readings

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Suggested Resources

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Philippines

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Introduction

Officially known as the *Republic of the Philippines*, the Philippines is an island nation located in the Malay Archipelago in Southeast Asia, a subregion of the continent of Asia. The country was named *Las Islas Filipinas*, The Philippine Islands, by Ruy López de Villalobos after King Philip II of Spain. Philippine culture has many resemblances with that of the West; for example, it is one of only two Roman Catholic countries in Asia, and English is one of the official languages.

History

The ancestors of the majority of the Filipino people settled in northern Luzon around 2500 BC, spreading through the Philippines and later colonizing most of maritime Southeast Asia and the Western Pacific Islands. The basic unit of settlement was the *barangay,* which was headed by a chief who was a leader over nobles, freemen, and dependents – including landless agricultural workers and slaves. Throughout the next 1,000 years, Muslim, Chinese, and Indian traders made contact with the Philippines. Traders and proselytizers from the Indonesian islands brought Islam, which by the sixteenth century, was established and reached the Manila area by 1565. Although in some areas Muslim immigrants set up territorial states ruled by rajas who exercised sovereignty over the barangay chief, animism, the belief that *everything is conscious*, or that *everything has a soul*, remained the religion of the majority of the Philippine islands.

Ferdinand Magellan and his crew were the first Europeans to arrive in the archipelago in 1521; thereafter, Magellan was killed at the hands of indigenous warriors. Miguel López de Legazpi arrived in 1565, forming the first Spanish settlements and paving the way for colonization. Roman Catholic missionaries converted most of the inhabitants.

Over the following 333 years, the Spanish military fought off indigenous revolts and external challenges. The most significant loss for Spain was the temporary occupation of the capital, Manila, by the British during the Seven Years' War. Before it was administered directly from Spain, from 1565 to 1821, the Philippines was governed from Mexico. The *Manila Galleon* traveled once or twice a year to Acapulco, Mexico, beginning in the late sixteenth century. The Philippines opened itself to world trade in 1834.

Demands for greater representation in Spain grew into a revolution in 1896, led by Andrés Bonifacio. Emilio Aguinaldo established a revolutionary government; however, revolutionary leader José Rizal was executed for treason on December 30, 1896. The Spanish–American War began in Cuba in 1898. The war soon reached the Philippines, as Commodore George Dewey defeated the Spanish squadron at Manila Bay. Aguinaldo declared the independence of the Philippines on June 12, 1898, and was proclaimed head of state. Together with Cuba, Guam, Puerto Rico, and Spain then ceded the Philippines to the USA; although by 1899, the USA was at war with Philippine revolutionaries. Though the struggle continued until 1913, Aguinaldo was captured by American troops in early 1901, at which time the USA proclaimed the war's end.

The country's status as a colony changed when it became the Commonwealth of the Philippines in 1935, which provided for more self-governance. On December 8, 1941, just 10 h after the attack on Pearl Harbor, Japan launched a surprise attack on the Philippines. The Philippine defense continued until the final surrender of US-Philippine forces on the Bataan Peninsula in April 1942 and on Corregidor in May. The majority of the 80,000 prisoners of war captured by the Japanese were forced on the infamous Bataan Death March to a prison camp 105 km to the north. Approximately 10,000 Filipinos and 1,200 Americans died before reaching the camp.

US General Douglas MacArthur's Allied forces landed on Leyte on October 20, 1944, while additional landings followed in other parts of the country. The Allies pushed toward Manila, and fighting continued until Japan's formal surrender on September 2, 1945. An estimated one million Filipinos had been killed, and Manila was extensively damaged.

Although the war had left the Philippines severely damaged, elections were held in April 1946, resulting in Manuel Roxas election as the first president. The Philippines achieved independence from the USA on July 4, 1946. After a series of presidents, Ferdinand Marcos was elected president in 1965. He initiated ambitious public works projects, intensified tax collection, and led the nation to unprecedented prosperity throughout the 1970s. With massive loans and economic aid from the USA, his administration built more roads than all his predecessors combined, and more schools than any previous administration. Although barred from seeking a third term, Marcos declared martial law on September 21, 1972, and ruled the country by decree. However, his authoritarian rule became marred by pervasive corruption.

Pressure against the Marcos regime crested when opposition leader Benigno Aquino, Jr., returned from exile and was assassinated on August 21, 1983. Following pressure from the USA and intense mass protests in the Philippines, on February 7, 1986, Marcos allowed a presidential election. The election was believed to be fraudulent, however, resulting in a heavily disputed outcome and a subsequent stand-off between military rebels and military loyalists, with protesters supporting the rebels. Soon, prominent cabinet officials resigned.

On February 22, 1986, a radio call for mass protest inspired the *People Power Revolution of 1986* (EDSA Revolution), 4 days of peaceful action by millions of Filipinos in Manila. The outcome of the action was the downfall of the Marcos regime and the inauguration of Corazon Aquino, widow of Benigno, as president. Government reforms and the return of democracy have been hindered, however, by substantial national debt, government corruption, coup attempts, a communist insurgency, and a Muslim separatist movement. Although the economy improved during the administration of Fidel V. Ramos, elected in 1992, the economic improvements were offset in 1997 by the East Asian financial crisis. The current administration, since June 30, 2010, includes President Benigno Aquino and Vice President Jejomar Binay.

Geography

The Philippines is an archipelago, a chain or cluster of islands, consisting more than 7,000 islands, with a total land area, including inland bodies of water, of approximately 300,000 km^2. It has the fifth longest coastline worldwide, with 36,000 km^2; it borders the Philippine Sea on the east, the South China Sea on the west, and the Celebes Sea on the south. The island of Borneo is located southwest and Taiwan is located directly to the north, while the Moluccas and Sulawesi are located to the south-southwest and Palau is located to the east of the islands.

The Philippines has a tropical maritime climate, usually characterized as hot and humid. There are three seasons: *tag-init* or *tag-araw*, the hot dry season or summer (March to May); *tag-ulan*, the rainy season (June to November); and *tag-lamig*, the cool dry season (December to February). Temperatures usually range from 21°C to 32°C, although it can vary depending on the season. The coolest month is January; the warmest is May.

Government

The Philippines is a constitutional republic with a presidential system of government, in which exists an executive branch that operates separately from the legislature – to which the executive branch is not responsible and by which the executive branch cannot be dismissed. It is governed as a sovereign state in which the central government is supreme and any administrative divisions, or subnational units, exercise only powers that the central government chooses to delegate. Frequently, countries are divided into subnational units, whereby simplifying the managing of the land and the affairs of the people. Subnational units are each granted a certain degree of autonomy and are required to manage themselves through their own local governments. The Autonomous Region in Muslim Mindanao, which is largely free from the national government, represents the sole exception to the country's inclusive sovereignty.

The Philippine President functions as the nation's head of state, head of government, and commander-in-chief of the armed forces. The president is elected by popular vote for a single 6-year term, during which he or she appoints and presides over the cabinet that represents the executive branch.

The Congress of the Philippines is its national legislature; it is bicameral, hence it has two chambers. The bicameral Congress is composed of the Senate that serves as the upper house, with members elected to a 6-year term, and the House of Representatives that serves as the lower house, with members elected to a 3-year term. The Senate is composed of 24 senators half of which are elected every 3 years. The senators do not represent a geographical district and are elected by the whole electorate, while the representatives are elected from both legislative districts and through sectoral representation.

The judicial power is vested in the Supreme Court, composed of a Chief Justice as its presiding officer and 14 associate justices who are appointed by the President. Since the Ramos administration, there have been attempts to change the government to a federal, unicameral, or parliamentary government.

Culture

Philippine culture is a combination of Eastern and Western cultures, with prominent facets that are noted in countries sharing a Malay heritage; nevertheless, its culture exhibits also significant Spanish and American influences. Common in the culture are traditional festivities known as *barrio fiestas* (district festivals) that are held to commemorate the feast days of patron saints; the Moriones Festival and Sinulog Festival are two of the most well known. These celebrations provide the community opportunities for feasting, music, and dancing.

However, due to modernization and the influence of other cultures, gradually, some traditions are being forgotten. The Bayanihan Philippine National Folk Dance Company has been extolled for its efforts to preserve the nation's traditional folk dances; in particular, dances such as the *tinikling* and *singkil* that feature the use of clashing bamboo poles. The tinikling, the National Dance of the Philippines, is an indigenous dance that involves two people beating, tapping, and sliding bamboo poles on the ground and against each other in coordination with one or more dancers who step over and in between the poles in a dance. The singkil, a popular dance performed during festive entertainment, is performed only by females and acts as an advertisement to would-be suitors. While manipulating fans, scarves, or their bare hands, the dancers step graciously in and out of clashing bamboo poles arranged in a parallel, rectangular, or crisscross fashion.

In terms of culture, one of the most obvious Spanish legacies is the Spanish architecture that has shaped the way many Philippine towns were designed around a central square or *plaza mayor*. Although many of the buildings reflecting Spain's influence were demolished during World War II, some examples remain, including churches, government buildings, and universities. Four Philippine baroque churches are included in the list of UNESCO World Heritage Sites.

An example of the American influence on Philippine society is the common use of the English language; this use has contributed to the influence of American pop cultural trends. Filipinos are regular consumers of contemporary American music and film.

Economy

With an estimated 2010 GDP of $189 billion, the national economy of the Philippines is the 45th largest worldwide. Primary exports include semiconductors and electronic products; transport equipment; garments; copper and petroleum products; and coconut oil and fruits. Major trading partners include China, Japan, the USA, Singapore, Hong Kong, and Saudi Arabia.

The Philippines is a newly industrialized country, with an economy that has been transitioning from one based on agriculture to one based more on services and manufacturing. Of the country's total labor force of approximately 38.1 million, the agricultural sector employs nearly 32%; however, it contributes to less than 14% of GDP. Conversely, the industrial sector employs approximately 13.7% of the workforce and accounts for 30% of GDP, and the 46.5% of the workforce involved in the services sector accounts for 56.2% of GDP.

Education

The Philippine Republic Act 9155 provides the framework for basic education in the Philippines; it provides for compulsory elementary education and free high-school education.

The National Statistics Office reports a simple literacy rate, the proportion of the population over age 15 that can read and write, of 93.4%, and a functional literacy rate of 84.1% for 2003. Literacy is about equal for males and females.

Filipino children may enter public school beginning at age four, although officially children enter elementary school at age 7 and attend for 6–7 years. Elementary school is followed for 4 years by secondary school, after which students may then sit for the College Entrance Examinations (CEE). Students who score well enough on the CEE may enter a tertiary institution for 3–5 years.

Though elementary schooling is compulsory, it is reported that 24% of Filipinos of the relevant age group do not attend. Reasons cited for lack of attendance include the absence of a school in the area, education being offered in a language that is foreign to the student, or financial distress. The school year in the Philippines is from June to March, with a 2-month break during April and May, a 1 week semester break during the last week of October, and a week or two of Christmas break.

Health Care

The majority of the health care burden is borne by private health providers. For example, in 2006, total expenditures on health care represented 3.8% of GDP; 67.1% from private expenditures, 32.9% was from government expenditures, and external resources accounted for 2.9%. Health expenditures represented about 6.1% of total government spending for 2006. The 2010 national health budget proposed $7 US per person. Retention of skilled practitioners is low, with approximately 70% of nursing graduates leaving the country to find employment. In 2001, there were about 1,700 hospitals, of which about 40% were government run and 60% private.

Migration

Since the 1970s, the Philippines has supplied thousands of skilled and low-skilled workers to the world's more developed regions. As of December 2004, an estimated 8.1 million Filipinos – nearly 10% of the country's 85 million people – were working and/or residing in close to 200 countries and territories. In the last 30 years, a "culture of migration" has emerged, with millions of Filipinos eager to work abroad. A nationwide survey of 1,200 adult respondents in 2002 found one in five Filipinos expressing a desire to migrate. Although the Philippines is largely a country of emigration, it does attract some immigrants. Traditionally, the foreign population in the Philippines consists of people of Chinese origin. Presently, there are roughly 36,000 foreign nationals working and residing in the Philippines.

Related Topics

- ► Asia
- ► Brain drain
- ► Health disparities
- ► Health outcomes
- ► Immigration in the global context
- ► Immigration status

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Photonarrative

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Photonarrative is the use of photographic images to tell a story about an event or chronicle, or some aspect of a person's life. Some claim that the practice originated with the French artist Nadar who published a series of photographs of the chemist Chevruel, each with a caption of the spoken words at the time the photo was taken. Sometimes known as a Photo Essay, photonarrative is essentially is a visual means of telling a story about an event, a social problem, a segment of society. The practice may go by other monikers, but the process is similar whether utilized by journalists, photographers, or researchers.

In the history of photography, there have been notable examples of the power of photographs to tell stories. The photographs of Dorothea Lange and Paul Evans, who were commissioned by the federal government to document rural life during the Great Depression of the 1930s, put a face on the suffering of the Great Depression. Lange's photographs of labor camp families have become iconic, enduring representations of the suffering and desperation of migrant farm workers.

Some photo essayists try to capture the cultural and social life of subcultures and communities. They work more like ethnographers – anthropologists and sociologists who use images to give in-depth representations of people's culture and various social phenomena – taking time to immerse themselves into the life routines of their subjects and communities. Their photos attempt to tell the story of what life is like, not as posed for the camera, but as if the photographer were a "fly on the wall" simply observing people as they naturally behave. Some examples of this are Paul Fusco's essay of coal miners in West Virginia or Laura Wilson's portrayal of a Hutterite colony in Montana. Of course, the photographer never becomes entirely invisible, and there is always an element of intrusion.

This type of photonarrative is also used in combination with text that explains or elaborates on the subjects, provides an interpretation of the image, or the reasoning behind the choice of certain images over others. An example is James Agee's commentary on his collaborator Walker Evan's carefully structured photographs of poor rural families in the Southeast, or Hart Crane's poem "The Bridge," accompanied by Walker Evan's photo of the Brooklyn Bridge. However, Dorothea Lange and Paul Taylor, in their book *An American Exodus*, attempted to move beyond "explanation" and "illustration" to a "third effect" in the way photographs and text work in combination to provide a new means of expression that evokes an emotional experience in the viewer.

Photonarrative uses photographs of individuals to tell a story of problems faced by others in similar circumstances. The sociologist Morrie Schwartz allowed himself to be photographed while his debilitating disease left him slowly losing use of all his muscles. While an interesting individual in his own right who would later be featured in the book "Tuesdays with Morrie," his story illustrates the challenges of aging, and of how not only the elderly, but also how people with health issues maintain human dignity in the face of losing control of bodily functions.

Photonarration is used to document events as they unfold, such as Paul Fusco's photographs of the farm-worker strike led by César Chávez. These images capture something of the atmosphere of the event. Journalist Tom Stanton vividly captured the feeling of despair during the siege of Sarajevo, particularly the fear in people's faces as they ran through "sniper alley." Likewise, Sebastião Salgado's large format black and white depictions of displacement, refugees, and laborers show the hardship of their experience etched in faces and bodies.

In the emerging fields of visual anthropology and sociology, there is a long history of using photographs to show various sides of the human experience, from portrayals of culture to documenting social problems. While the photographs are often used to supplement a scholarly text, they nevertheless stand on their own as a powerful and compelling narrative. Sociologist-ethnographer Steve Gold's photographs of Vietnamese and Russian immigrants in Los Angeles are a fine example.

Photographs have been used in the social sciences as interview tools. This is known as photo-elicitation, and carefully chosen photographs are utilized as the main prompts in open-ended interviewing. More recently, a new kind of methodology using photonarrative has been developed to facilitate conversations about a concern or issue in the community, and further to involve people significantly in research by having them use photographs to tell stories. Pioneered by public health scholar Caroline Wang, this technique is known as "photovoice." Photovoice puts simple cameras in the hands of ordinary people and trains them to take photographs of their lives and issues in the community that concern them. In similar fashion, filmmakers Briski and Kauffman used this technique with children of prostitutes in Mumbai's red light district. These photos are collected and used to generate discussion of community concerns from multiple perspectives. Caroline Wang used the photovoice method in China's Yunnan Province. Women in rural communities used cameras to chronicle their daily lives and to express their concerns and aspirations, and ultimately to bring these messages into policy decisions that affect their quality of life. In this type of photonarrative, the images are not the carefully constructed aesthetic of a Walker Evans, but rather the attempts to capture the common events of daily life and communal activity.

Related Topics

- ► Community-based participatory research
- ► Ethnography
- ► Methodological issues in immigrant health research
- ► Narrative research

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Physical Activity

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Immigration is often motivated out of a desire to improve the quality of one's life and the lives of one's offspring. Immigrants throughout the world may expect to find employment, better roads, clean water, public sanitation, and more, and perhaps higher-quality, educational opportunities for themselves and their children through access to public and private schools. Whether improvements are measured in terms of direct instrumental support or in terms of perceived opportunities, the scale of the effort to relocate one's self and family as well is weighed against these perceived benefits. People who migrate to a new country, particularly those who migrate from developing countries to the developed world, may also expect to find higher quality health care along with greater access, and a lifestyle where the risk of injury and accident are reduced and where healthy lifestyles are reinforced and supported. With respect to education and economic opportunity, these expectations are often met. However, there is overwhelming evidence that the pot of healthy lifestyle gold may not be waiting at the end of the migration rainbow.

Immigrants from developing countries, for example, often find many of these benefits when they arrive in the more developed world and continue to experience even greater benefits as their residence extends. At the same time, though, they also find themselves at much greater risk for weight gain, obesity, and the associated risks for chronic disease as they adapt to their new society. In this time of unprecedented international mobility and migration, the implications for the health of immigrants and the impact on provision of health care are staggering.

The underlying mechanism of weight gain and obesity is energy balance – calories consumed versus calories expended, or simply diet and physical activity. In particular, this discussion will focus on the relationship between immigration and opportunities for, and changes in, levels of physical activity. I will begin with a brief overview of the issues linking immigration and changes in physical activity, then turn to specific barriers to physical activity facing immigrants in more developed countries, and conclude with some suggestions for improving opportunities for physical activity for new immigrants.

The aspect of immigration that seems most often studied, either directly to assess a hypothesis within the research design, or as a control or adjustment when examining characteristics of immigration, is acculturation. Despite the difficulties in defining and measuring the concept of acculturation, researchers often look to this concept when trying to understand the consequences of migration. In very broad terms, we can define acculturation as a process of acquiring cultural capital in a destination country, a process embedded in migration. This process often requires the acquisition of some level of skill in the dominant language in the host country to facilitate exchange enabling employment, education, and access to services, including health care. Even a cursory review of the literature on immigration demonstrates the reliance of researchers on language skills as a measure of acculturation. The other dominant approach has been to use the length of time in the destination country as a proxy for acculturation. Both measures are used to represent the socialization that an immigrant will experience in their new social context.

Of course, acculturation is much more than language or time in a new country. Acculturation implies an understanding and adoption of social norms and values, local customs and expectations, and knowledge of one's context. Importantly though, in whatever manner we measure the concept of acculturation, we see that acculturation is associated with lower levels of physical activity among immigrants, regardless of their country of origin. In terms of overweight and obesity, immigrants are often likely to have had a healthier diet and more a physically activity lifestyle prior to their migration to a more developed country. While increased access to food and a more regulated, and perhaps safer, work environment are factors that can benefit immigrants in developed countries, immigrants also experience weight gain, obesity, and increased risk for chronic disease.

The reasons for this are many, and they are complex. They include the structure of transportation in the developed world which is decidedly in favor of the automobile as opposed to walking or use of public transportation. While the physical environment and norms in an immigrant's country of origin may be in favor of walking as a mode of transportation, where the expectation is to walk to and from school, work, or the local market, in the United States as in many developed countries, walking is not seen as transportation but as exercise. Walking is something additional, often at either the beginning or the end of a busy day on a stationary treadmill and not an integrated part of working, shopping, and commuting.

This limitation to physical activity is exacerbated by changes immigrants will find in both workplace activity and economic pressures. While immigrants often have more than one job to make ends meet and accept jobs that community workers are unwilling to accept, they also frequently find themselves in more sedentary occupations than they held in their country of origin. In the destination country, immigrants may find themselves in occupations such as store clerk, shop keeper, taxi driver, and computer programmer compared with the more active occupations like construction worker, painter, janitor, etc. When listening to immigrants talk about changes in their lifestyle within their new host country, one often hears how walking was a valued part of premigration life. They talk of people walking to and from their jobs, schools, markets, and social engagements, and about the culture of being out of doors in their country of origin. Many immigrants speak of sitting outside in the evening on the front steps to their home or in the front yard while neighbors, friends, and relatives would walk by and stop to chat from time-to-time only to then take they own turn on the evening neighborhood promenade stopping to visit and socialize with local families.

By contrast, developed societies depend more heavily on motorized transportation for many activities, including commuting to work or school, routine shopping for food and other necessary goods, and even for recreation. Pass by a school playground used for soccer on a Saturday morning and you will observe the resulting traffic jam and parking problems. The implicit message to those coming to developed societies may well be that walking is a sign of poverty and low social status and that if you are to belong in the new society, you will learn to drive yourself and your children to and from such destinations.

The built environment in developed countries adds another layer of barriers to physical activity for immigrants which are nonetheless barriers for the local population as well. The absence of sidewalks and poor street lighting has been shown to discourage physical activity and walking as transportation in neighborhoods throughout the world. The presence of trash, vacant lots, unrepaired buildings, bars, liquor stores, and even all-night convenience stores has been linked to lowered physical activity in residents within a self-described catchment area. Uneven walkways, streets busy with fast moving cars, and the noise and pollution from high-density traffic areas, all lead us to find ways to reduce exposure by limiting our time in outdoor activities. Further, as immigrants in the Western world have, on average, lower income jobs, they find themselves living in urban areas with high poverty, low resources, and high crime. In these types of urban, and rural areas as well, here is a perception that the environment is not safe, particularly for children. Add to this, the difficulties of language and the intense social stigma attached to immigrants in many developed countries and the idea of taking a walk becomes unacceptable.

Many studies note the need for safe walkways, green spaces, bike paths, and bike lanes on popular streets. Our market and shopping areas are congregated in the suburbs, where driving to work, shop, or play is required. Urban areas, where many immigrants live, are left to be serviced by convenience stores with limited choices and very little fresh or perishable food. Fresh food is frequently only available in supermarkets that are often located in areas where large, if not enormous, parking lots can be constructed once again reinforcing the need for powered-vehicle transport in order to buy fresh food.

Physical activity can also be limited by the lack of knowledge of one’s surroundings, a lack of equipment and clothing, and a lack of necessary skills or training. In a study of Somali youth who migrated to Maine with their families, barriers to physical activity included no knowledge of, or skill in, winter sports, a lack of winter “gear,” and, most importantly, cultural issues around appropriate winter attire, in particular the wearing of pants for adolescent Somali females. When these issues of appropriate winter clothing where addressed in a culturally appropriate manner, winter physical activity became an option for the Somali girls. In the absence of such solutions, though, immigrant children, and adults, experience barriers to physical activity simply due to their personal and social values and beliefs. A challenge in this regard is to ascertain the steps necessary to find balance for both the immigrant and existing populations.

Immigrants themselves are aware of the differences in lifestyle pre- to postmigration. Within the context of both completed and ongoing work in the area of nutrition and physical activity, this author has facilitated and attended several meetings with members of three immigrant communities (Brazilians, Haitians, and Latinos) in Somerville, MA, to discuss opportunities and barriers to physical activity and healthy lifestyle. Themes that have emerged throughout these conversations are:

- Work-related time constraints are fundamental obstacles to physical activity, healthy eating, and family meals. Immigrants often have more than one low-income job, most often, both parents work.
- The rigidity of parents’ work schedules makes it difficult to enforce children’s behavior.
- The built environment is not supportive of physical activity and many immigrants experience difficulty

adjusting to a colder climate and find temperature to be a barrier to exercise.

- Junk food is seen as a luxury in many developing countries. It is expensive and used as a special treat for events like a birthday celebration. In much of the developed world, junk food is available, appealing, affordable, and consumed regularly, every day.
- Younger generations favor assimilation more than their parents. This shift is noted in preferences of language, style of dress, and food selections putting immigrant youth at even higher risk for long-term health issues related to nutrition and physical activity.
- There is little support for immigrant physical activity in the community, particularly within the existing population. Institutions and governments could do much more to facilitate opportunities for physical activity in immigrant communities.
- Common foods that were readily available in the country of origin are often in short supply or not available in the new host country, and the supermarket may be too far away from where they live. Ways to enable higher-quality food access in low-income and immigrant neighborhoods should be addressed.

Conclusion

More work needs to be done to better understand the barriers and opportunities to increased physical activity for immigrants. Each of the themes above could be used to generate one or more hypotheses and/or public health interventions to address a specific facet of immigrant physical activity. Looking downstream from an immigrant's point of entry, host countries may want to look at employment practices that inhibit physical activity for both immigrant adults and their children. Minimum wage policies and work schedules combined with school schedules may make time for physical activity unattainable for both children and adults. As developed societies, we need to consider the type of society we are creating and cost of poverty to both individuals and to our societies in terms of poor health outcomes, functional limitation, and hospitalization.

Developed societies which are most often the destinations for immigrants should consider how healthy lifestyles and active living are supported. This is important for the existing populations and well as for immigrants. Walkable areas, bike paths, street lighting, traffic control, sidewalks, and integrated communities, where office, shopping, and living are within walking distance as opposed to urban/suburban development, are being designed to help address the sedentary lifestyle of the developed world. The framework of supports and barriers to physical activity constructed and maintained by our institutions, including government, as well as our norms and values must also be examined further. Representatives of one large immigrant population in Massachusetts suggested that universities that study immigrant populations do not do much to support healthy lifestyles in those communities. They cited the scale of athletic facilities, gyms, pools, health centers, etc., and asked why none of these were open to community members. Even in places where institutions do make buildings available, the open time itself is likely not enough to create an effective result. Immigrant populations may need instruction on how, why, and when to use certain facilities and equipment. In every meeting, where immigrant community members spoke, knowledge and education were among the first solutions they would suggest. "We need to know where we can go for physical exercise in the winter?" "We would like to exercise but who will take care of our children?" "How do we walk in our neighborhood when we are worried if it is safe?"

Established communities need to understand why it is important to make some of these changes. Many such changes will benefit those already in the community at least as much they do new immigrants. While socialization of new immigrants and expectations of acculturation are important, developed societies can benefit greatly from understanding the unhealthy effects of migration on new immigrants, particularly in the areas of physical activity and nutrition. Research shows clearly that the benefits of healthy communities extend beyond political and social boundaries and thus have a positive impact the health outcomes of nations.

Related Topics

- ► Behavioral health
- ► Body mass index
- ► Built environment
- ► Fitness
- ► Healthy immigrant

- ► Leisure-time physical activity
- ► Public health

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Physician–Patient Communication

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Communicating with patients may well be the most important element of clinical practice. It is also among the most complex and least well understood. Physician–patient communication is problematic for everyone. International migrants may face additional difficulties, but these are best understood as exacerbations of the standard problem.

Medicine is a professional service so physician–patient communication is generally thought of first in functional terms. The physician must collect information to understand the patient's health history and condition and make diagnoses and treatment recommendations; provide information and explanations to the patient; and promote adherence to medical advice, whether it be taking prescribed medications properly, diet, smoking cessation, or other health-related behaviors. Patients must be able to convey their complaints and wishes accurately; solicit information they desire; convey obstacles that may prevent them from following medical advice – such as drug allergies, occupational or family demands, and lack of financial resources; and understand their situation, prognosis, and options.

These instrumental functions depend on interpersonal factors to be successful. The patient must trust the physician's good intentions and competence, and be willing to confide intimate information. The physician must be able to trust information provided by the patient and accurately gauge the patient's informational needs and motivations, among other elements of rapport. Furthermore, the function of a medical encounter is not only to treat disease, relieve symptoms, and promote future health, but also to provide reassurance and comfort. This also interacts with the instrumental functions because the patient must have a satisfactory experience that will promote returning for subsequent visits and following medical advice.

Until the mid-twentieth century, the generally accepted physician–patient relationship in the West was of a nature now characterized as "benevolent paternalism." The expertise and wisdom to choose the appropriate treatment of disease resided entirely with the physician. The patient's role was to trust and to follow "doctor's orders." During the 1970s, and with increasing prominence in the 1980s, a movement grew in medicine to promote "patient-centered" care. Patient-centered interactions were defined by Lipkin et al. in 1984 as treating the patient "as a unique human being with his [sic] own story to tell." The various definitions of patient-centered care share consistency with the biopsychosocial model for health and health care, which sees health in more than just biological terms. For example, Epstein et al. propose that patient-centered communication must include: “(1) Eliciting and understanding the patient’s perspective – concerns, ideas, expectations, needs, feelings and functioning. (2) Understanding the patient within his or her unique psychosocial context. (3) Reaching a shared understanding of the problem and its treatment . . .. (4) Helping patients to share power and responsibility. . ..”

These ideals live uneasily with the reality that physician–patient encounters are asymmetrical in power, expertise, and usually in social status. After all, the reason for the encounter in the first place is that the physician has exceptional expertise. Physicians ultimately control what information they share with patients and what options they present. They monopolize the power to prescribe medications, authorize tests, and perform surgery. They have unique privileges to invade people’s bodily integrity and inquire into intimate matters that are never ordinarily discussed with strangers, or perhaps with anyone. They have immense cultural authority and prestige, and typically earn multiples of the income of their average patient.

Patients may not understand much of the vocabulary that physicians routinely use and may lack the background knowledge to accurately interpret what physicians tell them. They may be overawed by the physician’s elevated social status and reluctant or entirely unable to express doubt or objection, admit lack of understanding, or ask questions. It has been found consistently that people typically do not accurately remember or understand much of the information and instructions from physicians even immediately after a visit; and that people adhere to prescribed medication regimens only about half of the time.

The decision-making heuristics of physicians and patients may be quite different. Physicians base diagnostic conclusions and treatment recommendations on biomedical theories and statistical reasoning: the probability of a beneficial outcome of an intervention versus the probability of adverse effects, weighted by the physician’s judgment of the magnitude of possible benefits and harms. Patients may not understand these calculations or may simply use other criteria, such as prior experiences of people they know, social norms of their community, shorter time horizons, idiosyncratic aversions, cost and convenience, or alternative theories of health and illness, whether from formal systems or lay conceptions. They may or may not ever discuss these criteria with their physicians.

For international migrants, the most important additional difficulties may be classified as language discordance; cultural discordance – a category with many relevant components; lack of financial or other resources ordinarily available to natives; lack of knowledge typically possessed by natives; physicians’ attitudes which may include stereotyping and prejudice; and physicians’ lack of knowledge or inaccurate beliefs about their current circumstances. (Physicians’ lack of knowledge or inaccurate beliefs about possible exposures or other relevant history in the country of origin can be an important problem for clinical practice, but is less directly relevant to the subject of this entry.)

Language Barriers

While it is obvious that people who do not share fluency in a common language will have impaired communication, the problem of language barriers in medicine does have some less than obvious complexities. In fact, even when physicians and patients share the same native language, a language barrier exists in that physicians use specialized vocabulary and modes of expression which patients may not readily understand. When either the physician or the patient has some ability in a language in which the other is fluent, what degree of ability is sufficient to achieve acceptable communication, and how does this vary with the circumstances and nature of the encounter? How can the adequacy of second language ability be defined and practically assessed? How do the benefits and harms of communicating in a language in which one party has less than native fluency compare with the benefits and harms of communicating through interpreters? These questions remain open.

Language interpretation is a complex problem which has not been well studied. (Parlance in the field is that interpretation refers to speech and translation to written materials.) Patients are generally found to prefer language concordant physicians and to be more satisfied with their interactions when physicians speak their preferred language, but there is little direct evidence concerning differential outcomes, if any, in interpreted versus language concordant encounters.

Case reports have illustrated psychological and social harms that can result from having family members interpret. These include traumatization of children, disruption of family relationships, and deliberate manipulation or concealment of facts by the person serving as interpreter. Nevertheless, some people prefer to have family members, rather than a professional, interpret. Institutional policies in the USA increasingly discourage this, but it is more accepted elsewhere.

It is widely accepted that interpretation by trained, skilled professionals is much to be preferred, if not the only acceptable option in most circumstances. However, in most of the world, there are no legal or generally accepted standards for interpreter training, skills assessment, or accreditation. Only a few studies are based on direct observation of interpreted medical encounters, and these are generally based on small numbers of cases. (Observational research involving two or more languages is very laborious and the supply of bilingual investigators is limited.) It has been found that even professional interpreters frequently fail to interpret accurately or completely; may edit statements by physicians or patients according to their own judgment of what is relevant or appropriate; and may engage in behavior outside of the interpreter's professional role. Interpreted encounters have been found to be less patient-centered and to include less psychosocial content.

The extent to which these problems may have been reduced by increased professionalization of medical interpretation in recent years is unknown. Standards of practice and codes of ethics for medical interpreters have been developed and training programs have become more widely available in the USA in the past decade, but information about the proportion of language discordant encounters in which professional interpretation is provided is lacking. An alternative to having an interpreter physically present is the use of telephone interpreter services, but there is little evidence about which method, if either, is superior.

There is controversy about the appropriate role of the medical interpreter. The "interpreter as conduit" views the interpreter essentially as a "black box" who converts one language into another and is as invisible as possible. Although full equivalence of meaning across languages is often unattainable, achieving the closest possible equivalence while maintaining neutrality and nonintervention are still the goal. The "interpreter as manager" sees the interpreter as more active in facilitating communication by working to negotiate social and conceptual differences between the interlocutors (e.g., cultural barriers) while resisting being drawn into the interaction as a partisan. The "incremental intervention" model has the interpreter preferring what is essentially the "conduit" role, but expanding that role when it fails. Finally, the "interpreter as embedded in her cultural and linguistic community" model assumes that the interpreter shares the cultural background and community identity of the patient and functions as an advocate for the patient and the patient's cultural community.

Researchers from a variety of disciplines (e.g., anthropology, communication, and biomedicine) have also investigated the interpreter's role and have jointly argued that the conduit role is inadequate in cross-cultural medical encounters Rather, interpreters should seek to facilitate understanding and meaning between health care providers and patients. However, there is not yet full agreement on the ethical boundaries of interpreter behavior. A common consensus, however, is that interpreters are obliged to make any intervention transparent to all parties. Any exchange which the interpreter has with one individual must be interpreted in the other language, for the other party; it must be clear to all that the interpreter is actively intervening.

Even when a patient has skill in the physician's language which is sufficient to achieve success in work, school, and daily life, or even essentially the capabilities of a native speaker, are there still some respects in which clinical communication is less than optimal? There is evidence that people are less likely to reveal personal information or express affect when speaking a second language. Communication in the patient's first language seems to be especially desirable in psychiatry and psychotherapy. This also has been little studied.

Finally, language barriers can affect written communication, such as the ability to read drug labels or informational materials, or to find public health and medical information from sources other than the medical provider. The impact of such problems on physician–patient communication is indirect and little studied, but it may be hypothesized that people with limited literacy in the vernacular of a host country can have informational deficits that affect communication with their physicians.

Cultural Discordance

Interest in cross-cultural medicine first emerged in the 1970s, largely based in medical anthropology. The premise was that people, especially from outside of Europe and North America where the allopathic biomedicine had its principal development, might have explanatory models of health and illness that differed from those of allopathic physicians. These included formal, professionalized, and institutionalized systems – such as Indian Ayurveda and Chinese Medicine; less formal traditions, including shamanism, religious healing practices, and "folk" systems in which practitioners might be trained through apprenticeship; and lay explanatory models and healing practices followed within the family or close community. The essential problem of cross-cultural medicine was thought to be discordance of belief between physicians, and migrants or members of ethnic minorities who adhered to such "alternative" beliefs. "Cultural competence" was often promoted by teaching providers about "folk" illnesses and healing practices that might lead patients to discount or reject providers' advice and pursue their preferred remedies.

Today, it is generally understood that this emphasis was misplaced. Allopathic medicine (a term derived from early controversies in the development of scientific biomedicine in Europe and the USA which is used today as a non-invidious, if etymologically inappropriate label for medicine as taught in accredited medical schools and practiced by licensed medical doctors) is today accepted as authoritative in most of the world, even where it may exist beside other systems. What is more, many people who are native to the Western home turf of biomedicine adhere to non-allopathic beliefs and practices, including formal and informal systems, as witness extensive shelf space in corporate pharmacies filled with non-approved nutritional supplements and herbal remedies, and thriving practices of naturopaths, acupuncturists, faith healers, and so on. Yet physicians are not often enjoined to study these systems or routinely inquire about them of their native-born patients. The vast majority of individuals pursue them in addition to, rather than instead of, allopathic health care, and this is true in most of the world. In poor countries, many people may rely on non-allopathic healers because they do not have access to medical doctors – but they still prefer to see medical doctors when they get the chance. There are exceptions, to be sure, and there have been celebrated cases of individuals and families who have come into conflict with the medical institution in the USA and Europe over health beliefs. But this is not the most salient issue in cross-cultural medicine.

Of far more importance, culture shapes expectations about the physician and patient roles; interaction process; involvement of family; and other dimensions of communication and relationship. For example, physicians and patients may have differing understandings about relational boundaries, etiquette, or expression of affect. Physicians may not appreciate the importance some people place on involving family members in decisions. Gender role norms and boundaries may create discomfort over physical examination or interviewing. People may be offended by physician questions that are routine in one cultural context but suggest the patient may be transgressing strong cultural or religious proscriptions, such as alcohol use.

More broadly, theorists distinguish cultures along dimensions labeled Individualism-Collectivism (IC), Power Distance (PD) (also labeled "Group" and "Grid," in a roughly similar formulation), and Uncertainty Avoidance (UA). The dominant culture in the USA, and to a lesser extent much of Western Europe, is thought to be characterized by a high degree of individualism, which means that the needs and values of the individual supersede those of the group, defined as family, community, or a larger aggregation. High PD cultures are characterized by greater acceptance of differential social power. The USA and Western Europe tend to be low in PD. Cultures with high UA tend to value consensus, formal rules, and conformity. Again, the USA and Western Europe are characterized by a tendency toward low UA. However, all of these assertions refer only to general tendencies in comparison with some other regions of the world, and more collectivist, high PD and high UA people and groups are common within the USA and Western Europe.

These differences may influence people's expectations about the physician–patient relationship and interaction, symptom presentation, and decision-making processes.

For example, physicians from low PD contexts may expect patients to speak up if they are dissatisfied, do not understand something, or are reluctant to follow the physician's advice, but people from high PD cultures may not do so. People from more collectivist cultures may expect to involve family members in decision making, or even defer to others, whereas physicians from individualist cultures may expect the patient to be a more autonomous decision maker. While these ideas seem plausible and have anecdotal support, there is very little systematic research that applies them to cross-cultural medical communication.

It can be said that the norm of patient centeredness and shared decision making has advanced farther in the USA than it has in much of the world. Physicians who are US natives may erroneously expect people to speak up spontaneously if they have complaints or questions, do not understand instructions, or think the physician has failed to ask the right questions or lacks essential information, whether this is because of low PD or simply the evolving etiquette of the specific situation. (To be sure, US natives may also fail to do so.) There are only a few studies that compare interaction process in ethnically or culturally discordant medical encounters with concordant encounters based on direct observation and systematic coding. These have not entirely consistent results, but this is not surprising since they are not necessarily comparing the same cultural pairings. Generally, cross-cultural and cross-ethnic encounters tend to be shorter and have less psychosocial and interpersonal content.

Also important is the physician's limited understanding of the patient's life world. For example, the physician may give inappropriate dietary advice due to lack of knowledge about the patient's cuisine, child-rearing advice which is unlikely to be followed, or fail to appreciate the patient's lack of autonomy due to gender role or generational norms. Again, these problems are not confined to cross-cultural situations. Differences in social class, education, and financial circumstances can create similar failures in culturally concordant relationships. Cultural discordance merely adds additional complexity.

The Circumstances of Migrants

International migrants are frequently economically disadvantaged. They may face financial barriers to health care access and be less likely than natives to have regular contact with a physician who knows them personally. In the USA, undocumented immigrants and legal immigrants who have not yet met certain requirements for residency status and tenure are ineligible to receive publicly subsidized medical insurance. They are therefore likely to get medical care, if at all, in hospital emergency departments and safety net clinics where they receive only urgent care, from physicians who see them only once. Relationships of trust and confidence with physicians develop over time, and this cannot occur under such circumstances.

Migrants also may lack knowledge about the organization of the medical system in their host country, and have difficulty finding appropriate providers or getting to the right place at the right time, even if services are available to them. Jobs in the secondary or even illegal labor market tend not to provide paid time off, and family or other demands may make it impossible to keep appointments or mean they are kept at great sacrifice. Such problems might have indirect effects on physician–patient communication because of missed appointments, distress over having to wait a long time, or undisclosed anxiety about missing work or other obligations.

Stereotyping and Prejudice

While stereotyping and prejudice by physicians with respect to patients who are immigrants are often thought likely to occur, the problem has been little studied. In the USA, there have been studies of physician's responses to African American and White patients with similar presentations, and some differences have been found. There are differential outcomes and differential rates of some interventions, such as cardiac revascularization, for White, Black, and Latino patients in the USA, but it is not clear to what extent these should be traced to differential treatment by physicians, differential preferences or presentation by patients, or differences in the sites where people of varying ethnicity receive care. How such differences may apply to immigrants is unknown. (Latinos in the USA are not necessarily immigrants, whereas some Black people are.) It has also been found that Latino patients are less likely to be prescribed opioid analgesia when it is appropriate, perhaps because physicians presume they are more likely to be drug abusers.

One objection to the practice of teaching about "folk" health beliefs and practices in the name of cultural competence is that it can promote stereotyping. In a country where a particular belief or practice exists, not everyone will follow it. It may even be stigmatized among much of the population. In the current consensus view, it is best to inquire about people's health beliefs, rather than ascribe beliefs based on their national origin or ethnicity.

Summary

The most important problems in physician–patient communication for migrants center on language discordance, and cultural norms regarding relationships and interactions. Contextual factors also may be of some importance. It is important to keep in mind, however, that physicians and patients typically differ in social status, background, and expertise, and that problems specific to migrants are mostly extensions of problems that are pervasive. Our knowledge of physician–patient communication and international migration is quite thin. Above all, we must resist over generalization as every situation is unique.

Related Topics

- ► Ambulatory care
- ► Communication barriers
- ► Compliance
- ► Cross-cultural medicine
- ► Cultural competence
- ► Cultural humility
- ► Explanatory model of illness
- ► Health policy
- ► Interpreter services
- ► Language
- ► Limited English proficiency
- ► Medical interpretation

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Physicians

► Foreign medical graduates

Pibloktoq

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Pibloktoq (Piblokto) also known as Arctic Hysteria, is an abrupt dissociative episode with four distinct phases. The first phase, or prodrome, may last hours to days and consists of irritability and social withdrawal. The second, or excitement phase, consists of the sudden onset of extreme and wild excitement. During this phase, the individual affected may be seen tearing off his or her clothing, shouting, throwing objects, and running out of doors with a noticed lack of sensitivity to the extreme cold. This phase typically lasts about 30 min. The third phase, convulsions and stupor, follows this excitement. The individual may have convulsive seizures followed by extreme somnolence or coma due to the fatigue produced by the excitement. This third phase may last up to 12 h. The fourth and final phase, or recovery, is notable by complete recovery. Complete amnesia for this event is typically reported.

Pibloktoq is noted to affect the Arctic and circumarctic populations, namely the Inuit Eskimos. Recent estimates report 150,000–200,000 Inuit Eskimos worldwide. They are mainly distributed throughout Greenland, Canada, Alaska, other parts of the USA, Denmark, and Russia. Females tend to be affected more often than males and adults more commonly affected than children. There have also been reports of similar behaviors observed in sled dogs, frequently resulting in death. Such reports note sled dogs having convulsive fits followed by exhaustion or death. Most cases have been reported to occur during the winter months. There is little information regarding Pibloktoq occurring in other cultures or geographic areas.

Pibloktoq is defined as a culture-bound syndrome. Culture-bound syndromes are patterns of aberrant behaviors and troubling experiences which are recurrent and specific to certain localities or populations. They generally fall outside of traditional Western psychiatric categories or definitions of illness. Such syndromes tend to be recognized by the culture but are not necessarily thought of as illnesses. Each culture will have its own distinct way of defining such a syndrome based on the relevance to the culture. In the *Diagnostic and Statistical Manual, Fourth Edition, Text Revision* (DSM-IV-TR), pibloktoq is listed under dissociative disorder not otherwise specified as a dissociative trance disorder. This is defined as “single or episodic disturbances in the state of consciousness, identity, or memory that are indigenous to particular locations and cultures.”

There are many theories as to the causative nature of pibloktoq. These theories can be divided into biological, psychological, and social categories. The most prevalent current biological theory as to cause of Pibloktoq is hypervitaminosis A. Vitamin A is a lipid (fat)-soluble compound, known as retinoic acid. It may be found as a provitamin in green leafy vegetables. In this form, it needs to be converted into active vitamin A, which is subject to a regulatory feedback mechanism and, therefore, unlikely to lead to toxicity. However, it may also be found in its preformed state in foods such as liver, kidneys, egg yolks, and butter. In this state, it is quickly and easily converted to its active state with no regulation, therefore, more likely to become toxic. About 50–85% of the body’s vitamin A is stored in the liver. The Inuit diet is high in organ meats, specifically liver. The amounts of vitamin A in polar bear liver and seal liver are known to be toxic. There are both acute and chronic forms of vitamin A toxicity. In the acute-form symptoms include nausea, vomiting, vertigo (dizziness), blurry vision, drowsiness, and malaise. In chronic states, it may cause ataxia (gait disturbance), alopecia (hair loss), hyperlipidemia (elevated cholesterol), hepatotoxicity (liver damage), visual impairment, bone and muscle pain, and headaches, as well as fatigue and irritability. Signs of vitamin A toxicity have been reported in the European explorers of the past. Despite these reports, none noted a progression to a full episode of pibloktoq. Other biological theories hypothesized in the past include low calcium and vitamin D, as well as interrupted circadian rhythms related to the long periods of darkness throughout the winters.

Other theories fall under the categories of the psychological and social factors. Psychologically, it is thought to be something of a “functional hysteria” serving the function of helping an individual with the resolution of some internal conflict. Others have hypothesized that it may be a reaction to traumas, which had been high in the past during the long winters due to hunting accidents and possibilities of starvation. Socially, or culturally, many characteristics of a pibloktoq episode are similar to the behaviors in the ritual “drum song.” This ritual may be initiated during times of distress in the area. Behaviors included in the ritual may include high-pitched singing, arms moving frantically about, uncontrollable sobbing, and hysterical laughter followed by exhaustion. As a population, this ritual is thought to be an outlet for feelings of anger or hostility. When translated by an individual into an episode of pibloktoq, it is thought to be a catharsis for personal stressors.

Pibloktoq appears to be self-limited, and little intervention is required. The local people may intervene only to protect the individual from harming either themselves or others during the excitement phase. Many are known to have only one attack, but others may have repeated attacks. Each attack is generally followed by complete recovery and return to normalcy.

Related Topics

- ► Culture-specific diagnoses
- ► Mental Illness

Suggested Readings

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Plague

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History of the Disease

Plague is a disease affecting animals primarily; however, it can affect humans also. It is caused by the bacterium *Yersinia pestis*, which was identified first toward the end of the nineteenth century. The disease itself dates to ancient times and is thought to have originated in Central Asia. The first plague epidemic on record was the outbreak among the Philistines in 1320 BC, described in the Bible. Worldwide occurrences, or pandemics, have claimed lives on the order of tens of millions. Global outbreaks have included: the Justinian Plague in the sixth century AD, the "Black Death" of the fourteenth century decimated Europe's population, and the "modern pandemic." The modern pandemic occurred in the 1860s in China and persisted through the early twentieth century, killing millions as it spread from Hong Kong to 77 ports on five continents in 10 years. In the first half of the twentieth century, India was affected most severely by plague epidemics; then in the 1960s and 1970s, war-torn Vietnam became the country affected most by plague. Recently, plague has resurged in the nations of sub-Saharan Africa and the adjacent island of Madagascar; currently these account for more than 95% of cases reported to the World Health Organization (WHO). Since the Los Angeles epidemic in the 1920s, the plague has occurred in the United States mostly as scattered cases in rural areas; approximately 10–15 cases are reported yearly. In the United States, most human cases occur in two regions: (a) northern New Mexico, northern Arizona, and southern Colorado; and (b) California, southern Oregon, and far western Nevada. To illustrate the frequency and distribution of the plague, note that between 1989 and 2003, 25 countries reported approximately 38,300 cases, including 2,850 deaths. Most cases were reported in Madagascar, Tanzania, Democratic Republic of the Congo, Vietnam, Mozambique, Namibia, and Peru.

Favorable Conditions

Yersinia pestis persists in natural foci in relatively dry areas without thick woody vegetation, including areas such as: deserts, semideserts, steppes, savannas, prairies, and similar environments. The bacterium is harbored by local rodent and flea populations. Natural foci include North and South America, Africa, Asia, and southeast Europe; affected regions include areas in the Caucasus Mountains, the northern Caspian Sea, the Eurasian Steppes, Siberia, Iran, Turkey, China, India, Madagascar, southeast Asia, most South American countries, the Arabian Peninsula, and the four corners of Africa. In North America, natural foci of plague occur mainly in the western states of the United States, in southwestern Canada along the US border, and in northern Mexico.

Animal-To-Human Transmission

Humans acquire the infection from flea and animal bites, handling infected animal carcasses, or through transmission via respiration during animal-to-person or person-to-person contact. The most common animals to transmit plague in the United States are squirrels, rabbits, and prairie dogs, while undetermined species account for about one-third of cases. Domestic cats are implicated in the transmission from animals to humans also, occurring through bites or human respiration. Both sexes and all ages of patients are susceptible to disease, with the plague thriving in the unsettled conditions of war, natural catastrophes, and the relocation of refugees who lack public-health services. In all countries with a high occurrence rate, human plague demonstrates seasonal variation. In the United States, the season of highest frequency is from February through August.

Medical and Public-Health Preparedness

Yersinia pestis is a potential agent of bioterrorism, classified as category A (the highest) by the Centers for Disease Control and Prevention (CDC). Historically, plague victims were reported to have been catapulted into besieged cities; examples include use by the Japanese against China during World War II and the development of *Y. pestis* as an aerosol weapon during the Cold War. Active terrorist groups who have employed biological agents pose an ongoing risk, and the potential development of biological warfare by organized armies is a subject of utmost secrecy. Misuse by terrorists is considered an important national security threat requiring special measures for medical and public-health preparedness.

Disease Presentations

Plague develops usually 1 day to 1 week after penetration of the microbe to the human body. There are three main presentations: bubonic, pneumonic, or septicemic. Bubonic plague is the most common form and presents as high fever, headache, and weakness – accompanied by the appearance of a bubo. A bubo is an inflamed, very painful, lymphatic ganglion, with inflamed red skin overlying. It occurs mainly in the groin, the axilla, or the neck; however, it can occur elsewhere, such as the elbow, in cases in which a cat is the source of the infection. In some cases, people may have this presentation without the appearance of a bubo; this is called septicemic plague. Pneumonic plague, highly lethal and contagious, is the involvement of the lungs with development of a respiratory infection; this can complicate the previous forms or be present initially, especially in the case of acquisition through respiration. Plague can affect the meninges, the digestive system, or the throat. Without treatment, fatality is high, claiming one-half of patients with bubonic plague and virtually all patients with the septicemic or the pneumonic form. Appropriate and timely treatment substantially lowers the risk of death; however, it remains high. When death occurs, it is rapid, striking within a few days of the onset of the disease.

Treatment

Doctors suspect the presence of plague when a patient was exposed recently to infected animals or their fleas in an area with a high rate of occurrence. The presence of a bubo is a helpful indicator, but it is not universal. Special imaging of the chest is necessary to detect lung infections. To confirm the diagnosis, blood or bubo samples, expectorated phlegm, or other body fluids are collected and examined in specialized laboratories. Doctors begin treatment usually without waiting for a final diagnosis as a delay puts at high risk the life of the patient. Treatment is by specific antibiotics; streptomycin is the preferred treatment, but other medications are used sometimes because of its limited availability. All patients suspected of having the plague should be placed under isolation for a period of time. All suspected plague cases should be reported immediately to state health department authorities. Family members, care providers, and others with direct contact should be isolated also for a period of time and may benefit from preemptive treatment.

Preventive Measures

Reducing exposure is the best preventive measure. Persons living in endemic areas should use protective measures against rodents and fleas, including living and working in rat-proofed dwellings, removing food and harborage for rodents, using repellents, applying insecticides on their pets, and should avoid handling dead rodent carcasses. A vaccine, with limited benefit and use, is produced currently in limited quantities, but research driven especially by concern for bioterrorism is under way to develop improved plague vaccines. In the United States, the CDC fields a team of specialists to investigate cases of plague; interventions include pest control, education, and early detection of disease.

Related Topics

- ► Emigration
- ► Epidemiological paradox
- ► Health outcomes
- ► Immigration in the global context
- ► Life expectancy

Suggested Readings

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Suggested Resources

For information on the Centers for Disease Control and Prevention. http://www.cdc.gov/ncidod/dvbid/plague/

For information on the World Health Organization. http://www.who.int/csr/disease/plague/en/

Poland

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Introduction

Poland is a nation of almost 40 million people, living on 121,000 square miles in north central Europe. Outside of the capital city of Warsaw, and other large cities such as Krakow, most of Poland's citizens live in rural areas, working in agriculture, mining, or heavy industry. Poland is strongly Roman Catholic.

The character and outlook of the Polish people have been shaped by various hardships. Geographically, the county is composed of plains with few natural boundaries, save the Carpathian Mountains to the south and the Oder and Neisse rivers to the west. As a result, Poland is vulnerable to occupation and invasion by neighboring lands. This geographic vulnerability fosters political unrest; over the last century alone, Poland struggled with both dictator and communist rule. With constant challenges to land and citizenry, Poland has had difficulty keeping economic pace with Western Europe. As a result of these struggles, Poland has long been a country of net emigration as citizens seek better economic or political circumstance. Poland's 2002 entrance into the European Union, however, may change this equation.

Political History

The last one hundred years illustrate how challenges to Polish land and politics have shaped the Polish people. In 1795, the constitutional monarchy ended, and Poland's lands were completely partitioned between Prussia, Austria, and Russia. For the next 100 years, until the end of the First World War, therefore, Poland was a country in name only. Its people were held together largely by a common Catholic faith, which may explain Poland's continued fealty to the modern Roman Catholic church.

From 1920 to 1939, Poland was a self-governing nation and enjoyed some economic and intellectual development. The effects of the Second World War, however, were devastating: Poland lost proportionally more citizens than any other country in Europe (6 of 35 million people, or roughly 1/6 of the population). The capital city of Warsaw was leveled, farmlands were burned, and factories and industries were in ruins. Adding insult to injury, Allied leaders at the end of the war answered the "Polish Question" by allowing it to become part of the Soviet Bloc. Poland's citizens therefore moved from restrictions under German occupation to different restrictions under communism. Again, a common faith held people together during these difficult times, as did trust in family and community.

Poland again became a self-governing nation with the fall of communism in 1989 but then was left to struggle with a lack of resources for technological and economic advances. In 2002, Poland became a member of the European Union, which improved its economic and political position in Europe.

Polish Immigration

Due to the difficulties described above, Poland has long been a nation of emigration, receiving immigrants from other nations infrequently. Although Polish natives have immigrated to many countries over the years, the largest number of Polish immigrants outside of Poland is in the United States. Indeed, the 2000 United States census reflected over 800,000 Polish known immigrants in Chicago, making it the second largest city of Polish nationals outside Warsaw. Polish immigration to the United States began in Texas in the 1850s but spread to the Northeastern and Midwestern United States, where the climate (short summers and long harsh winters) and economic opportunities (mining, factory work) were most familiar.

The first wave of Polish emigration occurred in the late 1800s and early 1900s when opportunities in the rapidly industrializing West prompted uneducated and poorly skilled workers to emigrate *za chlebem* ("for bread"). These immigrants were interested in making a new home and life in their new countries and worked to establish large communities in cities such as Chicago, New York, and Detroit (commonly called *Polonia*). This group sought assimilation and raised their children to be Americans.

The second wave of immigration came after the Second World War, which left Poland devastated economically, physically, and emotionally. This group included the *za chlebem* immigrants, but also held a large number of intellectual dissidents and political refugees. As a group, members of this 1939 to 1950 wave were more educated and skilled than their earlier counterparts but, nevertheless, shared the goal of assimilating into United States life and culture.

A third wave of emigration from Poland began in the late1980s. Poland was a member of the communist Soviet Bloc from 1945 to 1989, and emigration was largely restricted to those who won "visa lotteries" or falsely promised that their stays abroad would be temporary. After communist rule, the United States dollar was much stronger than the Polish *zloty*, and Polish immigrants were drawn to relatively high-paying jobs in the United States. This group of both skilled and unskilled laborers were focused less on finding a new home and community in the United States and more on working to send money home. As a result, many in this group have not spent money on health or dental care, and have not assimilated into US culture or communities.

The fall of communism expanded emigration possibilities for Polish citizens seeking better employment, asylum, or different living conditions. Although many still come to the United States, Polish nationals wishing to remain closer to their home culture and family ties go to Western Europe and the Netherlands.

Polish Health Care

The Polish health care system has been affected by the geographic, political, and economic struggles outlined above. Access to good health care has been most lacking. First, the rural location of many Polish people means that visiting a doctor or clinic is difficult at best. Missing a day's work to travel to a clinic is an added negative incentive. Second, political upheaval produced spotty and undependable health care. For example, under communism, Polish citizens had free national health care, but the system was poorly funded and maintained. After communism, the country focused on reorganizing the system but lacked resources to train and staff the necessary workforce. Political upheaval also spawned mistrust, and even when health care was available, many Polish citizens preferred to seek help from their trusted family or priest.

Other factors contribute to health care challenges for the Polish people. The Polish diet is traditionally heavy in meat and root vegetables, often preserved for winter consumption in sodium-heavy pickling solutions. Alcohol is ubiquitous in Polish social gatherings, and many start drinking in their mid-teens. The Polish economy revolves around agriculture, mining, and heavy industry. Governmental regulations have been overlooked at times in the latter categories, exposing Polish workers to chemicals and inhalants that predispose to respiratory conditions, and cancers such as leukemia. Finally, lack of education has been a problem under both communism, and Catholic Church influence. For example, under communism Polish citizens were not widely informed about AIDs/HIV or transmission risk factors. Public education efforts in this area remained hampered after communism due, in part, to the opposition of the Catholic Church regarding safe-sex education.

Polish Immigrant Health

Predictably, Polish immigrants bring their dietary and health habits, along with predisposing conditions, to receiving countries. As described above, these include cardiovascular problems from poor diet, respiratory disease and cancers from unregulated work, alcoholism, and chronic pain that the stoic Polish immigrant may be reluctant to report. Dental problems are common in both Polish citizens and immigrants, owing to low numbers of dentists in Poland. Smoking is also common in Poland, adding to respiratory risk factors.

Although the widespread and social use of alcohol raises the risk of alcohol abuse and dependence in the general population, rates of thought and mood disorders are lower or equal to other immigrant populations. Studies show that immigrant mental health is related less to country of origin than to success of acculturation. Although more recent immigrants remain external to US culture, Polish immigrants traditionally acclimate well to the communities and cultures of their host countries. Such acculturation is related to higher subjective quality of life.

Emigration to Poland

Due to repeated hardships, Poland has been a net emigration country for years. Census information from Poland in 2002 reported that only 0.2% of the population was foreign-born. The Polish government has therefore adopted a fluid policy toward migration that has been especially successful since the opening of Eastern European borders in 2006–2009 (e.g., Bulgaria and Romania entered the European Union in 2007, expanding the local labor market). In a circular pattern of migration, temporary or seasonal workers come to Poland (largely from the Ukraine) for a limited work engagement, then return home. This introduces a beneficial labor force to Poland, but one that is unpredictable.

Related Topics

► European Union

Suggested Readings

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Political Asylum

► Asylum

Polygamy

► Marriage

Port of Entry

► Immigration processes and health in the U.S.: A brief history

Portugal

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Introduction

Located on the Iberian Peninsula in the southwest of Europe, Portugal is Europe's westernmost country. It is bordered by the Atlantic Ocean to the west and south and by Spain to the north and east; the Atlantic archipelagos of the Azores and Madeira are part of the state also. The country's official name is the Portuguese Republic, but the shorter designation is used more often. The land of today's Portuguese Republic has a long and varied history dating to prehistoric times.

Roman settlers had a profound influence on the Portuguese culture, particularly the language. In 29 BC, the territory was integrated into the Roman Empire as the provinces of Lusitania and a portion of Gallaecia. After the fall of the Roman Empire, the land was occupied in the fifth century by several Germanic peoples – the Suevi and the Visigoths. Subsequently, Muslim Moors conquered those Christian kingdoms in the eighth century and occupied most of the Iberian Peninsula. During the Christian Reconquista, or Reconquering, northern Portugal was settled as part of the Kingdom of Galicia. The Kingdom was recognized in 1143, and with the stabilization of its borders by 1249, Portugal claims to be the oldest European nation-state.

Portugal became the world's major economic, political, and military power when in the fifteenth and sixteenth centuries, it established a global empire that included possessions in Africa, Asia, Oceania, and South America. After a political crisis over succession to the throne, in 1590 Portugal was united with Spain for a time; however, in 1640 it reestablished full independence. As the monarchy was overthrown in 1910, democracy was established. However, it was unstable and replaced subsequently by the *Estado Novo* dictatorship. Following the Portuguese Colonial War and the Carnation Revolution in 1974, democracy was restored and the country relinquished its last overseas provinces, notably, Angola and Mozambique. In 1999, the last overseas territory, Macau, was handed over to China.

Geography and Climate

The geography of Portugal's mainland is divided by the river, Tagus, which flows from Spain, empties into the Tagus Estuary, and further into the Atlantic Ocean. Northern Portugal is mountainous toward the interior with several plateaus. Southern Portugal, however, includes the Algarve and the Alentejo regions. The Algarve is the southernmost part of the mainland; it is known for its hills, rich valleys, and coastline. The landscape of the Alentejo includes rolling hills and plains that are dotted by cork oaks and olive trees.

Portugal, defined as a Mediterranean climate, is one of the warmest European countries. The annual average temperature on the mainland varies from 13°C in the mountains of the north to over 18°C in the south. In areas such as the Guadiana Basin, annual average temperatures can reach 20°C, with summer temperatures over 45°C. In the high mountains, a maritime climate exists. The record high, 47.4°C, was recorded in Amareleja. The country has roughly 2,500–3,200 h of sunshine a year, averaging 4–6 h in the winter and 10–12 h in the summer.

Economy

Since the 1990s, business services have overtaken more traditional industries as the basis of Portugal's economic development model has shifted from public consumption toward a focus on exports, private investment, and the high-tech sector. Portugal scored 19th highest worldwide on *The Economist*'s 2005 quality of life index. It is a member of the United Nations and the European Union, and as of 2007 was the eighth most globalized country in the world according to the Swiss Federal Institute of Technology's globalization index. Portugal has a strong tradition in the fishing sector, and it has one of the highest rates of fish consumption per capita. With Portugal's transition toward tertiary sector growth, travel and tourism will continue to be critically important to the economy. Portugal has niche attractions such as health, nature, and rural tourism.

Politics

Since the ratification of the Constitution of 1976, Portugal has been a democratic republic; Lisbon, the nation's largest city, is the capital. The constitution grants the separation of powers among legislative, executive, and judicial branches. The four main institutions detailed in the constitution are the President of the Republic, the Parliament, the Government (headed by a Prime Minister), and the courts.

The President is elected to a 4-year term and has a supervisory nonexecutive role. Parliament is comprised of 230 deputies who are elected for a 4-year term. The government, headed by the Prime Minister, chooses a Council of Ministers, which comprises the

Ministers and State Secretaries. The courts are organized into several levels: judicial, administrative, and fiscal branches.

Healthcare

The Portuguese health system is formed by three coexisting systems: the National Health Service (NHS), special social health insurance schemes for certain professions (health subsystems), and voluntary private health insurance. The NHS provides universal coverage. In addition, about 25% of the population is covered by the health subsystems, 10% by private insurance schemes, and another 7% by mutual funds.

The Ministry of Health develops health policy and manages the NHS. There are five regional health administrations that implement the national health policy objectives, develop guidelines and protocols, and supervise health care delivery. Decentralization efforts have aimed at shifting financial and management responsibility to the regional level. The NHS is funded largely through general taxation. Employer (including the state) and employee contributions are the main funding sources of the health subsystems. Direct payments by the patient and voluntary health insurance premiums account for a large proportion of funding as well.

Immigration and Emigration

Historically, Portugal was a country characterized by emigration. In recent years, however, Portugal has experienced immigration such that no simple characterization adequately describes the country's emigration and immigration trends – although emigration still greatly outnumbers immigration. While net migration in the 1990s was positive, the meaning of migration is complex for Portugal and cannot be understood by the binary nature of net migration alone.

Portugal and its authorities have developed an expansive view of migration supported by links with the longstanding Portuguese diaspora. It is reported that worldwide, there are more than 100 million persons with recognizable Portuguese ancestors – owing to immigration and the Portuguese Colonial Empire – the first global empire in history. From the sixteenth century, inhabitants of Portugal immigrated in large numbers to destinations such as India, the Americas, Macau and East-Timor, Malaysia, Indonesia, and Africa. With the exception of Ireland, between 1886 and 1966, Portugal lost residents to emigration more than any West European country. From the middle of the nineteenth century to the late 1950s, nearly two million Portuguese left Europe to live in Brazil and the USA. Due to massive immigration in the late nineteenth and early twentieth centuries, approximately 40 million Brazilians have relatively recent Portuguese background, and about 1.2 million Brazilian citizens are native Portuguese. Significant numbers of Portuguese minorities exist in Israel (Portuguese Sephardic Jews), the Netherlands, the USA, France, Venezuela, Brazil, and Turkey. In the USA, there are Portuguese communities in New Jersey, the New England states, and California. In the Pacific, Hawaii has a sizable Portuguese population that dates back to 150 years. Since 1940, Canada – particularly Ontario, Quebec, and British Columbia – have had significant Portuguese communities.

Portugal's Ministry of Foreign Affairs has registered and attempts to maintain ties with those who have emigrated. Notably, the number of emigrants from Portugal outnumbers by 10 to 1 the number of foreigners and those with foreign ancestry who have immigrated to Portugal. Members of Portugal's diaspora community have maintained close relations with their homeland. This relationship is manifest in frequent visits to Portugal, regular sending of remittances (approximately 3% of GDP in 2000), faithful viewing of Portuguese television programs, significant participation in civil society associations and parliamentary elections, and consumption of "ethnic" goods.

In addition to this rich heritage, Portugal has always had a special relationship with its former colonies. Brazil, along with the association of Portuguese-Speaking African Countries (PALOP) that includes Angola, Mozambique, Guinea-Bissau, São Tomé and Principe, has played a prominent role in Portugal's migration history. Immigrants from PALOP states have recently been joined, however, by arrivals from nontraditional source countries.

Portugal continues to balance these two forces: an enormous diaspora that maintains close social, economic, and cultural ties with Portugal – and immigrant flows from former colonies that continue to benefit from some legal preferences, such as the demand for a shorter period of continuous residence in Portugal in order to request Portuguese citizenship.

Related Topics

- ► Brazil
- ► European Union

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For information on Portugal from the World Health Organization. http://www.who.int/countries/prt/en/

For information on Portugal from the United Nations. http://www.un.int/portugal/atun.html

Posttraumatic Stress Disorder

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People of any age who experience or witness distressing, life- or injury-threatening events may be psychologically affected by them and experience a range of symptoms that includes nightmares, insomnia, flashbacks of the event, psychological numbing, or avoidance of reminders of the event. For many individuals, these symptoms fade over time. However, for some individuals, such symptoms persist and form the basis for a psychological disorder referred to as posttraumatic stress disorder (PTSD). PTSD is classified as a clinical anxiety disorder that results from experiencing a traumatic event. According to the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR)*, the event may involve: (1) direct experience of actual or threatened death, serious injury, or other threat of harm either to a person's physical integrity; (2) witnessing such events; or (3) learning about the unexpected or violent death, serious injury, or threat of death or harm experienced by a family member or close associate. The person's response to the event must involve intense fear, helplessness, or horror. Responses in children may also include agitated or disorganized behavior.

PTSD is characterized by the development and persistence of three clusters of symptoms in response to the traumatic event(s): increased arousal (e.g., hypervigilance, insomnia, irritability), re-experience of the traumatic event(s) (e.g., nightmares, intrusive thoughts, flashbacks), and avoidance of stimuli associated with the event and numbing of general responsiveness (e.g., efforts to avoid thoughts, feelings, places, activities associated with the event; detachment; diminished interest in important activities; restricted range of affect; and sense of foreshortened life or future). In children, symptoms are expressed differently. For instance, younger children may experience nonspecific frightening dreams instead of flashbacks or trauma-specific nightmares, and daytime recall may involve repetitive play, drawing, or reenactment of the event or trauma-related themes. Children's responses to the event may also include somatic complaints (stomachache or headache), as well as regressive, antisocial, aggressive, or destructive behavior. Although most persons recover over time, a sizable minority of individuals' symptoms will persist. A diagnosis of PTSD requires that at least 1 month has transpired since the experienced traumatic event. PTSD is considered chronic if symptoms persist beyond 3 months, and in some individuals the disorder may continue for years.

PTSD is not without controversy. Of particular significance is the fact that the construction of PTSD as a disorder links psychological distress to the experience of specific events. Thus, its diagnosis can serve social and political purposes by standing as medically backed, hard evidence of a person's (or group's) suffering and may thereby be used both to identify legitimate victims and justify governmental and nongovernmental responses to those victims. In the context of immigrants, such responses could include humanitarian assistance or determination of asylum or refugee status. Another controversial aspect is that although PTSD as a diagnosable disorder was originally developed with war-related experiences as the triggering event(s), the type of triggering event has expanded over time to include a much wider range of events: for example, vehicular accidents and childbirth. Whether the PTSD construct codifying reactions to war experiences is equally valid or applicable to the complex distress experienced by persons in other circumstances (e.g., child maltreatment, torture, and refugees) is debated. In a related vein, the current PTSD diagnostic criteria may not adequately capture the poorer physical, affective, behavioral, cognitive, or social functioning displayed by children with the disorder. Whether the constellation of adverse symptoms and functioning reflects PTSD with comorbid conditions or the proposed alternative "complex PTSD" condition is unclear. Furthermore, the appropriateness of the disorder across cultures has been questioned because cultural groups may have specific idioms of traumatic reaction or distress not encompassed by the DSM-IV classification. However, collectively, the presence of the three symptom clusters in traumatized persons throughout the world has lent credence to the validity of PTSD as a diagnosable disorder.

PTSD can be devastating to persons' health and well-being, affecting individuals in numerous ways: for example, lower self-esteem, increased behavior problems, impaired interpersonal skills and social functioning, poor school or work performance, increased risk of self-harm, and poorer general health and greater somatic complaints. Moreover, although the precise causative pathways are unclear, PTSD may increase the risk for other co-occurring disorders, including depression, dissociation, and substance abuse. Longitudinal studies of PTSD's course are rare, but available evidence suggests that worrisome proportions of individuals with PTSD show no significant remission over time.

Both psychologic and pharmacologic approaches are used to treat PTSD. In general, psychological treatments consist of activities such as therapist-led, imaginal exposure to the traumatic event(s) via oral, drawn, or written recollections in order to gradually confront and overcome memories and "triggers" of the event; training in relaxation skills; restructuring inaccurate or unhelpful thoughts and feelings about the event; uncovering and processing of previously unconscious thoughts and emotions (this latter approach being more psychodynamic in nature). In a recently developed therapy, eye movement desensitization and reprocessing, the client recalls the traumatic event while visually following the rapid, back-and-forth movement of the therapist's finger or hand. Pharmacologic treatment is used to decrease PTSD symptoms. Selective serotonin reuptake inhibitors (SSRIs) are approved for use in adults with PTSD. Current evidence suggests that SSRIs may also be effective in pediatric PTSD, but there is not yet sufficient evidence to support their use alone with children.

Exposure, cognitive behavioral, and stress management approaches, as well as pharmacologic treatment, have shown effectiveness in treating PTSD. However, it is important to note that the systematic, meta-analytic research providing such evidence has relied largely on nonimmigrant North Americans and Europeans; the evidence for the efficacy of narrative exposure or cognitive behavioral techniques specifically among refugees or asylum seekers is present but is more limited.

PTSD is a special concern among immigrants, particularly for the nearly 16 million refugees and asylum seekers around the world. Recent meta-analytic reviews of psychiatric conditions among refugee populations have reported PTSD prevalence rates ranging from 9% to 31% for adults and 11% for children. Thus, even conservative estimates suggest substantial numbers of immigrants with clinical PTSD. Moreover, the striking heterogeneity in prevalence rates observed across individual investigations (e.g., from 10% to 90%) reflects not only differences in sampling and assessment methods but also differences in the complex configuration of etiological, protective, and risk factors that shapes the actual experience of an immigrant: for example, type, severity, and timing of threatening events encountered; presence of family or other supportive individuals; and presence of other stressors experienced by an immigrant (explained below) that may increase the likelihood of developing PTSD or increase its severity.

Studies of PTSD among immigrants reveal that the potential for experiencing PTSD-inducing events occurs throughout any of the phases of immigration: premigration, migration, and postmigration. For example, potentially traumatic premigration stressors might include events such as war, torture, persecution, famine, or natural disasters, and may have been primary factors in individuals' decision to leave their countries of origin. The migration or transit experience itself may be psychologically and physically traumatic. Travel circumstances may be perilous, as immigrants move through war zones or other areas of social unrest or upheaval. Transport may involve crossing large bodies of water in small, unseaworthy vessels, being smuggled in ill-equipped, hidden compartments of trucks or ships, swimming across dangerous rivers, or crossing deserts on foot. The transit experience may also involve high risk of sexual violence, forced labor, or confinement/imprisonment. Also, persons in refugee camps and detention centers, whether these locations are situated "in transit" or within the host country, may be at risk of physical and sexual violence from other refugees, staff, or both. Once in the host country, immigrants, particularly refugees or undocumented migrants, may have limited economic resources and therefore live in disadvantaged areas, with elevated rates of violence and crime. The stress of life in a new sociocultural environment, particularly with diminished material and social resources, can be traumatic and may heighten risk of family violence. One important conclusion to be drawn from the literature on traumatic stress and immigration is that an immigrant need not be a refugee or asylum seeker to have traumatic stress symptoms: even for those individuals who migrate voluntarily to a new country for economic reasons and the hope of a more prosperous life, the travel or resettlement period may be traumatic.

Increased frequency and severity of exposure to violent or otherwise disturbing, life-threatening events throughout the migration experience are recognized risk factors for the development of PTSD among immigrants. Research on posttraumatic stress has also identified other factors that act to increase the risk, or conversely, decrease the likelihood of posttraumatic symptomatology. These factors may also operate throughout the immigrant experience. Individual characteristics such as preexisting chronic physical illness or psychological and behavioral problems may increase risk, while positive self-esteem, the ability to adapt to new situations, a good temperament, and "positive beliefs" (e.g., ideological commitment to one's side in a political struggle or finding personal meaning in adverse events) may act as protective factors. Social support has been consistently identified as a factor either reducing the risk of posttraumatic stress or mitigating its effects. Thus, the presence or absence of family members, friends, or other members of one's social network influence the degree to which disturbing events become psychologically traumatic. Child refugees unaccompanied by other family members may be especially vulnerable. Along these lines, it is important to recognize that even if physically present, normally supportive individuals may be incapable of providing support to others because of the distress they experience in response to traumatic events. Thus, for example, parental distress may increase risk of PTSD among the children.

Upon arrival in the new host country, the immigration or asylum-seeking process itself may be stressful. As described above, detention centers or refugee camps may be dangerous. Immigrants may endure economic hardship, unemployment or underemployment, including well-educated professionals who are unable to practice their profession in the host country because of licensing or other legal issues. Reduced economic resources may force immigrants to live in inadequate housing in disadvantaged neighborhoods, with poorer resources and increased violence and crime. Immigrants may experience acculturative stress as they try to adapt to new (often disadvantaged) living circumstances, a new language, and a new sociocultural milieu. Immigrants may also experience discrimination from host-country nationals, other immigrant groups, or both. Moreover, because immigrant children frequently attend school and therefore learn the host-country language faster than older family members, both immigrant parents and children may need to adapt to their children's role as the family's interpreter or "cultural broker." Of course, some immigrants may also experience the threat of denied asylum or discovery of one's undocumented status and subsequent deportation. Collectively, such compounding stressors – immigration-related legal processes, fear of denial of asylum status, economic hardship, discrimination, and acculturation – may facilitate the development of posttraumatic stress symptoms or exacerbate existing symptoms. Moreover, services for immigrants, including refugees or asylum seekers, may be economically or socially inaccessible, fragmented, or lack the adequate expertise to recognize and treat mental health issues, including PTSD. Even if the expertise is present, treatment of PTSD among some immigrants may be complicated by numerous factors, such as the lack of culturally validated diagnostic or assessment measures, differences in therapist's and client's cultural understandings of trauma, the need for assistance from the client's family or community to get or keep the client in treatment, the need for interpreters, the possibility that in some instances continuation or exacerbation of PTSD symptoms may be seen as advantageous to an immigrant seeking refugee status or asylum.

Despite these formidable circumstances, services have made notable strides over the years in treating immigrants with PTSD and collectively have learned important lessons to increase their effectiveness. First, it is critically important to recognize that any single immigrant group is not homogeneous. Psychological, social, political, and economic differences among immigrants exist in the home country before migration, and, especially given the complex experiences of immigrants during the actual migration process, differences likely exist among individuals of the same immigrant group after their arrival. Services for PTSD cannot rely on a "one-size-fits-all" approach to be effective. Also, individual and group resilience should be recognized and used in therapy. Indeed, the narrow view of immigrants with PTSD solely as *victims* of trauma should be avoided.

Second, services for immigrants with PTSD need to be as comprehensive as possible (e.g., mental health services integrated in broader services), addressing ongoing basic needs, assisting with legal procedures, and mitigating stress related to change in family economic circumstances (often for the worse) and social roles (children as cultural brokers), language barriers, and discrimination. These stressors may actually be a greater source of immediate distress to immigrants in the host country than traumatic stress.

Third, the need for cultural sensitivity and understanding in treating immigrants with PTSD cannot be overemphasized because sociocultural barriers may preclude treatment even in settings where services are affordable and easily accessible. Ideally, pairing an immigrant with PTSD with a practitioner of the same cultural or ethnic group could foster more effective communication. However, such cultural matching is not always possible. In this regard, it is important for clinicians to recognize that the broader immigrant community to which an immigrant belongs may constitute an important source of learning, understanding, and support to both clinician and client. For example, an immigrant's religious institution may serve as a critical resource for information and even a preferred meeting place, where private matters can be discussed without the stigma of seeking help in a mental health facility.

Concerning culturally sensitive treatment, although current therapeutic techniques may rest on imaginal reexposure to and discussion of the traumatic event(s), not all cultural groups may find such "retelling" therapeutic. In fact, these approaches may be counterproductive or even harmful among persons coming from locations where information-gathering procedures were used for nefarious purposes. In the case of children, the school may be an important site for both recognizing and treating PTSD. Such services may be more accessible to children if offered at a school than in a clinical setting. Also, school-based services may provide an opportunity to address broader issues related to acculturation that immigrant children face, and may offer an avenue through which immigrant children's parents and other family members may be engaged and assisted.

In conclusion, PTSD is a substantial problem among immigrants, particularly among populations of refugees and asylum seekers. While important strides have been taken to improve its recognition and treatment, more work is clearly needed to develop more effective, culturally valid ways to assess and treat this disorder.

Related Topics

- ► Asylum
- ► Child abuse
- ► Discrimination
- ► Domestic violence
- ► Refugee
- ► Refugee camp
- ► Stress
- ► Torture
- ► Trafficking
- ► Trauma
- ► Trauma exposure
- ► Violence
- ► War-affected children

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Suggested Resources

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National Child Traumatic Stress Network. www.nctsn.org

UNHCR: The UN Refugee Agency. www.unhcr.org

Poverty

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Economists assess wealth and poverty using a variety of measures; the three most common include income, assets, and socioeconomic indicators. Socioeconomic metrics account for health, nutrition, infant mortality, sanitation, and other indices of well-being. Considering the lived experience, poverty can be defined as lacking the resources to satisfy basic human needs – such as clean water, nutrition, health care, education, clothing, and shelter. When persons are impoverished to the degree that basic human needs cannot be met, they are existing in a state of absolute poverty.

Relative Poverty

Relative poverty is defined as having fewer resources or a lower income as compared to others within a society or as compared to those in other societies. It is estimated that at this time approximately 1.7 billion people are living in absolute poverty. Notably, before the opportunities secured by the Industrial Revolution, poverty was commonplace for the vast majority of the world's population. The Industrial Revolution affected nearly every aspect of daily life, as average income and population began to exhibit unprecedented sustained growth. From 1800 to the year 2000, the world's average per capita income increased more than tenfold, while the world's population increased more than sixfold.

Causes of Poverty

There are scores of theories on the origin of poverty and why it persists. The divergent theories are organized around a variety of epistemological themes. However, researchers agree that the causes of poverty at the macro level are complex and interrelated, and that there are many occurrences that can intensify poverty's effects. Once a community or society has reached an impoverished state, they are predisposed to crises. For example, natural disasters frequently cause famine, hunger, and poverty in areas of the world in which persons are barely surviving already. In regions where food production and availability are only marginally sufficient to provide a sustainable food supply, this predicament intensifies when droughts or other natural disasters obliterate crops and critical infrastructure. Once a region's food production and supply have been severely diminished, it becomes necessary to import food. However, many of these countries do not possess sufficient funds and an infrastructure to enable them to import the life-sustaining food, thereby magnifying the pervasiveness of poverty.

Effects of Poverty

One of the most concerning outcomes of poverty is its impact on the health of individuals, communities, and societies. Approximately 18 million people a year die from causes related to poverty. Those living in poverty have a much shorter life expectancy. According to the World Health Organization, hunger and malnutrition are the single greatest threats to the world's public health, while malnutrition is by far the greatest contributor to child mortality. Malnutrition is present in one-half of all cases of child mortality; annually, approximately 11 million children living in poverty die before their fifth birthday. Frequently, women in poverty bear children into poverty – children who likely cannot be nourished sufficiently. Malnutrition leads to a weakened immune system and frequently hastens the onset of disease. Considering the population worldwide, the three most common diseases related to poverty include AIDS, malaria, and tuberculosis, while other common ailments include measles, pneumonia, and diseases affecting the gastrointestinal tract.

Social Determinants of Health

The social determinants of health are the conditions in which individuals are born and live their lives. These conditions are shaped by the distribution of resources, including money, at all levels. In large part, social determinants are associated with the disparities in health across and within countries. The range in average life expectancy worldwide is from 34 years in Sierra Leone to 81.9 years in Japan. Social determinants help to explain why the poor, as compared to their wealthier counterparts, suffer disproportionately from disease and premature death. Examples include Indonesia, where the under-five mortality is nearly four times higher in the poorest fifth of the population than in the richest fifth, and England and Wales, where the latest data reflect a 7.4-year gap in life expectancy between men in professional occupations and men in manual labor occupations.

Education

It has been documented extensively over the last century that in terms of educational outcomes, children from poorer backgrounds do worse than students who are more privileged financially. If children are impoverished greatly, they may lack access to any opportunities for a formal education. Disparities in educational attainment between children from rich and poor families continue. A recent study entitled "Higher Standards, Better Schools for All" detailed that one's educational achievements are strongly linked to the parents' social and economic backgrounds. Poor children have reduced access to health care and, in general, a reduction in the quality of the care. Frequently the effects manifest as poor cognitive development, frequent illness, hunger, fatigue, and other illnesses that impede students' educational attainment.

Housing

Each year, more than 3 million persons in the United States alone experience homelessness, including 1.3 million children. According to recent national studies, many more Americans are at risk of homelessness. Millions of US households spend greater than 50% of their income on rent. It is estimated that no more than 30% of a household's disposable income, total income less total taxes, should go toward housing. For these millions, the thinnest of margins stands between them and homelessness – a layoff from work, a health emergency, or one of a variety of other potential crises. Beginning in the early 1980s, the number of homeless Americans grew dramatically, and the homeless population grew increasingly diverse – including mothers and fathers, sons and daughters, and all manner of racial and ethnic backgrounds. A full one-third of the current US homeless population is comprised of families, while almost one-half works but does not earn enough to pay for housing.

Poverty Reduction

Worldwide, there are countless initiatives to eradicate poverty – from local grassroots endeavors to broad movements aimed at shaping federal policy. Historically, poverty reduction has occurred as the result of economic growth. Modern technology leads to increased production, providing opportunities for increased wealth generation. Many consider the core of the global antipoverty movement to be the modernization of agriculture and increasing yields. Notably, three-quarters of the world's poor are rural farmers.

Additional efforts aimed at addressing poverty include extending rights to land ownership; making financial services accessible, especially savings; ridding institutions of corruption; creating stable infrastructures; addressing inequities in access to technology; and, perhaps most critically, providing access to quality health care – including public health and health education initiatives aimed specifically at empowering women and other marginalized groups within the global population.

Related Topics

- ► Child health and mortality
- ► Cross-cultural health
- ► Dietary patterns
- ► Disease prevention
- ► Food insecurity
- ► Global health
- ► Health barriers
- ► Health determinants
- ► Public health

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Suggested Resources

For information on global poverty. http://www.globalissues.org/

For information on hunger and poverty worldwide. http://www.greatergood.org/issues.html

For information on the World Health Organization. http://www.who.int/en/

Pregnancy

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Pregnancy is a normal physiologic process in all cultures but presents various challenges to immigrant women who have limited support systems.

The complaints of various aches and pains cross all ethnic and socioeconomic groups. The management of pregnancies and the multitude of discomforts that accompany may vary. In many ethnic groups, techniques and homemade remedies may be contraindicated in pregnancy but have been sanctioned as essential practices for generations. The health care provider must possess a level of cultural competency that respects traditional techniques and practices but protects the expectant mother and neonate from associated documented or theoretical harm.

Prenatal counseling is necessary for discovery and avoidance of genetic disorders. Among immigrant women, this is a service which is not affordable or sought after.

Early prenatal care has been associated with the most positive outcomes when caring for both low- and high-risk obstetrical patients. Although most immigrant women who do not receive traditional prenatal care deliver viable healthy neonates without maternal complications, many women suffer from unsuspected poor outcomes. It is recommended that women seek prenatal care as soon as they discover they are pregnant.

Immigrant women who are obese or undernourished remain a challenge during pregnancy. Nutritional balance that includes all needed food groups is difficult because cultural norms and traditional eating habits dictate selected diets. A provider or nutritionist who is well informed is essential but not always available. Clear weight-gain goals should be communicated to the pregnant women by a health provider that has an understanding of cultural practice and which will enhance a providers' goal to manage maternal weight and fetal growth.

Education of women that include expected changes in body image, discomfort, and significant changes in emotional status is the cornerstone to detect preventable pregnancy complications. Conditions such as urinary tract infections resulting in pylonephritis, hypertensive disease, and preeclampsia carry warning signs easily recognized and reported by expectant mothers. Use of kick counts during the second trimester for surveillance of fetal well-being is easily taught and accepted by immigrant women.

Women who have had previous operative deliveries are at risk for uterine rupture and should be counseled appropriately. Many women have had multiple operative deliveries and should be offered elective deliveries prior to onset of labor.

Contractions that warrant attention during the prenatal period (preterm) or immediately prior to parturition should be recognized and reported. Preventing preterm delivery and preparing for a safe and supportive experience depends on the expectant mothers understanding of how critical this symptom is to preventive care.

Breastfeeding and sexual activity are two major topics that are discussed among immigrant women. Breastfeeding is a desirable and expected behavior in most immigrant communities. Historically this has been a practice that most women respect as a part of motherhood. Recently, there has been a slow rising trend toward bottle feeding that stems advertisements and promotions that offer free formulas as well as other needed newborn supplies. The World Health Organization (WHO) recommends exclusive breastfeeding for women with human immunodeficiency with studies supporting benefits versus risks of combining breast milk with bottle feeding.

Sexual activity is a subject rarely discussed by pregnant women but is safe unless there is evidence of abnormal placental location or preterm labor.

The three deadly delays have been extensively discussed and used as the focus for many innovative programs that target maternal and neonatal mortality. Delay in recognition of a potential life-threatening condition, transport to a specialized medical facility, and delay in prompt medical intervention are the most challenging areas in delivering optimal care.

Limited health care workers and local facilities in rural areas prevent close monitoring of pregnancy which would detect warning signs of complications such as preeclampsia, infection, bleeding, and protracted labor. Once these common complications are recognized, transport to a medical facility equipped to handle such emergencies may be by foot, mule, or public transport resulting in loss of valuable time for intervention. Those women who do present in a timely manner often receive delayed or ill-advised care resulting in death. Immigrant women who find language as an additional barrier to access to care are more vulnerable to these poor outcomes. Every effort should be made to develop a system that addresses these challenges starting with the immigrant community. Identification of community outreach workers who can be taught to recognize warning signs is desirable.

Many immigrant women find themselves in communities that lack essential equipment and supplies as well as clean water. This lack of infrastructure adds an additional burden to health care providers when attempting to deliver safe health care.

Pregnancy is a normal physiologic process that subjects all women to both physical and psychological changes. Most women handle these dynamic changes without significant and chronic complications. Other women have significant physiologic changes that warrant close observation and early intervention. Immigrant women may be part of this later group.

Related Topics

- ► Breastfeeding
- ► Maternal dietary intake
- ► Midwife
- ► Pregnancy outcomes
- ► Prenatal health promotion

Suggested Readings

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Pregnancy Outcomes

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Pregnancy outcomes are as diverse as the many immigrant groups that are displaced or relocated but remain as a primary focus as we attempt to meet the millennium development goals developed by the World Health Organization in 2002. These goals target developing countries and outline goals, objectives, and interventions to decrease the morbidity and mortality in women and children by 2015. The factors that must be considered when attempting to improve pregnancy outcomes are numerous and may directly or indirectly influence pregnancy outcomes of a given group. The overall concerns target the recognition and management of common disease entities that remain the most common causes of maternal morbidity and mortality.

Comparative studies have looked at maternal characteristics and the availability of resources, health care workers, and medical facilities. The overall conclusion is that prenatal care with community involvement may pressure a community to implement policy change that decreases the loss of life for mothers and infants. This community type of pressure brings about a minimal decrease in maternal morbidity in populations where maternal mortality has remained high. Most causes of maternal death are from preventable causes.

Death related to pregnancy is defined as death that occurs while pregnant or within 42 days of the termination of pregnancy. The causes of death are irrespective of the duration or the site of the pregnancy, and may be from any cause related to or aggravated by the pregnancy or pregnancy management; accidental or incidental causes are not encompassed in this definition. The major causes of maternal death are preeclampsia, hemorrhage, and infection.

Preeclampsia is one of the most feared obstetric emergencies. This may result in the death of the mother or the fetus from an unexplained pathologic process. The preeclampsia continuum of hypertensive disease, altered multisystem dysfunction, loss of clotting mechanisms, and seizures still remains an unrecognized entity that warrants early intervention and delivery. In many communities the resources such as antihypertensives, antiseizure medications, and the ability to deliver a neonate operatively are scarce.

Postpartum hemorrhage is another leading cause of death. Lack of uterine tone, cervical and vaginal tears, and placenta previa and abruption require emergent recognition and intervention. Minimal interventions by trained laypersons could prevent loss of life from the most common cause of bleeding which is uterine atony.

Infection, the third threat to maternal health and survival, continues to be a major challenge in all settings. Within the immigrant populations, lack of simple hand washing in overcrowded living quarters with inadequate water sources may result in an outbreak of infectious disease that claims many lives.

Fetal and neonatal deaths are attributed to both maternal and fetal factors. One recognized contribution to neonatal death is preterm birth. Immigrant and refugee women have a high burden of premature births resulting in neonatal deaths. This can be attributed largely to the overall stress to which these women are subjected.

Stress may also be one cause of premature birth and it may involve the production of corticotrophin-releasing hormone originally found in the hypothalamus of the brain, but it also produced by the placenta. Levels rise substantially several weeks before birth, which stimulates the production of prostaglandins, which in turn induce labor. Early production can lead to premature birth. Stress can increase the production of corticotrophin-releasing hormone by the placenta, which would initiate labor and cause premature birth. Stress has become frequent in developed countries, as terrorist threats, actions, and their aftermaths are experienced in otherwise stable populations. Offspring whose mothers were stressed during pregnancy show strong evidence, from experimental biology with animals, that intrauterine stress affects neurodevelopment and alters behaviors in ways that are thought relevant to models of cognition, aggression, anxiety, and depression. Prenatal stress changes the way that glucocorticoids and sex hormones regulate neurogenesis in the developing brain, e.g., in the hippocampus by modifying the fetal hypothalamic-adrenal axis (HPA) and other systems. Stress in pregnancy perturbs endocrine function in animal models of diabetes, cardiovascular disease, and metabolic syndrome. Recent work shows sex differences in fetal responses to maternal stress that may be specific to the gestational age at which the stress is applied experimentally.

In addition to the common challenges of pregnancy, immigrant women who are challenged with a new environment, language barriers, and limited health care options may be at risk for poor pregnancy outcomes.

Related Topics

► Pregnancy
► Prenatal health promotion

Suggested Readings

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Prejudice

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Being prejudiced involves negative feelings toward members of a specific social group. Prejudice is a bias, a preconceived notion which is not based on reason or an actual experience; hostility toward a race, sex, or other class of people. The terms "prejudice," "stereotypes," and "discrimination" are often used interchangeably; however, there are distinct differences between the three. Feelings of prejudice involve a biased judgment that is based on faulty claims and is expressed toward the targeted group as a whole. Close attention is paid to information in support of the prejudice and used to confirm the negative belief. Prejudice, which involves attitudes, is much different from discrimination, which is a negative behavior expressed toward a specific group. Discrimination is behavioral and can be demonstrated in an overt or covert manner. Stereotypes are the beliefs held about a group's behavior, character, and/or intellect. Despite the differences between the three terms, they tend to heavily influence one another. Stereotypes, a cognitive factor, fuel prejudice, an attitude or emotion, which results in discrimination, a behavioral element. This interrelated process is central to its social influence.

Expressions of Prejudice

There are two ways to express prejudice – blatant and subtle. Blatant prejudice is a pronounced and direct way of displaying prejudice and involves two main components. The first component involves a sense of threat from the "out-group" (the group toward which prejudice is being expressed), which invokes a negative response from the in-group (the dominant or mainstream group). For example, this can include the out-group being identified as genetically inferior, thus denying there is discrimination against the group. The second component opposes close contact with the two groups, including marriage and any sort of sexual contact. Essentially, blatant prejudice is a straightforward ousting of the out-group from the broader society, exemplifying their distinctiveness from the dominant group. Subtle prejudice is a vague and indirect way of displaying prejudice. Subtle prejudice has three main components: defense of traditional values, the exaggeration of cultural differences, and the denial of positive emotions. The defense of traditional values suggests that the out-group is estranged because their behavior is inconsistent with standard norms of the dominant or mainstream society. The out-group is used as a scapegoat, which threatens conventional morals. All too often, this component of subtle prejudice is correlated with the "authoritarian personality," which supports a more conservative ideology. The exaggeration of cultural differences blames the out-group's disenfranchisement to cultural distinctions. It is believed that out-groups and in-groups differ in beliefs, and these different beliefs, values, customs, and attitudes provoke intergroup fear, distrust, ignorance, and disapproval, which may eventually lead to violence. Lastly, the denial of positive emotions encompasses the in-group's lack of positive emotions toward the out-group as well as the failure to admit its negative feelings. These emotions are not directly displayed; however, they are subtle biases which covertly indicate prejudice feelings. Often, these concealed feelings may be implicit prejudices which can affect overt behavior.

Sources of Prejudice

Prejudice has been known to originate from a source of threat. When a group's interests are threatened, they are most often experiencing fear. The effect of fear usually motivates prejudice and causes opposition between different groups. Prejudice usually plays a major role in protecting or enhancing perception of group value. When a group's interests are at stake, they retaliate by attacking the opposing group in order to retain the in-group's positive image and display group membership pride. Criticizing another group boosts the dominant groups' confidence, allowing them to feel superior and uphold their value.

Four distinct types of threat have been identified as realistic threat, cultural or symbolic threat, intergroup anxiety, and negative stereotypes. *Realistic threat,* derived from the realistic conflict theory, is simply when the in-group's economic power and well-being is allegedly threatened by the out-group. Threats can arise due to competition between groups over scarce resources such as land, employment, and money. This major cause of prejudice can allow opposing groups to view each other as enemies, increasing intergroup negative views. *Cultural threat,* also known as symbolic threat, is when the out-group's values, lifestyle, and attitudes threaten the worldview of the in-group. Threats arise not only because the opposing worldviews are different, but also due to the "moral rightness" of the in-group. The in-group believes their values are being weakened and thus feel threatened and as a result prejudice is heightened. This particular threat can be explained by the social identity theory, which suggests that individuals perceive themselves positively as an in-group member and express favoritism toward their own social group. The need to enhance one's own self-worth allows the out-group to be viewed as inferior. Our own cultural identity allows us to value our own group's distinctiveness over another group's identity. *Intergroup anxiety,* the lack of contact between groups and the anxiousness that results from this group segregation, is very important in explaining its relation to prejudice. Intergroup interaction is often due to fear of rejection and embarrassment. The groups tend to have no prior experience or contact with each other, perceive themselves as being dissimilar, and have strong views about their own group values. *Negative stereotypes* serve as a negative expectation on the part of the in-group, of the out-group's behavior. Stereotypes are beliefs about a social group that its members are believed to share. However, when portrayed negatively they can carry a prejudiced undertone. These four distinct forms of threat are related to theories explaining why prejudice persists.

Prejudice is known to be prevalent in race, sexual orientation, gender, ethnicity, and religion. Given its strong and perverse history, prejudice against racial groups is the most commonly studied focus. Racial prejudice is an antipathy based on a negative prejudgment against another race. It is most often a collective process where four main feelings are present: (1) superiority, (2) subordinate race is viewed as distinctively different, (3) entitlement to privilege, and (4) fear that subordinate race will threaten the position of the dominant race. Race prejudice is used as a protective factor for the dominant group, such that their advantaged group position and self-esteem can be maintained. The need for a positive group identity drives these prejudiced beliefs. Race prejudice shall only see a decline when and if racial harmony is sought out and when group position no longer holds its strong relevance.

Prejudice and Immigrants

The emerging importance of immigrants and immigration policy has reached the forefront in prejudice research and literature. Prejudice against immigrants is causing an exceptionally troubling dilemma. The theoretical framework suggests that immigrants are often seen as a threat to native culture. As immigrants assimilate into society, they may be faced with negative attitudes from members of the receiving society. Research tends to suggest that immigrants are evaluated more negatively when they pose a threat to those of a host country via cultural threat and/or realistic threat. These perceived threats lead to xenophobic fears which may lead to harsh immigration policies. This cycle of prejudice can grow in intensity and focus. In order to diminish the negative perception of immigrants across society, a number of issues, such as group similarities, links between groups, and common goals, need to be addressed. The support of intergroup interaction is needed to emphasize group similarities which in time may transmit more favorable attitudes toward immigrants. The increase in contact and familiarity with immigrants can work to eradicate prejudice by highlighting the link between immigrants and natives. Finally, recognizing common goals for social and economic progression could reclassify immigrants and natives as having a common identity, which could improve the immigrant native relationship.

Summary

Most often prejudice is learned through a process called social learning. Social learning theory states that prejudiced views can be adopted by direct experiences with significant others and peers. Direct contact with outgroups can also create negative views about particular groups. Just as bigotry is learned, it can be unlearned. However, unlearning can be more difficult and more time consuming. Despite the many efforts to reverse the damaging effects of prejudice, it persists for many reasons. It can continue due to the need for a dominant group to feel authoritative and to increase their sense of worth. However, prejudiced views are not inevitable; there are ways to mitigate the effect of prejudices. Ways to combat prejudice include intergroup contact, reclassifying or recategorizing social groups, and cognitively rebutting stereotypes.

The intergroup contact hypothesis predicts that increased contact between in-group and out-group members could prove to eradicate prejudice. This contact could give opposing social groups an opportunity to learn about each other and possibly create new social groups. By simply obtaining knowledge about another group, tension and stereotypes can be broken and friendships and bonds could be formed. Recategorization involves shifting the boundaries between the in-group and out-group. The common in-group identity model suggests that recategorization can indeed limit the negative effects of prejudice. This model implies that when opposing groups view themselves as a part of a single social entity, the in-group/out-group barriers are eliminated, and as a result antagonism and prejudice are tremendously reduced. Inclusivity can be a beneficial method to learning to foster positive views about opposing groups. Lastly, breaking the habit of relating stereotypic traits to certain social groups can be difficult. However, research has shown that it can be beneficial in negating prejudice. Since stereotypes are cognitively essential to adopting prejudiced beliefs, the weakening of stereotypes can directly affect its implicit link with prejudice, resulting in reduced stereotypes and prejudiced beliefs. Even though this process takes effort and time, it can prove to be valuable in the long-term learning process.

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Related Topics

- ► Discrimination
- ► Ethnic minority group
- ► Multiculturalism
- ► Race
- ► Racism
- ► Social learning theory
- ► Xenophobia

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Suggested Resources

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Prenatal Care

- ► Pregnancy
- ► Prenatal health promotion

Prenatal Health Promotion

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Prenatal health promotion is the cornerstone for delivering information and directing prenatal as well as preconceptual care. Existing programs have invested in extensive outreach programs to advocate early care to promote positive maternal and neonatal outcomes. Many of these outreach programs are careful to address language barriers, cultural competence, and accessibility. Programs that include comprehensive gynecologic screening are essential for women who range in age from menarche through menopause.

Health care beliefs and traditional practices remain the primary challenge when attempting to engage women in accepting preventive care options. Immigrant women who clearly see pregnancy as a normal life process may not see the need to present for costly preventive evaluations. Statistically, most Latino women who have no documented prenatal care remain healthy throughout their pregnancies and delivery healthy normal-weight neonates. In contrast, African-American women who have little prenatal care fall victim to preterm labor, preterm delivery, very low-birth-weight births, and neonatal deaths.

Multiple studies suggest that some immigrants may not believe that preventive care is of value especially when the health care of women has not been a priority in their home countries. Small group sessions within the community that allow women to socialize while they receive needed information are valuable vehicles to promote wellness. Understanding basic female anatomy, physiology, the menstrual cycle, pregnancy, and sexually transmitted disease prevention in lay terms has been a successful strategy establishing trust and limited unwarranted concerns. These outreach sessions have been effective in establishing networks of support that also address the psychological trauma that often accompanies both intra- and intercountry displacements. These sessions allow pooling of limited resources and offer affordable referral services.

Empowering women to take control of their health through education is the hallmark of wellness, including prenatal and preconception health care. Exercise, nutrition, self breast exams, and weight management remain the gold standards for all age levels. Careful assessment of pertinent health challenges may warrant more extensive health surveillance. Family history of reproductive cancers such as breast cancer requires greater patient knowledge and understanding for early recognition. Recognition of the importance of wellness of all women despite immigrant status can contribute to the overall health of a community and society in general.

Related Topics

- ► Birth control
- ► Birth defects
- ► Health promotion
- ► Infant mortality
- ► Midwife
- ► Pregnancy
- ► Reproductive health

Suggested Readings

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Prescription Drug Use

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A United Nations panel has reported that abuse of prescription drugs worldwide will soon exceed illicit drug use. The International Narcotics Control Board (INCB), based in Vienna, Austria, noted in its 2006 report that medications containing narcotic or psychotropic drugs are becoming the drugs of choice for many abusers, and that drug traffickers are responding by increasing diversion and the production of counterfeit drugs. The problem is particularly severe in the United States; according to the INCB, cannabis is the only illicit drug that is more widely abused than prescription drugs – even more so than analgesics, stimulants, sedatives, and tranquilizers. Between 1992 and 2003, the number of individuals in the USA abusing prescription drugs increased from 7.8 million to 15.1 million.

Fueling the production of counterfeits is the increased demand for prescription drugs. In North America, such demand has led to the distribution of counterfeit oxycodone that contained illegally produced fentanyl. According to the World Health Organization, in developing countries where poverty and lack of access to health care influence many to seek medications on the black market, 25–50% of all medicines consumed may be counterfeit.

Persons use prescription drugs to (a) treat illnesses that they have, (b) treat illnesses that they believe they have, (c) to become intoxicated, or (d) a combination of one or more of these. Immigrant use of prescription drugs is complicated for many reasons. First, to acquire prescription drugs, many immigrants travel back and forth from their country of residence to their country of origin – where prescription drugs may be more readily available or less expensive.

Immigrants not fluent in the language of the country of residence may not receive adequate instruction concerning how to take prescription drugs. Therefore, it is likely that they will not have as good an outcome when taking them as people fluent in the language. Access to multilingual pharmacy instruction helps more people take medications in the way they were prescribed. In their country of residence, immigrants may have different ideas than health care providers about how to take drugs. They may come from cultures where people regularly self-prescribe medications; however in the new culture, this may not be advisable. This leads to people bringing drugs from one country into the other and to health care providers not being entirely aware of the medications their patients are taking.

In addition, in countries with and without universal health care, the cost of prescription drugs for immigrants may add a significant financial burden to the health care system. Experts are concerned about the growing cost. The exact amount of the cost seems to vary based on the immigrant population, the drug in question, and the costs associated with the country's health care system.

Related Topics

- ► Chronic pain
- ► Drug abuse
- ► Drug use

- ► Pain
- ► Self-medication
- ► Socialized medicine
- ► Vitamins

Suggested Readings

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Suggested Resources

For information on the Institute for Global Ethics. http://www.globalethics.org/

For information on the International Narcotics Control Board. http://www.incb.org/

For information on the National Center for Biotechnology. http://www.ncbi.nlm.nih.gov/guide/

Professional Dissonance

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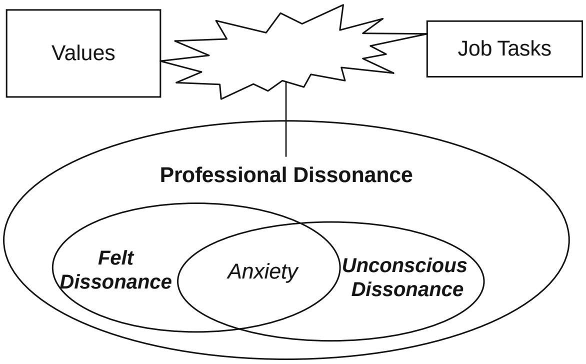
Professional dissonance is defined as *a feeling of discomfort arising from the conflict between professional values and job tasks*. It has been developed through the application of cognitive dissonance theory and existential theory to the study of values and ethics and the realities of practice climate in the mental health social work arena. It is easily applicable to working with immigrants and may yield information regarding helping professionals' reactions to difficult scenarios in work with immigrants such as the aftermath of discrimination and deportation, negotiating institutional bias, and managing personal biases related to this population. The figure below uses a visual schematic to illustrate dissonance (Fig. 1).

The concept of professional dissonance seeks to add a new element to the discussion around burnout and job longevity by exploring the ways helpers feel torn or ambivalent about the ways their values and job interventions coexist. In this way, the professional dissonance concept relates to the burnout literature in that it attempts to understand the inner lives of helpers and *how* their inner thoughts and outer actions may contribute to burnout. This is especially true if the helper's ways of resolving their dissonance lead to negative feelings about consumers individually and as a group. An example is provided by the long-term social worker who has become so frustrated with his or her inability to help immigrant children who are also involved in child welfare programs that the social worker begins to associate abusiveness with a particular demographic "Well XXX group just doesn't value children the way we do."

Importantly, an individual helper's insight into his or her own dissonance reduction processes may wax and wane, in much the same way that a person unconsciously uses a defense to manage anxiety but is not aware of what he or she is doing. Even if a person is aware, once experienced dissonance has been reduced or resolved, the person is comfortable again and has a stake in remaining comfortable rather than rehashing the reasons for the initial dissonance. This is important in understanding professional dissonance as a supervision issue because the role of the helper's supervisor may be to stimulate dissonant discussions that raise



Professional Dissonance. Fig. 1

anxiety in an effort to illuminate constructive dissonance reduction; in the context of the helping agency, these discussions may help raise awareness of potentially problematic practices.

Related Topics

- ► Ethical issues in research with immigrants and refugees
- ► Ethical issues in the clinical context

Suggested Readings

Taylor, M. F. (2006). Is self-determination still important? What seasoned social workers are saying. *Journal of Social Work Values and Ethics, 3*(1), http://www.socialworker.com/jswve/content/view/29/44/

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Program Management

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Program management is a mechanism through which organizations create projects and realize their goals and objectives. Multiple projects may support a particular program with each project having specific purposes, tasks, and deadlines. Program management and project management are often distinguished by the following characteristics: (1) Projects deliver discrete products or outputs with achieving deadlines a predominant feature. (2) Programs create outcomes and focus on the long-term benefits to the organization. A central feature of program management is the importance of doing it right and attaining the maximum benefits. The benefits occur based on the capacity of the programs to change and respond to different external influences. These influences may include technology, or economic and social circumstances.

Program management provides oversight of projects and includes several key aspects. *Governance* includes defining roles and responsibilities for the program. *Management* of the program focuses on the essential planning and administration of program activities and specific projects. *Financial management* includes the implementation of specific practices and controls to ensure fiscal stability. *Structure* refers to the establishment of physical space, technology, staff, and creation of a work environment to support the program. Finally, *planning* is central to the program achieving objectives of the organization. The planning occurs at multiple levels in the organization with multiple goals, all consistent with the mission of the organization.

Successful program management requires executing several tasks. These tasks include: (1) problem identification; (2) needs assessment; (3) planning goals; (4) program design; (5) information management; (6) fiscal procedures; (7) project monitoring; and (8) program evaluation. Collectively, these tasks create the successful operation of the program. Periodic evaluations of the program ensure that the program continues to serve the intent of the program and respond to changes in the environment.

Immigrants seeking services often experience programs at multiple organizations and programs that have program eligibility and service requirements. Depending on the organization, the program effectiveness in meeting the need of immigrants may be variable. Organizations like the World Health Organization (WHO), United States Agency for International Development (USAID), and local nongovernmental organizations (NGOs) offer examples of programs specific to the needs of immigrants.

Related Topics

- ► Health services research
- ► Mixed methods
- ► Non-governmental organization
- ► World Health Organization

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Kettner, P. M., Moroney, R. M., & Martin, L. L. (1999). *Designing and managing programs.* Thousand Oaks: Sage.

Lewis, J. P. (2007). *Fundamentals of project management.* New York: American Management Association.

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Hanford, M. F. (2004). Program management: Differences from project management. http://www.ibm.com/developerworks/rational/library/4751.html. Accessed March 8, 2010.

Program management. http://en.wikopedia.org/wiki/Program_management

Promotora

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The word *promotor de salud* in the Hispanic/Latino community is synonymous to an individual who is from the community and works for the health and well-being of the community. The male version in Spanish is called *promotor*, the female is called *promotora*. *Promotores de salud* is the plural term. Many Hispanic/Latino immigrants have been served and helped by *la promotora de salud*. In many instances, the female description is the one used since the majority of *promotores* are female. *Promotoras de salud* may be the most commonly used term.

There are an infinite number of descriptions (close to 35 terms) that have been associated with *promotores*. The term commonly used is that of Community Health Worker (CHW). *Promotores* are those who serve Hispanic/Latino communities. Recently, and in part of the great recognition of the role of community health workers in the community, there is a standard occupational classification (21–1094 code) from the Bureau of Labor Statistics for CHWs. The CHW Section of the American Public Health Association has adopted the following definition of the CHW:

- "A CHW is a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This trusting relationship enables the CHW to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery. A CHW also builds individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support and advocacy."

Documentation on the uses of CHWs can be found in the USA as early as 1950. Some programs that initially involved CHWs include county health departments, migrant health programs, university departments of public health, and Indian Health Services. The proliferation of CHWs to work on the expansion of health services to underserved communities (including immigrant communities) became a reality as a result of legislation enacted in 1962 with the Federal Migrant Health Act of 1962 and the Economic Opportunity Act of 1964.

Promotores de salud working in the Hispanic/Latino community have for many years addressed the health-related needs of immigrant communities. *Promotores* help individuals not only to address health needs but, also, they play many other functional roles. Examples of the health and non-health roles include: (1) providing a variety of "informal" but "direct" involvement to enhance actions that relate to the delivery of health services; (2) promoting advocacy and actions to solve problems at the individual, family, and community levels; (3) serving as a bridge to encourage individuals (many of which are immigrants) to understand how to navigate systems (including the health system); (4) promoting the support of people by giving advice, guidance, pertinent information to reach a service in the community, bridging cultural, linguistic, and literacy differences, facilitate social support; (5) providing community education, access, and adherence to preventive care and monitoring of risk, treatment, and promotion of self-care and follow-up care.

For many immigrants, *promotores* de salud are the synergy and hope that are required to live "in community" at times when there are many financial, social, family, and individual constraints and challenges. Immigrant families may be exposed to great sources of stress as they strive for a better life in the USA. There are many transformative processes that immigrants undergo as they immigrate. These include changes in the family and in the social system. Immigrants must cope with new realities as the new environment brings new challenges and opportunities. *Promotores de salud* provide much support to the immigrant individual and family member (including emotional support) serving a variety of roles. The *promotora* tries to solve problems at various levels in the lives of the immigrant by seeking support from different agencies and institutions.

Given the amount of evidence that currently exists in the research literature, the work of *promotores de salud* is becoming legitimate. Soon *promotores* will be officially part of the health team for many agencies, institutions, hospitals, and other health-related services. That means, employment for *promotores* will improve as the concept of prevention in the health care reform becomes a reality. How would this employment work for *promotores de salud*? There are several options. One is the opportunity of getting reimbursements from Medicaid as a result of the work *promotores de salud* do with individuals for improving their health conditions, including control and management of diseases like diabetes, and with providing prevention for reducing risk factors such as high blood pressure, high cholesterol, obesity, and many more. Another option is that employers in clinics, community-based organizations see the value of *promotoras* and invest in them, by creating a financial infrastructure in their agencies. Bringing *promotoras* to be an integral part of the systems of health care, health promotion, and disease prevention is the future.

In providing services to many immigrants communities, *promotores de salud* work as volunteers and are not being remunerated financially. Thus, a mixed model of *promotores* exists, those who are paid and those who are not. There is a heated debate as to whether *promotores* should always be paid for their services. Some groups believe that the "volunteer nature" of *promotores* will always exist because *promotores* love to help people in their community. Thus, there is an element of altruism present in the *promotora* who works for the community where she is from. *Promotores de salud* are always connected to the needs of communities. In addition, they respond to those needs (particularly health needs) by always receiving the best training possible. Training is an important prerequisite for success of the *promotora*. Training and adequate supervision of *promotores de salud* is becoming a prerequisite for the practice of *promotores de salud* in communities. Currently, two states, Texas and Ohio, offer credentialing of CHWs. This practice is also somewhat controversial.

Related Topics

- ▶ Community
- ▶ Community health workers
- ▶ Community-based participatory research
- ▶ Health care utilization
- ▶ Latinos

Suggested Readings

Dower, C., Knox, M., Lindler, V., & O'Neil, E. (2006). *Advancing community health worker practice and utilization: The focus on financing*. San Francisco: National Fund for Medical Education.

Eng, E., & Young, R. (1992). Lay health advisors as community health agents. *Family & Community Health, 15*(1), 24–40.

Reinschmidt, K., Hunter, J., Fernandez, L., Lacey-Martinez, C., Guernsey de Zapien, J., & Meister, J. (2006). Understanding the success of promotoras in increasing chronic disease screening. *Journal of Health Care for the Poor and Underserved, 17*(2), 256–264.

Rhodes, S., Long, K., Zometa, C., & Bloom, F. (2007). Lay health advisor interventions among Hispanics/Latino. *American Journal of Preventive Medicine, 33*(5), 418–427.

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Prostate Cancer

- ▶ Cancer
- ▶ Cancer incidence
- ▶ Cancer mortality
- ▶ Cancer screening

Prostitution

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According to the Universal Declaration of Human Rights, everyone has the right to freedom of movement and residence within each state, to leave any country – including his or her own – and to return to his or her country of residence. The lack of social and economic opportunities for prostitutes in economically deprived countries remains a chief cause of migration. Often this phenomenon among female prostitutes is referred to as the "feminization of migration." It has been documented well by Kamala Kempadoo, who argues that migration is a result of oppressive globalization for many poor countries. In terms of the legality of their trade and the systems of support within the trade, prostitutes may be better off in another country. Conversely, being a migrant and a prostitute can present a double illegality – with little to no access to health and legal and social support services. The following offers a brief examination of historical aspects of migrant prostitution, a short overview of legal challenges that migrant prostitutes face, and a discussion of the health implications for migrant prostitutes.

The Page Law of 1875 was the first legislative statute in the USA to restrict immigration federally. Named after California Republican Horace F. Page, the law banned the immigration of women from entering the USA for purposes of prostitution and other immoral acts. Page testified that many Chinese women who came to the USA and settled in San Francisco were not the wives of Chinese immigrants, but they were polygamous concubines or prostitutes. Furthermore, he contended they were no more than slaves, contrary to the American system of free labor. Prior to the introduction of the Page Law of 1875, several statutes were implemented in California in an attempt to prevent the entry of Chinese women, claiming they jeopardized the health, morals, and lives of its citizens. This was the first passage of repressive migratory laws specifically aimed at preventing prostitutes from entering the USA. In more recent years, laws such as the Trafficking Victims Protection Act (TVPA) have served as smoke screens for the protection of victims. The TVPA, enacted in 2000, has continued to sanction the arrest, detainment, and deportation of migrants working as prostitutes in the United States.

Accurate numbers of international migrant prostitutes are hard to determine, largely because in most countries it is an underground activity. A report by TAMPEP estimated that there was an average of 65% of migrant sex workers within the European Union (EU), with the majority of these migrant sex workers being third-country nationals – non-EU citizens. An extremely restrictive legal framework consisting of residency status, access to the labor market, and legal regulations on prostitution reinforces the vulnerable status of migrant prostitutes. Prostitution is discussed frequently within the context of discrimination, violence, and trafficking, but rarely in terms of autonomy, human rights, or self-regulation. Often migrant prostitutes who experience violence, harassment, and poor working conditions are unable to report this to authorities for fear of deportation, expulsion, or other undesired legal ramifications. Language and cultural barriers, social isolation, fear, and dependence on brothels or pimps contribute to the vulnerability of migrant prostitutes.

The health implications for migrant prostitutes are connected primarily to HIV/AIDS and other sexually transmitted diseases. Migrant and mobile prostitutes, especially those who are undocumented, have very limited to no basic health education and healthcare. Many migrant prostitutes do not establish medical care, and if they do, treatment is rarely continued to resolution of the condition. This scenario presents for migrant prostitutes a high degree of risk for contracting a disease, a condition not being treated properly and unwanted pregnancies due to poor contraceptive knowledge. In countries where prostitution holds some level of legality, often there are labor-related regulations in place that one must follow in order to work as a prostitute; the most common regulation is mandatory health checks. However, because migrant prostitutes are residing in the country illegally, their illegal status poses a barrier for them to adhere to the mandate. Therefore, access to care for undocumented prostitutes is dependent on a variety of factors including: ability to pay, interpretation availability, provider cooperation, and confidentiality regarding occupational status. UNAIDS recommends that to make sex work safer, occupational health and safety standards should be adopted and that health service providers should be trained in addressing stigma, discrimination, and violence.

Related Topics

- ▶ Barriers to care
- ▶ Citizenship
- ▶ Human rights
- ▶ Illegal immigration
- ▶ Sex work and sex workers
- ▶ Trafficking
- ▶ Universal Declaration of Human Rights

Suggested Readings

Agustin, L. M. (2007). *Sex at the margins: migration, labour markets and the rescue industry.* London: Zed Books.

Brussa, L., & Karner, B. (2009). In M. C. Boidi & F. A. El-Nagashi (Eds.), *Sex work in the context of migration, sex work migration health: A report on the intersections of legislations and policies regarding sex work, migration and health in Europe.* Amsterdam: TAMPEP International Foundation.

Kempadoo, K. (2003). Globalizing sex workers' rights. *Canadian Woman Studies, 22*(3–4), 143–150.

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Abrams, K. (2005). Polygamy, prostitution, and the federalization of immigration law. *Columbia Law Review,* 105(3): 641–716. Universal Declaration of Human Rights, Article 13. (1948). United Nations. http://www.un.org/en/documents/udhr/. Accessed March 1, 2010.

For information from the European Network on HIV/STI prevention and health promotion among migrant sex workers (TAMPEP): www.tampep.eu

For information from the Prostitutes Education Network (PENet): www.bayswan.org/penet.html

For information from the United Nations on sex worker rights: Best practices policy project: www.bestpracticespolicy.org

Psychological Acculturation

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Acculturation describes changes, cultural or psychological, that occur as a result of prolonged firsthand contact between two different cultures. *Psychological acculturation* describes changes that occur at the individual psychological level. This construct helps us to study and understand changes, adaptation, and other psychosocial processes that occur when immigrants and refugees settle in a host country with a different culture – which in most cases is the dominant and majority culture with the most social power.

Historically, it was assumed that acculturation proceeds along a linear direction, as newcomers and minority groups gradually relinquish their traditional cultural identities, values, customs, and other characteristics, and become absorbed or assimilated into the mainstream culture of the dominant host group. At the midpoint along this trajectory, individuals may be described as bicultural, straddling between two cultures.

It has since been recognized that a bidimensional model more aptly captures the varieties of acculturative strategies that newcomers may employ. From this perspective, newcomers and minority groups may identify with their heritage culture and the host dominant culture to varying degrees. Some may maintain aspects of their heritage culture as well as adopting elements from the host culture, using a strategy of *integration.* Alternatively, some may disengage from their heritage culture and completely adopt the host culture through *assimilation.* Some may not take up the host culture, but maintain their traditional heritage culture using the strategy of *separation.* This may be a viable option especially when there is a critical mass to maintain a cultural community, such as an ethnic enclave. Finally, with *marginalization*, they may find themselves disengaged from both traditional and host culture. It is believed that integration may be associated with better mental health, while marginalization may lead to increased vulnerability and adverse effects on health. The other two strategies may occupy an intermediate position.

Acculturation may not neatly fall into these four strategies uniformly across all domains of an individual. For example, individuals may adopt mainstream dietary practices or clothing out of necessity, while retaining traditional cultural values in other areas. Further, acculturation is not a static state. Individuals may vary their acculturative strategies with time due to personal and contextual psychosocial events or factors. For example, some developmental models describe changes in ethnocultural identities over time that may be applicable to certain individuals from minority groups and immigrants. While the details vary, such models often describe an initial wish, attempt, or actual identification with the dominant sociocultural group. The individuals may then come to realize that the fit might not be perfect or possible, arising from cultural differences, power inequity, or experiences of outright discrimination and rejection. The individuals may then re-identify with their own cultural or ethnic identity, rejecting the dominant culture. For some individuals, they may eventually attain internal reconciliation and integration of the different cultural values and identities.

Thus, many factors affect the process of acculturation, including both individual internal factors, such as personality, preferences, and personal history, and external factors, such as the host culture and other societal forces. The Interactive Acculturation Model proposes that the attitudes of the host cultural group can be described in an analogous bidimensional model: *integration*, the attitude that immigrants should ideally retain their heritage culture and adopt host culture; *assimilation*, immigrants should relinquish the heritage culture and be assimilated into the host culture; *segregation*, immigrants should retain their own culture, and be segregated into their own communities; and *exclusion*, immigrants should neither try to adopt the host culture nor retain their traditional culture. In addition, it has been proposed that some immigrants and host group members may actually subscribe to an *individualist* ideology – that culture is not an important identifying variable and each person should be treated as an individual. This may especially be found in more individualistic and less collectivistic cultures.

The host cultural group and the immigrant groups may prefer different acculturative strategies, and one group's preference may affect the other. The dominant group with more social power may make it difficult for the non-dominant group to actualize their preferred acculturative strategies. This can result in problematic and conflictual intercultural relationships. Among the dominant cultural group, integrationists, assimilationists, and individualists are open to the idea that immigrants can become full members of the host society, while segregationist and especially exclusionists tend to have rejecting attitudes toward immigrants.

From a larger societal or national perspective, policies may affect acculturation. A *pluralistic multicultural policy* values the nation's culture as well as the immigrants' heritage culture, providing resources and funding to support the maintenance of both. A *civic policy* similarly is permissive of both cultures, but does not actively support immigrants' heritage cultures with funding or resources. An *assimilation* ideology, or "melting pot," supports the national culture and the relinquishment of other competing cultures. An *ethnist* perspective is the least tolerant, and may never grant full status to immigrants or other ethnic groups in their own society.

The process of acculturation may potentially lead to the positive adaptation of immigrants and the enrichment of the host society. Conversely, certain acculturative strategies at the societal, host group, or individual level and the resulting interaction among these levels may give rise to increased tension, conflict, discrimination, and inequity. This, along with other psychological, social, and cultural stressors, gives rise to *acculturative stress* for immigrants, which may lead to adverse health outcomes.

Related Topics

- ► Acculturation
- ► Acculturative stress
- ► Melting pot
- ► Segregation
- ► Stress

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Psychological Distress

► Stress

Psychopathic Personality

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Psychopathic personality has two meanings, one meaning in psychiatry and another in the context of immigration to the USA. While the initial meaning for immigration may have sought to be similar to psychiatry's definition, it is actually an example of psychiatric terms being misused by both legislative and judicial arms of the government.

Mental Health Definitions of Psychopathy

Psychopathy describes a subgroup of persons with Antisocial Personality Disorder. Up to 1% of people may be categorized as psychopaths, though rates may be 7–20 times higher in prisons. The average criminal is not a psychopath.

Hervey Cleckley, in his seminal work, *The Mask of Sanity* (1941), described characteristics of psychopaths, who appear normal on the surface ("the mask") but are merely mimicking personality traits of others. A lack of empathy for others is the primary defect. Other characteristics of psychopaths, described by Cleckley, include superficial charm, insincerity, untruthfulness, lack of remorse, egocentricity, fantastical behaviors, lack of a life plan, inability to learn from experience, unreliability, and lack of irrational or delusional thinking or affective responses. Sexual experiences inevitably occur without a capacity for love or relationship. They say what they have seen others say in apparently similar situations.

More recently, researcher Robert Hare developed the Psychopathy Checklist-Revised, which is used by mental health professionals to assess psychopathy. Building on Cleckley's description, deficits are rated in areas such as interpersonal relationships, emotions, and self-control. Scores on the PCL-R are predictive of violence and recidivism as well as response to treatment.

In sum, persons with psychopathic personality have a fundamental defect in their ability to have empathy for others. They are superficially charming and can be charismatic manipulators who do not have consciences. This description is quite different from all that was previously included in US immigration policy.

"Psychopathic Personality" and Immigration to the USA

A long history of exclusion of sexual minorities from the US is the backdrop for the intersection of immigration policy with "psychopathic personality." The 1917 Immigration Act excluded immigrants who were "mentally defective" or who had "constitutional psychopathic inferiority" from the USA. The Public Health Service's definitions of homosexuality reinforced the characterization and the effect was to ban homosexual immigrants. The Immigration and Naturalization Act (INA) of 1952 passed by the Senate and House excluded those with "psychopathic personality, epilepsy, or a mental defect" from immigrating to the USA. These terms were considered to include both homosexuals and "sex perverts." "Sexual deviation" was added to the exclusion list by a 1965 amendment. By the Immigration Act of 1990, Congress abandoned the exclusion of homosexuals, and did not reference the "psychopathic personality" or "mental defect." (However, Congress did not make provisions for same-sex couples to immigrate).

Deportation proceedings occurred in 1959 against George Fleuti, a Swiss national admitted into the USA in 1952. Because he was gay, he fell under the "psychopathic personality" category under the INA. Later, the 1967 case of *Boutilier v. INS* was decided by the Supreme Court. Mr. Clive Boutilier was admitted to the US in 1955, made a brief trip to Canada in 1959, and applied for US citizenship in 1963. His partner, his siblings, his mother, and stepfather lived in the USA as well. He had been arrested for sodomy in 1959, a charge which was later dismissed. He was asked to submit an affidavit about his sexual history and based on that, was diagnosed as "afflicted with a class A condition, namely psychopathic personality sexual deviate" by the Public Health Service. Two psychiatrists submitted reports noting that he was gay, but that he did not have a psychopathic personality. The Court needed to decide whether "psychopathic personality" included homosexuals. His deportation was upheld.

Related Topics

- ► Homosexuality
- ► Immigration processes and health in the U.S.: A brief history
- ► Inadmissibility on health grounds
- ► Mental illness

Suggested Readings

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Duenas, C. A. (2000). Coming to America: The immigration obstacle facing binational same-sex couples. *Southern California Law Review, 73*, 811–841.

Suggested Resources

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Psychotherapy

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Psychotherapy is a form of psychological intervention. Most commonly, it involves a form of therapeutic dialog between a therapist and a client, or "talk-therapy." It may be used to treat mental illness, such as depression and anxiety disorders; help overcome situational emotional difficulties, such as grief and coping with other stressors; make long-term personal changes, such as aspects of personality; or enhance various aspects of life, such as improving interpersonal relationships and living a more fulfilling life. Psychotherapy is often conducted in individual sessions between a therapist and a client. It may also be conducted with couples, families, or in small groups.

Currently, there are many types of psychotherapy in practice, based on different models and theories of psychological health and psychopathology. One of the earliest forms of modern psychotherapy is psychoanalysis pioneered by Sigmund Freud. This continues to be practiced, and has a great influence on the field, as many other therapeutic models incorporate its ideas and assumptions, such as: the mind unconsciously influencing one's behaviors; past trauma, loss, developmental deficits, or other formative experiences shaping present predisposition and behaviors; problems being caused by psychological conflicts or deficits and the use of compensatory defense mechanisms; and the notion of transference and countertransference reactions, i.e., the client's and therapist's respective unique psychological and emotional reactions to one another in therapy related to therapeutic issues, personal issues, or past experiences. Different types of therapy may widely differ in their relative emphasis on the importance of the relationship between the therapist and the client; the importance of cognitive insight (knowing) versus emotional experience (feeling) versus behavioral changes (doing); the level of activity of the therapist, from empathic listening to actively interpreting or teaching; the focus on the past versus the present; and the focus on the client's life outside of therapy versus moments transpiring in therapy between the therapist and the client. The duration of psychotherapy varies. Time-limited short-term therapies may consist of 12–16 weekly 1-hour sessions, while open-ended therapies may last months to years.

Several types of psychotherapies are commonly practiced. Psychodynamic psychotherapy derives most directly from psychoanalysis. Depending on the therapist, it may be subdivided into various schools, including ego-psychology, object-relations, or self-psychology, and may locate variably on an expressive-supportive continuum. Cognitive-behavioral therapy (CBT), which is relatively amenable to be manualized for research, has a large body of empirical support for a variety of specific disorders. In CBT, the therapist tends to be more active and directive, and collaborates with the client to explore the connections between thoughts, emotions, and behaviors. It aims to correct *cognitive* errors, such as negative automatic thoughts and core beliefs about the self, others/world, and the future, and use *behavioral* strategies to facilitate change, such as planning activities to increase motivation or setting up a hierarchical list for systematic exposure to desensitize feared situations. Other evidence-based therapies include behavior therapy (BT), dialectical behavior therapy (DBT), manual-based family therapy, interpersonal psychotherapy (IPT), multisystemic therapy (MST), and parent training. Although there are many different types of therapies, "common factors," such as the *therapeutic alliance* between the therapist and the client, have been found to account for a significant part of psychotherapy's beneficial effects.

From a cross-cultural perspective, in addition to common Western psychotherapies, *cultural-embedded healing practices*, such as shamanism, may share some common healing elements with Western psychotherapy. *Culture-influenced psychotherapies*, such as Morita or Naikan psychotherapy, are unique psychotherapies that are generally not practiced in Western countries, and are developed and practiced in Asian countries. In recent development, many Western developed psychotherapies implicitly or explicitly share elements of traditional Eastern philosophies or practices. For instance, some therapists have incorporated Buddhism explicitly into traditional psychoanalysis. The newer developed "third-wave behavioral therapies," such as Dialectical Behavioral Therapy (DBT), Mindfulness-based Cognitive Therapy (MBCT), and Acceptance and Commitment Therapy (ACT), all include elements of *acceptance* and *mindfulness* from Zen Buddhism.

In applying psychotherapy in cross-cultural situations, cultural competence becomes especially important. Practitioners may need to make philosophical, theoretical, or technical adjustments. Culturally competent elements, including requisite attitudes, knowledge, and skills, can be identified longitudinally in all phases in therapy, including preengagement, engagement, assessment, therapy, and termination phases. For example, self-reflection and awareness of potential sociocultural transferences and countertransference may become an important consideration in therapy. In understanding the client and applying the therapeutic model, culture needs to be taken into account, and an Outline for Cultural Formulation may be used to enhance this understanding. With Outline for Cultural Formulation, five domains are explicitly considered: (i) the client's cultural identity (including acculturation); (ii) explanatory model of illness; (iii) sociocultural factors (including stressors and supports) and levels of functioning; (iv) cultural factors in the relationship between the therapist and the client; and (v) a summary of cultural factors in assessment, diagnosis, and treatment.

Using culture as a reference point, practitioners can consider whether their psychotherapeutic interventions, including the formulated goals and the chosen therapeutic content and process, are culturally reinforcing, culturally congruent, culturally neutral, or counter-cultural. None of these orientations are inherently superior, and each may be therapeutic to the client in different circumstances at different points in time in therapy.

Thus, psychotherapy can be an important therapeutic intervention for immigrants of diverse cultures if sociocultural issues are taken into consideration. In addition, it is important to note that practical issues such as transportation, childcare, cost, and language barriers may result in inequitable access to treatment or premature dropout from psychosocial interventions.

Related Topics

- ► Ambiguous loss
- ► Anxiety
- ► Bereavement
- ► Cultural humility
- ► Grief and grieving
- ► Mood disorders
- ► Music therapy
- ► Stress
- ► Trauma

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Public Charge

- ► Immigration status
- ► Poverty

Public Health

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Introduction

Public health is concerned with optimizing the health of populations by preventing diseases and promoting healthy behaviors, environments, and policies through efforts of both government and private-sector organizations and individuals. Its scope includes but goes beyond assuring that people have access to health care and services: public health encompasses the health of individuals in the contexts of family, community, workplace, environment, and society both nationally and internationally.

The functions of public health include: prevention of epidemics and disease spread, protection against environmental hazards, prevention of injuries, promotion of healthy behaviors, response to disasters, and assurance of the quality and accessibility – though not necessarily the direct provision – of health care services.

Challenges to Promoting and Protecting the Health of Immigrants

Immigrant populations present unique challenges to national and international systems of public health. As of 2007, there were 34.2 million US residents of foreign birth, over half of whom originated in Latin American countries and over a quarter of whom originated in Asian countries. Whether they are naturalized citizens, noncitizen residents, or undocumented residents, these immigrants may face threats to health and well-being that are different from those confronting the native-born population. These special challenges arise from migration status itself, from personal circumstances, or from the environments where individuals and families work and live.

First, immigrants may have diseases acquired in their countries of origin that are otherwise well-controlled in the USA. For example, some enter the USA with tuberculosis needing ongoing and aggressive treatment. Immigrants in the USA may have difficulty in finding customary foods and therefore lack adequate nutrition. They may not have important information about vaccinations against preventable infections for themselves and their children. They may be exposed to dangerous environments and social conditions that compromise their health.

Language barriers may isolate them from health-relevant information or impair the quality of their interactions with health care providers. Fear of detention, whether or not justified, may deter immigrants from seeking governmental assistance, advice, and health-related services. Immigrants in the USA use social services at rates well below those of the native-born population.

Noncitizen immigrants often work in agriculture. Census data show that over three times the percentage of noncitizen immigrants (2.2%) work in farming, fishing, and forestry occupations as do percentages of citizens both native-born (0.5%) and naturalized (0.6%). In farm labor, where undocumented workers may comprise half or more of all workers, the migratory nature and seasonality of employment put workers at risk of inadequate housing, unfair labor practices, injuries, and exposure to toxic pesticides.

Immigrant populations in the USA disproportionately lack health insurance, due in part to their overrepresentation in industries where employer-provided health plans are less common and in part to their limited eligibility for public health care programs.

Public Health Law and Policies for Immigrant Populations

Public health depends on contributions from private sector organizations and individuals, but its core functions depend on governmental organization, delegation, and oversight. Public health has international, national, and – in the United States – state- and local-level components. The World Health Organization promulgates policies and calls upon individual nations to support and implement them. Federal agencies in the USA regulate food and working conditions, contribute to national health policy making, support health services, conduct and fund research for health and health care, support health professional education and development, and provide expert advice and consultation to agencies, institutions, and individuals. Each individual US state fulfills its responsibilities for health of the public separately both from other states and from the federal agencies. States also contain public health systems at the level of counties and cities. This wide distribution of governmental authority and responsibility for public health means that numerous public health systems can influence the health of immigrant populations.

International

In 2005, the World Health Organization (WHO) revised the International Health Regulations (IHR) and created a system of infectious disease reporting. The IHR is intended to inhibit the spread of disease and to protect national populations from imported diseases. Unlike its earlier version that limited regulation to a few specified diseases, the IHR of 2005 includes any and all disease posing significant harm to humans. It requires each nation to have a core public health capacity that is capable of monitoring disease outbreaks and, when they threaten to spread beyond national borders, providing notification to WHO authorities. The IHR specifies protections for travelers, including immigrants.

The WHO adopted a “Global Strategy for Health for All by the Year 2000.” Its purpose is to assure that resources for health become more evenly distributed, emphasizing both governmental and personal responsibilities in preventing illness and relieving the effects of disease and disability. Pursuing the goal of health for all persons at a level sufficient to permit socially and economically productive lives, WHO sets health standards, monitors health status, and maintains health statistics. Among the nations that have opted into Health for All strategies, the United States has taken a minor part.

Domestic

The USA has numerous separate agencies at the federal, state, and local levels and many organizations both voluntary and for-profit with authority to make policies affecting public health. Among all of these entities, there is overlapping scope of authority and no clear or consistent hierarchy.

At the federal level, the United States distributes responsibility for various aspects of public health among a number of agencies. The Centers for Disease Control and Prevention (CDC) contributes expertise, information, and tools needed to protect the health of people and communities. The Food and Drug Administration (FDA) monitors the safety and effectiveness of drugs and vaccines as well as the safety of the food supply, cosmetics, dietary supplements, and other products. The Department of Agriculture (USDA) works to enhance food safety and to provide food assistance and nutrition education. The Health Resources and Services Administration (HRSA) helps to improve access to health care services for people who are uninsured, isolated, or medically vulnerable by training health professionals and improving systems of care in rural communities. The Department of Labor (DOL) enforces fair labor and housing standards under laws specifically intended to protect migrant and seasonal farm workers.

State and local public health agencies screen for, vaccinate against, and/or treat infectious diseases such as HIV/AIDS, seasonal influenza, and infectious diseases of childhood. School attendance laws in every state require that children be vaccinated against measles, mumps, rubella, pertussis (whooping cough), hepatitis B, and other infectious diseases. Since tuberculosis outbreaks in US port cities have been traced to immigrant populations, the federal government mandates a program to test and treat all immigrants to the USA for tuberculosis under guidelines established by the CDC. In addition, state laws mandate tuberculosis reporting; and many state and local public health agencies also identify and treat cases regardless of the person’s ability to pay.

The Safety Net

While access to health care services represents only one of many public health concerns, it deserves particular attention because immigrants in the USA may suffer systematic exclusion from the nation's health care systems. Exclusion may result from lack of health insurance, low incomes, language barriers, and living in rural areas where availability of health professionals and services is sparse. A patchwork of safety-net programs – including health insurance, direct services, and emergency services – helps to support the needs of immigrant populations.

Health Insurance

Medicaid is a program that each state funds jointly with the federal government within federal guidelines. Rules for eligibility and duration of Medicaid coverage are complex and vary state by state. Generally, those eligible include low-income pregnant women and children, parents, disabled adults, and the elderly; typically ineligible are those persons who are childless non-elderly adults. Children and some adults whose incomes are slightly above the Medicaid-eligibility limit may qualify for the Children's Health Insurance Program (CHIP; formerly called SCHIP), which is also jointly sponsored by states and the federal government. Only immigrants with permanent resident status are eligible for Medicaid and CHIP, usually subject to a 5-year residency requirement. Undocumented immigrants are generally not eligible, but a few states do provide CHIP coverage for pregnant women without regard to immigration status.

Low-Cost Direct Services

Community and migrant health centers provide health services at low cost or no cost, with fee scales adjusted to the patient's ability to pay. There are over 7,000 such community centers in all states; there are 147 centers focused on migrant farm workers' needs in 39 states and Puerto Rico. The services available include wellness check-ups, treatment for illness and injury, prenatal care, immunizations, dental care, prescriptions, and mental health and substance abuse care.

Emergency Care

Hospitals in all states are subject to federal law requiring that they provide treatment, stabilization and, if necessary, referrals to anyone who needs either emergency health care or childbirth services – regardless of ability to pay. Anyone needing such care may go to a hospital emergency department and receive treatment within the particular hospital's available expertise. The demand for these services may be heavy at times and in certain locations because emergency departments have become the provider of last resort for populations lacking health insurance or access to regular physicians and clinics.

Conclusions

Public health systems and policies encompass immigrant populations but fall short of meeting their particular needs and vulnerabilities. International regulations are designed to prevent disease spread among nations rather than to assist or protect individuals. Immigrants in the USA face health threats often greater than do native-born citizens but lack access to services due to restrictions from public insurance, lack of employment-based coverage, and apparent reluctance to seek care. The newly enacted health insurance reform legislation (March of 2010) does little to improve access to health insurance and health care for noncitizen US immigrants regardless of legal status.

Related Topics

- ▶ Access to care
- ▶ Chemical exposure
- ▶ Environmental exposure
- ▶ Farmworkers
- ▶ Five-year bar
- ▶ Global health
- ▶ Immunization
- ▶ Infectious diseases
- ▶ International Health Regulations
- ▶ Medicaid
- ▶ Medical examination (for immigration)
- ▶ Migrant farmworkers

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Public Health Insurance

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Public health insurance in the United States refers to the use of public funds for medical care of individuals. The Veterans Affairs and Indian Health Service use public funds and provide medical care for their respective populations, for example. By far the most familiar public insurance programs are the Medicare and Medicaid programs. Enacted as Title XVIII of the Social Security Act in 1965, Medicare was created as a comprehensive health insurance program for older Americans. The program was expanded in 1972 to provide coverage for persons with disabilities. Eligibility for the Medicare program is not based on financial need; but rather is a federally funded entitlement program. Financing for Medicare Part A's Hospital Insurance benefits, for example, derives from a FICA (Federal Insurance Contributions Act) withholding tax applied to wages. Medicare Part B for physician, outpatient hospital, home health, and medical equipment and supplies is optional and funded in general by beneficiaries directly. An estimated 46 million individuals are covered under the Medicare program in 2010. The Medicaid program was also established in 1965 as a federal–state partnership under Title XIX of the Social Security Act to provide health insurance for low-income Americans, including many older Americans (referred to as dual eligibles). Depending on a state's per capita income level, the federal government pays from 50% to 76% of a State's Medicaid program costs, with the remainder being funded by each state. The Children's Health Insurance Program (CHIP) was established in 1997 and can either be a separate state program or a component of a State's Medicaid program and is available to cover children up to 300% of the federal poverty level. Fifty-eight million individuals are estimated to be covered under Medicaid and CHIP programs in 2010.

In addition, some states and local governments have established publicly funded health insurance or health coverage programs for certain portions of the safety net population (for example, county indigent health programs, and family planning programs).

Private health insurance in the United States is primarily operated through the many large and some small employers who offer health insurance to their employees as a fringe benefit. Additionally, individuals may purchase private health insurance for themselves and/or their families in the individual market. Private health insurance is generally regulated at the state level.

The gap between public programs and private insurance accounts for the uninsured in the USA, which according to the most recent estimates exceed

46 million individuals. Individuals without insurance in the United States are less likely to have a usual source of care, seek early prevention and intervention services, and both report being in poorer health and have measurably worse health outcomes than their insured counterparts. They are more likely to postpone care and therefore require more acute and expensive treatment at later stages in many disease processes. The uninsured account for substantial proportions of the unnecessary and preventable hospitalizations and inappropriate utilization of emergency departments for primary care related conditions.

When large numbers of individuals are uninsured, the costs of providing generally uncompensated care falls upon healthcare providers, particularly safety net providers such as publicly funded hospitals, and local governments. Additionally, providers seek to cover their losses from uninsured care by charging higher fees to their insured consumers. These higher healthcare fees are in turn passed on from insurers to the insured individuals who pay for the insurance premiums. As insurance premiums rise, some employers raise the cost-sharing rates for their employees or drop coverage altogether, and/or individuals drop coverage due to its unaffordability. This, in turn, creates more uninsured, and the cycle of cost-shifting and fewer insured individuals continues.

The majority of the uninsured nationally are citizens (80%). That figure is estimated at 76.3% for Texas. The Pew Hispanic Center estimates there were about 6.8 million uninsured undocumented immigrants in 2007 who accounted for 15% of the uninsured (Kaiser Family Foundation, December 2009). Estimates suggest that 7 of 10 immigrants are either naturalized citizens or lawfully residing noncitizens who together account for 9% of the US population. Approximately 11.9 million undocumented immigrants make up 4% of the population and 5.4% of the workforce. Some 40% of noncitizens (lawfully residing and undocumented) have private insurance, but they are significantly more likely to be uninsured than citizens, with 46% of noncitizens lacking coverage. This higher uninsured rate reflects more limited access to private and public coverage, because while noncitizens are as likely to work as citizens, they often do so in jobs and industries that do not typically offer employer-sponsored health coverage.

Passage of the Affordable Care Act of 2010 has only minimally impacted access to public or employer-sponsored insurance for immigrants in the United States. Immigrants are generally defined as foreign-born individuals residing in countries other than their country of origin. In the USA, this includes naturalized citizens and noncitizens (both lawfully residing and undocumented). Undocumented immigrants, for example, remain ineligible for the expanded Medicaid program. Lawfully residing immigrants without access to employer-sponsored coverage would be eligible for federal subsidies for coverage obtained through state health insurance exchanges upon verification of their citizenship status and income. Additionally, states have the option of allowing enrollment into Medicaid by those lawfully residing immigrants during their first 5 years in the USA. The consequence of not addressing expanded immigrant access to coverage in federal health reform places the full costs of healthcare delivered to these individuals squarely on state and local governments, business owners, and residents who therefore have a continued incentive to provide healthcare to this population in the most cost-effective manner possible.

Public–Private Partnerships

Because the costs of providing care to the uninsured fall mainly upon local and state public and private stakeholders, there are significant incentives for these stakeholders to find ways to effectively partner to minimize these costs. CHIP buy-in programs for above-income eligible children, publicly funded reinsurance programs, and 3-Share programs are a few of the innovative public–private partnerships that have been created in recent years to address subpopulations of the uninsured. Three-Share (or multi-share) programs are public–private local or state collaborations to provide low-cost health benefit coverage for small businesses and their employees. They are public in the sense that local, state, and/or federal sources of funding often comprise a portion of the premium subsidy and that local publicly funded safety net providers are often found within the programs' provider networks. They are private in the sense that private funding may also be available for the subsidy pool and often private safety net providers are in their provider networks and benefit from reductions in the uninsured resulting from these programs in their community. Three-Share Plans are particularly effective programs in that they leverage each dollar contributed by the public–private subsidy fund with two additional dollars from the small business employer and his/her employee. Without that subsidy dollar, much of the other contributions are not harnessed to cover the costs of uncompensated care for the uninsured.

The concept of multi-share or 3-Share programs originated in Michigan. The first 3-Share program – Access Health – began in Muskegon, Michigan. Existing 3-Share Plans are located in Pueblo, CO; Duluth, MN; Wayne County, MI; Muskegon, MI; Texas; and Arkansas. Common characteristics among local access to care programs have been noted by Blewett and colleagues. These common characteristics are: (1) they are community-based initiatives, (2) run by nonprofit organizations, (3) have eligibility requirements for participation, (4) are generally for low-income individuals, and (5) the program usually has a limited benefits package as well as a closed provider network. Each of the 3-Share programs mentioned above meets all of the defining 3-Share criteria. Most plans promote prevention and wellness through primary care and offer such services as physical examinations, immunizations, mammography’s, and health education. As a way of promoting wellness, Wayne County 3-Share and the AR HealthNetworks program in Arkansas, for example, do not exclude participants for preexisting conditions. By doing this, members are encouraged to seek care for their conditions.

The Employee Benefit Research Institute suggests there are certain features of a 3-Share program that must be tailored to the specific community where it is implemented in order for it to be successful. Additionally, research on local access programs to determine what factors beyond a subsidy influence enrollment reveals that having a subsidized, affordable program available to members in the community is not enough to attract participation if the community members do not like the plan features. Awareness of the program as well as clear information on how to apply and enroll in the program is important to attract members. Specifically, among programs where both the employer and employee were subsidized, program features important to subscribers were having a large provider network, covering preexisting conditions, and offering at least some first dollar coverage for preventive services or office visits.

3-Share Programs: Texas

Approximately 24% of uninsured Texans are noncitizens. In Texas, approximately 20% of native US citizens are uninsured. Nearly 29% of naturalized citizens in Texas are uninsured. More than half (54.5%) of noncitizens in Texas are uninsured. Federal rules require state Medicaid programs to provide certain mandatory benefits for certain mandatory populations, and allow states to cover other optional benefits and populations. Texas remains one of the few states that have not exercised such Medicaid expansion options. Because of this, a significantly lower percentage of low-income individuals are covered by the Texas Medicaid program than are covered by Medicaid programs in other States. This makes 3-Share Plans particularly useful for reaching low-income working adults in Texas.

Texas Department of Insurance State Planning Grant (SPG) research shows that the majority (76.6%) of the uninsured in Texas are working age adults. While the majority of working-age adults obtain their health care coverage through an employer-sponsored plan, the percentage of employers who offer coverage to their employees has been declining – particularly among small business owners. In 2008, Austin-based economic analysis and public policy consulting firm TXP reported that while the percentage of businesses offering employer-sponsored health insurance among large (200+ employees) businesses remained fairly constant at 99% during the period 2000–2007, the percentage of small (3–9 employees) businesses dropped precipitously from 57% in 2000 to 45% in 2008. In 2007, only 53% of Texans had health coverage through their jobs, compared to the national average of 61%. Programs aimed at low-income employees of small businesses are critical to reducing their numbers among the ranks of the uninsured in both Texas and nationally.

A 2004 SPG survey of Texas small employers revealed that while 81% of employers believe that they should provide insurance if they can afford to do so, the number one obstacle to small employers offering coverage is cost. Due to their size, location and health status of their employees, small businesses face healthcare premiums significantly higher than their large employer counterparts. An additional barrier to offering coverage for their employees is the complexity of the insurance market and the need for simpler enrollment materials and processes. Small businesses do not have the typical employee benefits staff found in large firms so their owners handle these matters themselves and often lack the time to adequately assess programs, meet with insurance brokers multiple times to determine the best program, and to complete application paperwork. In order to address this barrier, 3-Share programs strive for transparency in their business and employee eligibility criteria, premium rates, and covered benefits.

TexHealth Harris County 3-Share Plan began offering coverage in December 2009. Businesses eligible for the TexHealth Harris County 3-Share Plan are those employing between 2 and 50 employees, who have been in business for at least 1 year, who have not offered group health insurance to their employers in the past 12 months, and who have at least 30% of their employees eligible for subsidy assistance. All employees of an eligible small employer are allowed to enroll in the plan, but only those whose pretax income is below $16.00 per hour (roughly 300% of the federal poverty limit) are eligible to have up to one third of their monthly premium cost covered by the public–private subsidy pool. Subsidy funding for the TexHealth Harris County 3-Share Plan comes from contributions or grants from the City of Houston, the State of Texas, and the federal State Health Access Program grant awarded to Texas by the US Health Resources and Services Administration.

Many 3-Share programs, including the Galveston and Central Texas 3-Share Plans, offer a single benefit plan at the same cost for all enrollees. The TexHealth Harris County 3-Share Plan offers two benefit plans and varies the premium costs based on the age and sex of the employees as a means to further encourage the enrollment of younger employees. Thirty percent of the uninsured are of relatively young (19–29 year-old) individuals who do not purchase insurance because they are healthy and do not see insurance as a necessary investment, or because they earn relatively lower wages and thus do not consider insurance a necessity. Immigrants are highly represented among these young, low-income uninsured persons.

Using an average premium of $240 per member per month (PMPM), the employer is required to pay at least 50% of the monthly cost (or ~ $120 PMPM), the subsidy can cover one third or about $80 PMPM, and the subsidy eligible employee pays about $40 PMPM. For higher income employees, the cost is shared only between the employer and employee. A premium in the range of $40 PMPM can represent a much more affordable percentage of a low-income worker's earnings than the typical 50+ % share he or she might be required to pay for a traditional insurance product offered by his/her small employer.

In a unique twist on the public–private partnership model, TexHealth Harris County 3-Share Plan utilizes two third party administrators through which to operate its two benefit plans – United HealthCare for Plan A and Community Health Choice for Plan B. UnitedHealthcare is one of the largest commercial insurance companies in both the large and small group markets in the United States and Texas. Community Health Choice is a Medicaid and CHIP health maintenance organization owned by the Harris County Hospital District. This unique partnership between an insurer with expertise in small commercial group coverage and a health plan with expertise in managing the care of low-income populations provides an ideal solution for the Houston marketplace. Enrollees have the choice of plans, along with the provider networks and premiums associated with those plans.

In its first 6 months of operation, the TexHealth Harris County 3-Share Plan enrolled 31 businesses with 178 employees. The average hourly wage of enrolled employees is just below $14 per hour, with 80% of total enrollees eligible for subsidy assistance. Forty-three percent of enrollees are between 18 and 35 years of age, and 61% represent traditional racial minorities. Early results show that the program is reaching those groups most represented among the low-income uninsured population. Businesses that have enrolled to date include a wide variety of business types, including construction and food service, among which immigrants are highly represented among the workforce.

An economic impact analysis of 3-Share programs in Texas conducted in 2008 by TXP, for the TexHealth Coalition found that fully implementing 3-Share programs statewide could:

- Provide almost 400,000 more Texas employees and their dependents with coverage within 3 years and as many as 700,000 Texans in the next 10 years if Texas has the same experience as some of the established, older 3-Share programs
- Generate over $700 million in additional healthcare spending in Texas
- Boost annual economic activity by just over $1.7 billion
- Create about 16,000 permanent new jobs
- Generate nearly $30 million in new tax revenues from newly created jobs and healthcare spending

The ability to leverage a subsidy dollar to secure an additional 2 dollars from employers and employees makes for an effective public–private partnership to addressing access to coverage for low-income employees of small businesses.

Conclusion

Although the major public insurance programs (Medicare, Medicaid and CHIP) in the United States cover an estimated 80+ million people, or roughly 27% of the population, and private health insurance is purchased by employers and individuals to cover 170+ million people, roughly 46 million remain uninsured and in need of safety net providers and programs. Large numbers of uninsured create large uncompensated care burdens for healthcare providers, higher insurance premiums for the insured, and poorer health outcomes in our communities. As the number of uninsured individuals has climbed since public programs were instituted in 1965, there has been an increasing need for state and local public–private partnerships to develop creative mechanisms through which to offer and finance care for these individuals. Programs like 3-Share Plans, in which public dollars are leveraged to bring in private dollars, represent cost-effective and efficient means to finance coverage for the low-income working component of the uninsured population, just as CHIP buy-in programs have addressed coverage for children in low-income families who earn more than program income limitations. As immigrants comprise a significant proportion of uninsured individuals in the United States, they stand to benefit from such local public–private partnerships.

Related Topics

► Access to care
► Barriers to care
► Health insurance
► Medicaid
► Medicare

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Puerto Rico

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The Commonwealth of Puerto Rico is a United States territory situated in the northeastern Caribbean Sea basin, where the Caribbean Sea and Atlantic Ocean waters meet. The archipelago includes Puerto Rico mainland and its islands: Vieques, Culebra, and Mona.

Immigration to Puerto Rico Prior to the Twentieth Century

Puerto Rico received its first European immigrants in 1493 after the second voyage of Christopher Columbus. Around 1,500 Castilian Spaniards settled first in the Guaynabo area. American Indians called *Tainos* inhabited the land with an estimated population of 50,000 that almost perished entirely due to slavery, diseases, suicide, escape, and unsuccessful fight against the conquerors. Thousands of African slaves from what are today Ghana, Nigeria, the Republic of Benin, the Guineas, and Togo replaced the Tainos in the gold industry. More Spaniards arrived and founded new towns along the Caribbean coast and later in the mountain regions, where they may have mixed with the remaining Tainos.

In 1815 Spain signed the “Royal Decree of Graces” that permitted free immigration of non-Hispanic European Catholics to Puerto Rico. Most were Spaniards, but thousands of farmers arrived from other countries such as France, Portugal, Malta, Ireland, Germany, Lebanon, Scotland, and Italy. The population grew from 150,000 to almost a million, Spaniards being only 55% of the foreign-born.

African runaway slaves from other Caribbean territories also arrived to the island, after Spain signed the “Decree of Graces of 1789” that permitted slaves to buy or earn their freedom. From 1795–1844, the first and smallest Dominican immigration to Puerto Rico occurred after Santo Domingo suffered the Haitian invasion. Despite so much diverse immigration, it was during the nineteenth century that Puerto Rico developed its strong national identity.

Immigration to Puerto Rico in the Twentieth Century

In the twentieth Century, Puerto Rico became a United States (US) territory, making it an attractive destination for immigrants escaping from dictatorial governments. In the 1930s Jewish refugees moved from Hitler’s Germany and in the 1940s and 1950s, hundreds of Galicians left Franco’s dictatorship in Spain. In the 1960s Cuban, Chinese and Jewish businessmen left Cuba after Castro’s government nationalized their businesses, while a few Dominicans ran away from Trujillo’s dictatorship. After Trujillo’s regime (1961), thousands of lower class Dominicans moved to Puerto Rico due to extreme poverty. Around 60,000 Dominicans live today in Puerto Rico, which is 56% of the foreign-born population. Dominicans have concentrated in the San Juan metropolitan area working as unskilled workers for lower pays than Puerto Ricans. Many arrive to Puerto Rico illegally, risking their lives by crossing the wild waters that divide both countries. Their illegal status (estimated to be 30%), their high intermarriage rates with Puerto Ricans, and their disadvantaged socioeconomic background have been a controversial issue for Puerto Ricans and the local government.

Other recent immigrants to Puerto Rico are Southern Americans from different social segments. Almost 5% of Puerto Ricans on the island are US-mainland born, reflecting the constant migration back and forth to the mainland US. Non-Puerto Rican US citizens have also moved to the island to work as professionals in the pharmaceutical and manufacturing companies, mainly in the northern and eastern areas.

Puerto Rican Emigration prior to the Twentieth Century: The Spanish Colonial Era

There is little known about Puerto Rican emigration prior to the twentieth century. It is likely that the first to leave the island were thousands of *Tainos* who escaped to the Lesser Antilles and South America, after the Spanish colonization. During the sixteenth to nineteenth centuries there may have been minimal movement to Spain, South America, and other Caribbean territories. By the late nineteenth century, earthquakes and hurricanes destroyed the island’s economy bringing unemployment, malnutrition, and extreme poverty. As a consequence, a small wave of Puerto Rican skilled workers immigrated to the Dominican Republic to work in the sugar industry.

Puerto Rican Emigration in the First Half of the Twentieth Century: The US Territory Era

In 1898, the USA won the Spanish-American War against Spain and Puerto Rico became a US territory. During the first decade, only 2,000 Puerto Ricans immigrated to the US mainland, settling mainly in New York City. Another 5,000 jobless laborers were recruited by the renowned *Big Five* sugarcane corporations in Hawaii, due to a workers shortage there. Today there are about 30,000 Puerto Ricans in Hawaii.

On March 2, 1917, the Jones-Shafroth Act granted US citizenship to Puerto Ricans. A month later the US declared war on Germany and 18,000 now US citizen Puerto Rican men emigrated to military bases around the world to serve in World War I. Thousands of Puerto Rican men moved to US industrial complexes to keep up with war artillery and other markets demands. Over the next 30 years, tens of thousands continued to move to Brooklyn and northeastern Manhattan forming Puerto Rican communities in East Harlem (a.k.a "*El Barrio*"). During 1945–1965, Puerto Rico experienced the *Great Migration* in which Puerto Ricans arrived to the US mainland at rates of 45,000 people per year. The federal, state and island governments coordinated active massive recruitment of semi-skilled workers who were needed by major US industrial cities to sustain their market expansions. The most common destinations were: New York City, Newark, Hartford, Chicago, and Philadelphia.

After settling in the US, many immigrants faced discrimination at work, in school, and in the neighborhoods. Salaries were much lower than their non-Hispanic White counterparts. Puerto Ricans were unable to find proper housing, nutrition, and education. Most had to move into poor neighborhoods that had high crime rates and had rampant drug use. Reliance on welfare, food stamps, and other government programs became an option to bring food home and pay rent. Other workers began to portray Puerto Ricans as delinquents, drug addicts, and welfare leeches. Despite all this, emigration to the US mainland continued until 1953 when it reached a peak, with about 200,000 Puerto Ricans living across the nation. Then it began to decline until the mid 1960s for several politico-economical factors.

Puerto Rican Emigration in the Second Half of the Twentieth Century: The Commonwealth Era

In 1952, the US Congress approved the development by Puerto Rico of its own constitution and a Commonwealth status began. Luis Muñoz Marin (first governor elected by popular vote) began a transition of Puerto Rico's economy from an agricultural to an industrial one. In the 1950s rapid industrialization occurred under the name of *Operation Bootstrap* that promoted bringing US industries to Puerto Rico in exchange for cheap labor and federal tax exemption. One hundred US companies became interested, and as a result Puerto Rico became a large pharmaceutical manufacturing center.

Industrialization required development of an infrastructure, and therefore Puerto Rico improved in many areas including better roads, schools, illumination, potable water, and sewage systems. Subsequently, emigration to the US mainland began to decline since jobs were in surplus and quality of life had improved substantially. In the 1970s Puerto Rico had negative emigration for the first time since the nineteenth century. However, in the 1980s and 1990s Puerto Ricans had achieved higher salaries and with financial prosperity, population growth was dramatic. The college graduate rates increased substantially leading to a surplus of professionals. Also, other markets around the world were offering cheaper labor and Puerto Rico's tax exemption laws expired. All these factors prompted US industries to leave and a new cycle of emigration began, but this time mainly to Florida.

Health Issues of Puerto Ricans in the US and Puerto Rico: General Health and Demographics

Puerto Ricans are the second largest Hispanic group in the US after Mexicans (9.6% of all US Hispanics). Of the eight million Puerto Ricans, half live on the island and the other half live on the US mainland. Two-thirds of mainland Puerto Ricans are second generation migrants and one-third is first generation migrants. This first generation moved to the US mainland prior to 1990 (60%) and a second group migrated during the period 1990–2000 (25%). Mainland Puerto Ricans are 10 years younger, with a median age of 28 years and 75% are less than 45 years old. They make twice the salary ($34,000/year) of their island counterparts. Mainland Puerto Ricans are less likely to fall below the poverty line (24% versus 45% of island Puerto Ricans). However, Puerto Ricans residing in the USA are two times less likely to be homeowners and three times less likely to have a college degree compared to island Puerto Ricans. Mainland Puerto Ricans also have the highest unmarried and the second highest single-woman household rates among all US Latinos.

Life expectancy in Puerto Rico is 74 years for men and 82 years for women, ranking 27th and 9th worldwide, respectively, similar to US rates. Clinical research suggests that place of birth, acculturation, and sex play a role in discrepancies when comparing health outcomes. For example, Puerto Rican women have the lowest death rate of all Latinas in the USA, but Puerto Rican men have the highest death rate among all Latino men. Higher acculturation of Puerto Ricans and being US born increases health risk behaviors (e.g., smoking, lack of exercise) and consequently mortality.

Puerto Ricans moved to urban areas in New York, New Jersey, Illinois, Florida, and Pennsylvania, and in smaller numbers to California, Connecticut, Massachusetts, and Ohio. After 1990, Florida has become the most common destination with almost a million Puerto Ricans residing in the Orlando area. Puerto Ricans came mainly from the uneducated poor lower class and were predominantly dark-skinned with a more mixed or African heritage.

These demographics along with moving to colder climates and poor English proficiency may explain the outcome differences between Puerto Ricans and other Hispanics in the US. For example, Cubans came from the educated, more English proficient, light-skinned middle and upper classes and moved to a similar tropical climate (Miami), making them less of a target of racism than Puerto Ricans. In the last 2 decades, middle class Puerto Rican professionals have moved to the US due to a professional surplus in the island and unemployment. This has contributed to intellectual fugue or polarization and a reduction of the middle class.

Characteristics of the Puerto Rican Patient

Despite having the highest health insurance rates among all US Latinos, Puerto Ricans have worse health status compared to other Hispanics with low insurance rates. They also tend to use health care less, especially for preventive measures.

Like other Hispanics, Puerto Ricans have a high degree of *familismo* which is a strong orientation toward both the nuclear and extended family. A good example of this is that most of the people in a doctor's waiting room might be family members rather than patients. Most of the time Puerto Ricans prefer to have a family member present when seeing a doctor and delegate the responsibility of narrating the history and of asking questions to their family members (especially elderly patients). Family members feel that they must help the patient with less English proficiency and less educational attainment. Furthermore, family members may have the responsibility of transporting the patient and administering medications.

The relationship with the physician tends to be a patriarchal one. Family involvement in a patient's treatment may improve patient outcomes. Some patients may also prefer to use Spanish when seeking health care. They may be also at higher risk of medication side effects and may prefer nontraditional treatments and may present more frequently with atypical symptoms of diseases.

Risk Behaviors

Many times individual behaviors may increase the risk for medical illnesses. These behaviors can include such things as failure to use seat belts while in a car, nonuse of condoms during sexual activity, as well as use of tobacco, alcohol, and drugs. Studies have shown that needle sharing, intravenous drug use, polydrug abuse, and heterosexual multiple partners are clear risks for progression of HIV. When a person has a higher number of risk behaviors, they more likely are to be unemployed, single, and have a lower educational level.

Puerto Ricans have lower rates of tobacco use compared to the general US population; however, Puerto Rican men have higher rates of alcohol dependence than most other Hispanic subgroups and their US cohorts. Hispanics have a lower rate of substance abuse than non-Hispanic Whites.

Top Five Reasons for Death

Puerto Ricans who live in Puerto Rico have heart disease as the leading cause of death. This is followed by cancer, which is the second leading cause of death. In third place is diabetes, fourth is hypertensive disease, and accidents are the fifth leading cause of death.

For Hispanics, including Puerto Ricans, living on the US mainland, the top five causes of death are heart disease, cancer, accidents, stroke, and diabetes, in that order. Unfortunately the data for the causes of death are not more specific for Hispanic subgroups. In comparison though, accidents as a cause of death are higher for those living on the US mainland perhaps because of the types of employment that Hispanics take once in this country. This may be more applicable to the other Hispanic subgroups, especially those without citizenship.

Infant Mortality

Stateside Puerto Ricans have the highest infant mortality rate (8.3 per 1,000) of all US Hispanics, as well as the highest unmarried rates and the second highest single female householder rates. Fertility rates of both mainland Puerto Ricans and island Puerto Ricans are also among the highest. Studies have shown increased rates of late or no prenatal care in Puerto Rican mothers, increasing probability of infant mortality, and overall worse health status later in life.

Asthma

Hispanics as a group have a lower percentage of asthma (5.0%) when compared to non-Hispanic Whites (7.4%) and non-Hispanic Blacks (7.8%). However, Puerto Rican asthma rates are twice as high (13.4%). About 18% of adult women and 9% of adult men are reported to have asthma currently. Also the lower the income, the higher the amount of asthmatics found.

HIV

Although HIV/AIDS is ranked as the 16th cause of death for Hispanics, when individual subgroups of Hispanics are analyzed, Puerto Ricans living on the island have twice the rate of new infections (45%) compared to the rate in the mainland US population (23%) and US mainland Hispanics (29%). Males account for 65% of new HIV infections in Puerto Rico, injection-drug use (39%) and heterosexual contact (37%) being the most common transmission routes. This is different from the US mainland, where unprotected male-male sexual relations is the primary mode of HIV transmission.

Transmission is highest between the ages of 30–49, correlating with rates of injection drug use. As a result, Puerto Rico has implemented efforts to target drug use infection, such as: needle exchange programs, selling of syringes without medical prescription, and drug rehabilitation program promotion.

Puerto Ricans seem more educated about HIV risk than Mexicans for instance, but this knowledge does not prevent risk behaviors. Also engagement in high sexual risk behaviors seems to increase with acculturation. Puerto Rican men have the highest injection drug use among Hispanics.

Homicide

Homicide rates have declined among all races and ethnicities, but continue to be the 7th leading cause of death for Hispanics. Puerto Rican men seemed to be the most affected group among Hispanics, having twice the risk of dying from homicide compared to Puerto Rican women. Puerto Rican men have the highest rates of death, compared to other Hispanic men. This particular segment of the population should benefit from strong substance use, HIV, and homicide prevention programs.

Psychiatric Diseases

When compared to other Hispanic subgroups, Puerto Ricans have higher rates of depression and anxiety. Second generation Puerto Ricans have an increased rate of substance abuse, while third generation Puerto Ricans have an increased rate of all psychiatric disorders. Puerto Rican immigrants have the same rate of mood and anxiety disorders as the mainland US-born population. This is in contrast to other Hispanic immigrants, which have lower rates of psychiatric illness compared to the US population in general.

Summary

Puerto Rico's history, geography, politics, and cultural background result in a very unique population which is clearly different from other Hispanics. This can help to explain why Puerto Ricans may have unique healthcare issues and should not be simply looked at as *another* Hispanic subgroup. Analysis of the Puerto Rican population is very important, as extrapolating information from other Hispanic subgroups and applying it to Puerto Ricans may be detrimental to their healthcare. Puerto Ricans' health issues should be viewed within their singular context.

Related Topics

- ▶ Acculturation
- ▶ Acquired immune deficiency syndrome
- ▶ Addiction and substance abuse
- ▶ AIDS knowledge
- ▶ Anxiety
- ▶ Asthma
- ▶ Familismo
- ▶ Hispanics
- ▶ Homicide
- ▶ Infant mortality
- ▶ Language
- ▶ Latinos
- ▶ Physician-patient communication
- ▶ Risk factors for disease

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Q

Qualitative Research

- ► Methodological issues in immigrant health research
- ► Narrative research

Quality of Life

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Most often used interchangeably with terms such as life satisfaction, happiness, and subjective well-being, it is important to understand that quality of life (QOL) reflects both objective and subjective factors that affect personal growth and reflection of oneself. Objective factors such as income and education along with subjective factors such as one's satisfaction with one's education or income play a major role in effecting one another. Quality of life refers to a subjective evaluation of the fulfillment of a person's needs, goals, and wishes. It can include every aspect of one's life such as health, family, finances, and career. Quality of life is a multidimensional approach known to have three main components: subjective well-being or life satisfaction, functioning in social roles/self-care, and access to social and physical environmental resources. Its complex interaction between external conditions and internal perceptions is unique and essential to understanding its many impressions on human health. Quality of life serves as an umbrella term to many of its other related terms; it often lacks a succinct and consistent definition, which allows it to be used vaguely and leaves the interpretation up to its readers. Early research proclaims there to be three components to subjective well-being: life satisfaction, positive, and negative affect. The key component – life satisfaction – is considered to be mostly equated with quality of life. Happiness, on the other hand, is deemed a subcategory of positive affect; a short-term concept dependent on mood and situation.

The quality of life demonstrates the degree of satisfaction one has with their daily life. Life satisfaction is a term coined by Ed Diener, a distinguished psychologist whose research focuses on subjective well-being, life satisfaction, and positive psychology. Diener et al. (1985) created the Satisfaction with Life Scale (SWLS), a five-item scale which measures the cognitive judgments of satisfaction with one's life. It can be determined by your ability to make choices about the way you wish to live your everyday life. It is naïve to think that quality of life will be the same for everyone, for it is greatly subjective and is influenced by many different factors.

The term quality of life is a multi-approach measure used to explain micro- and macro-level factors and the effect they have on human life. Quality of life measures have often been used to predict economic progress and stability. The field of economy measures the quality of life by using the "quality of life index," which includes the following nine indicators to determine a country's quality of life: material well-being, health, political stability and security, family life, community life, climate and geography, job security, political freedom, and gender equality. Research shows that unemployment, a country's prosperity, and economic growth are highly correlated with quality of life. Economists have studied how economics can have a major impact on how the quality of life is perceived.

Quality of life measures have also been used in areas such as public health, health research, and medicine. The concept of health-related quality of life (HRQOL) refers specifically to the functional status, emotional

Sana Loue & Martha Sajatovic (eds.), *Encyclopedia of Immigrant Health*, DOI 10.1007/978-1-4419-5659-0,

state, and the impact of illness on patient health. The Center for Disease Control and Prevention (CDC) specifically uses this to track HRQOL in various populations and forms interventions to enrich public health. The CDC uses an assessment called the Health Days Measure to evaluate HRQOL; it consists of 14 items which are calculated by estimating the number of healthy and unhealthy days. The number of overall days when a responder felt that their physical/mental health was not good would constitute as unhealthy days. The number of overall days when a responder felt that their physical/mental health was good would constitute healthy days. Healthy and unhealthy days are then compared and if there are 14 or more unhealthy days recorded, this would indicate a significant stage of impairment. Health-related quality of life has shown to be an essential tool for identifying health concerns and encouraging the concept of healthy lives.

Positive psychology is often used to study and increase the quality of life. Positive psychology is a field of study which promotes a holistic view of human fulfillment. It is considered the study of mental health instead of mental illness. Positive psychology seeks to identify and uplift character strengths to improve life satisfaction. Its goals are to enhance one's well-being by strengthening their positive character and then by enhancement of positive communities and cultures. Positive personal traits such as courage, interpersonal skills, perseverance, and originality can be used to effect larger institutions and encourage responsibility, civility, tolerance, and work ethic. These traits have been known to act as buffers which protect against instability, lack of satisfaction, and even mental illness. The objective of positive psychology is to allow people and the communities in which they live to flourish by using the skills they already possess and focusing on the basics of enjoyment and livelihood at the upmost level. Positive psychology does not focus on the negative states of human mental health; instead of single-mindedly treating mental illness by restoring damage, it improves individual's outlook on life by providing encouragement and acknowledging strengths and virtues. This emerging field of scientific study serves as a foundation for improving the quality of life.

Still seeking to be valuably incorporated into the study of quality of life is the study of resilience. Resilience and quality of life are two psychological terms which are often explored independently. However, they should be addressed collectively due to their direct impact on well-being. Resilience is the ability to adapt to stressors in life such as trauma, death, and other sources of stress. This interdisciplinary element serves as a buffer to risks that can affect both your physical and mental ability. Traits often associated with resilience are decisiveness, self-care, responsibility, support, and optimism. Many researchers believe that genetics plays only a partial role in coping with stressful events; learning resiliency coping skills is also advantageous while facing stress. There are two main attributes that impact resilience: protective factors and protective mechanisms. Protective factors are considered inherent traits, a natural ability one can possess. Protective mechanisms are deemed to be coping skills adopted from successfully handling adversity. Therefore, these factors can be influenced by personality characteristics as well as learned skills. Resilience can produce a positive entity and moderate risk factors that may negatively affect the quality of life. Despite their detached disciplines they share a close relationship with each other; whereas resilience can prevent the quality of life from being damaged by life stressors. Resilience is the ability to adapt to adversity and the quality of life is the successful evaluation of adversity and how it affects well-being. Future collaborative research should address the interconnection of these two terms.

Immigrants are impacted heavily by migration and the quality of life. It is important to recognize that both are extremely fragile physical and emotional situations. The relationship between immigrants and the quality of life are twofold. Migration is usually caused by push and pulls factors; these factors are highlighted in four categories: political, economic, environmental, and demographic. Push factors are instances that cause for outmigration such as environmental disruption, crime, and high population pressures. Pull factors motivate migration and can be seen as incentives; this depends heavily on economic factors, for instance, decent wages, economic freedom, upward social mobility, urbanization, and the acquiring of new skills and opportunity to succeed. Since migration has been known to be a distressing event full of sacrifice, emotional turbulence, and lifestyle changes, it can have a varying effect on the quality of life of immigrants. A negative effect on the livelihood of immigrants by push/pull influences could result in a significant decrease in the quality of life, whereas acquiring their anticipated needs following migration could possibly result in an increase in the quality of life. However, once immigrants have settled into their aspired positions, the quality of life may change for natives as well. Some individuals may associate immigration with dangerous population growth, a depletion of resources, a strain on infrastructure, higher costs of living, and a decrease in economic gain. Therefore, natives may perceive a decrease in the quality of life due to immigration. It is important to take into consideration that the opposition that immigrants may face could diminish migrants' quality of life.

Related Topics

- ▶ Mental health
- ▶ Mental illness
- ▶ Pain
- ▶ Stress

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Quarantine

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Introduction

The quarantine and isolation of immigrants has occurred many times throughout civilized history. Often quarantines are invoked before they enter a new country, although there have been instances during which certain immigrant populations were quarantined in response to an outbreak. Quarantines of immigrants may involve a medical inspection where only those displaying signs and symptoms of a communicable disease are isolated. Others involve detaining all immigrants for a specified period of time longer than the incubation period of the suspected disease. Immigrant quarantines are often compulsory for the individuals, and so most of this paper will focus on mandatory quarantines. Many social, legal, ethical, and epidemiological issues arise out of the practice of quarantine, including the relationship between individual civil rights and population health.

A note about terminology is appropriate as terms are often confused. *Isolation* is the practice of isolating an individual known to be contagious, commonly in a health facility, for the duration of the illness. *Quarantine* confines people who have been exposed to a communicable disease for the disease's presumed incubation period.

History of Quarantine

The idea of quarantine has been around since ancient times. The Bible describes the confinement of lepers away from society. The name quarantine derives from the Italian word *quarante*, which referred to a thirteenth century policy requiring the holding of merchant ships for a period of 40 days before entering the port. Communicable diseases such as bubonic plague, small pox, and tuberculosis have caused widespread death in the past and have often led to attempts at quarantine to control the spread of disease. Modern medicine has largely eradicated these diseases in developed countries. Therefore, the idea of quarantine is foreign to many persons today, whereas it would have been a commonplace part of society a century ago.

Perhaps the most famous example of immigrant quarantine occurred at Ellis Island during a wave of mass immigration into the USA in the late eighteenth and early nineteenth centuries. Inspection agents at the station gave each immigrant a brief health inspection. Those with visible signs of sickness were held for a period of several weeks, whereas healthy immigrants were processed in a few hours. Three thousand would-be immigrants died in quarantine, and about 2% of would-be immigrants were sent home due to having a contagious chronic disease or criminal background. One third of the American population today can trace their ancestors to immigrants who arrived through Ellis Island. Today, medical inspections are often done at the embassies or affiliated health center of the originating country before the immigrant arrives in the USA.

Epidemiological Issues

The purpose of quarantine is to halt the spread of infectious disease in the general population. Because most infectious diseases transfer by human to human contact, isolating infected individuals from society until they are no longer contagious can prevent the further spread of disease.

These factors affect the ability of quarantine to be successful: the duration of the incubation period, the attack rate of the disease (i.e., how contagious it is), the number of persons infected, and the ability to identify and isolate those infected. If the incubation period is long, and the population infected is believed to be widespread, a strategy of prevention and treatment may be more effective. It should be noted that quarantine can potentially put more people at risk than they would have otherwise been. This can occur in instances where uninfected persons are quarantined with known infected individuals, increasing risk of transmission.

Legal Issues

In the USA, individual states have their own quarantine laws along with federal laws. In 1884, President Arthur issued the first proclamation granting federal authority to create and operate quarantine stations. Today, Title 42 U.S.C. § 267 provides the legal basis for the US government to create quarantine stations to deal with the control and prevention of communicable disease. The Surgeon General is in charge of creating and managing such stations, and has broad authority of their scope of power. In the UK, quarantine acts were often passed by Parliament as an outbreak began to occur.

The International Health Regulations is binding international law authored by the World Health Organization that deals with global health risks. This document reaffirms the State's right to implement procedures such as quarantine and isolation to prevent the spread of communicable diseases. The IHR document is not limited to specific diseases, but anything deemed to be a "health risk."

In the USA, the federal government has the legal right to enforce quarantine and isolation. However, this federal quarantine law is arguably unconstitutional because it allows detention without a hearing and counsel or due process, and this would appear to be a violation of the fourth, fifth, and sixth amendment of the Constitution. Although immigrants are noncitizens, the 14th amendment prohibits the states from denying persons in its jurisdiction due process. Recent court decisions have clarified that detainees have the right to counsel and a fair hearing. However, the CDC regulations call for short-term detention of several days without counsel or hearing. Many legal questions remain including how long and under what circumstances the government may enforce quarantine.

Social Issues

Quarantine can be stigmatizing for the persons detained. Because of 24 h news cycles and the relative rarity of quarantines, suspects may find themselves the center of intense media scrutiny, such as was the case with Andrew Speaker in 2007. Other persons, even friends and family, may see the person as "diseased" and want to avoid further contact with them even after cleared. If the quarantined victim is indeed responsible for spreading a contagious disease causing morbidity and mortality, the public may turn hostile toward the victim.

If the disease in question is associated with a particular race or ethnic group this can lead to stigmatization of that group. For instance, the SARS epidemic was largely associated with persons from

Southeast Asia. Outbreaks in California in the nineteenth century sometimes led to quarantine and detention of entire villages of Chinese immigrants.

Infected persons who are quarantined may be treated as if they were criminals by the persons responsible for detaining them. They may be subject to a detainment center that resembles a prison, and handling by guards with handcuffs and force. Because many outbreaks are a crisis, the government agencies responsible for controlling the disease may have to act quickly. Actions may be taken that in hindsight were overly abusive and put innocent persons at additional risk.

Enhancing public health may not be the sole reason or the driving factor behind quarantining immigrants. In the case of Ellis Island, medical inspections were instituted largely to appease certain groups such as "Nativists" who worried about "impure" immigrants ruining American culture, eugenicists, progressives, and moral crusaders. Tests for sexually transmitted diseases were largely ineffective, but placated moral crusaders. Tests of "feeble-mindedness" served no public health purpose, but yet resulted in the deportation of 75–100 would-be immigrants per month.

Ethical Issues

Ethical issues around quarantine generally revolve around the trade-off between individual civil rights and the public welfare. Quarantine, especially involuntary quarantine, involves a sacrifice of certain rights in that a person is held in detention. Persons who refused to be quarantined can be arrested and fined in many countries, despite the fact that they have done nothing criminal. This also potentially violates some international documents such as the UN treaty on human rights. Many people, when sick and dying, would prefer to spend their final days with family and friends, rather than detained in isolation.

On the other hand, individuals who refuse to be quarantined can place the health and well-being of others in danger. Typhoid Mary, an Irish-immigrant who arrived in America in the late nineteenth century, is known to have infected 53 people with typhoid fever, 3 of whom died. She spent the last 24 years of her life in isolation against her will, a clear violation of her civil rights. However, many people's lives may have been saved by her detention.

Conclusion

Quarantine and isolation are controversial acts that balance individual autonomy with the public's health and welfare. The social and ethical issues that arise out of quarantine are complex, and many of the legal questions surrounding quarantine have yet to be answered.

Related Topics

► Autonomy
► Bureau of Immigration and Customs Enforcement
► Communicable disease of public health significance
► Ellis Island
► Immigration and Naturalization Service
► Immigration processes and health in the U.S.: A brief history
► Inadmissibility on health grounds
► Infectious diseases
► International Health Regulations
► Medical examination (for immigration)
► Refugee health and screening

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Race

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Race is the division of people by physical characteristics and is best understood as a social construct rather than an innate genetic or biological difference. Thanks to the recent work of the human genome project, we now know that there is greater genetic variance within what have been considered to be races than there is between races. Accordingly, the labels "Caucasian," "Black," and "Asian" convey meaning based on irrelevant characteristics such as a particular physical trait or the perceived presence or absence of such qualities as industriousness, reliability, cleanliness, and similar characteristics rather than the scientific truths that these characteristics were once thought to represent.

Though race-based distinctions may not be valid scientifically, societal labels based on race continue to help us as individuals living in a society to understand one another through social networks resulting from our various categorizations. Nevertheless, these distinctions are based on morally irrelevant characteristics and, as a result, are inherently dangerous. The problem with imposing various social categorizations upon groups of individuals based on irrelevant characteristics is that these characteristics are neither inherent nor inheritable. Rather, individuals constantly transcend these categorizations by marrying an individual of another race, passing for another race, and, perhaps most importantly, by not possessing the morally irrelevant characteristics on which we base our distinctions in the first place. What happens as a result is that we as a society become mired in distinctions of the past that in many respects no longer matter or matter only in the sense of accurately historicizing an era and its current impact.

From the immigrant perspective, it is difficult to understand why society continues to organize itself by an outmoded structure which has the effect of marginalizing and causing individuals to feel as though their only path is to act in accord with irrelevant and predetermined ideals. In many places, depending on the country and region of the receiving society and whether the immigrant has the necessary means, the immigrant may have the power to decide whether he or she will conform to the receiving society's race-associated expectations or navigate society according to a different identity. In the many circumstances where fluidity is not an option, immigrants often combine and accord themselves by ethnic similarities. While in practice this may look like the same ordering that morally irrelevant race-based distinctions accomplish, ordering by lines of ethnicity is different insofar as it hinges primarily on self-valuation and identification with a particular group's relevant characteristics as defined by the group, such as common mores, language, and religion.

A large body of published research suggests that health disparities persist as related to immigrant status and ethnicity even after adjusting for age, gender, education level, income, severity of disease, and other variables. These disparities have even been documented in countries (such as Canada) that have universal health care systems. Essentially, international reports suggest that nothing, not even universal care without a mandated waiting period to access care, equalizes disparities between immigrants and nonimmigrants with respect to health care access.

For example, in the United States, the US Census Bureau estimates that some 46 million American citizens and foreign nationals do not have access to health care. Additionally, some 25 million Americans are underinsured or have disproportionately high medical

Sana Loue & Martha Sajatovic (eds.), *Encyclopedia of Immigrant Health*, DOI 10.1007/978-1-4419-5659-0,

expenses relative to their incomes. The worst situated group appears to be noncitizen Latinos. The Census Bureau estimates that approximately one-third of this population is uninsured and without formal access to healthcare. American citizens who identify as Latino, on the other hand, fare better for a variety of reasons, including increased acculturation to US culture, as reflected in better mastery of the English language. As a result, English-speaking noncitizens have insurance levels comparable to non-Hispanic White citizens of similar income and employment levels.

Latino individuals who speak English and are US citizens are uninsured at a slightly higher rate than non-Hispanic White citizens (33% versus 28%). Noncitizen Latino individuals who speak primarily Spanish and are US citizens, however, have significantly higher uninsured rates at 41%. The gaps in coverage increase even more significantly for non-US-citizen Latinos. Among noncitizen Latinos who speak English, about 55% are uninsured, while among noncitizen Spanish-dominant speakers, 72% are uninsured. These data suggest that the USA may not be entirely welcoming with respect to ethnicity.

The implications of ethnicity in the context of healthcare access are confounded by citizenship status. In the United States, although an individual's English language competency may not compromise access to healthcare, citizenship status directly affects one's ability to participate in government-assisted care, such as Medicaid and State Children's Health Insurance Program (SCHIP). With few exceptions, federal legislation prohibits benefits to immigrants until they have resided in the USA legally for a period of 5 years. Even after this 5-year period has expired, legal barriers to reliance on such programs may continue to persist. This lag time bears directly on immigrant health insofar as many immigrants forgo primary and preventive health services until they are eligible for government services. When used appropriately, primary and preventive health services help to defray the exorbitant healthcare costs associated with critical care problems and emergency medicine.

Lack of adequate care extends beyond the ways in which immigrants are denied access to health care and the kind of care they ultimately receive. Immigrants at disproportionate rates are not included and are not required to be included in clinical research. It is possible that language differences and differing attitudes toward human experiments lead both to a reduced willingness on the part of investigators to include immigrants as research participants and on the part of immigrants to volunteer for participation in research. The effects of immigrants' exclusion from research are observed in three primary ways.

First, failure to include immigrants in research overlooks the ways in which culture impacts or could impact an individual's reaction to drug and/or psychological therapy. Second, the US government's mandate to include minorities in research does not ensure sufficiently large numbers of minorities in studies to permit subgroup analyses. Third, government guidelines perpetuate antiquated race-based distinctions. Because the guidelines cover minority, but not immigrant populations, the government implicitly accepts race as a force in the USA while failing to consider that immigrants can and do self-identify in ways other than race. Further, the guidelines do not require researchers to contemplate immigrants or the study's implications for immigrants. Accordingly, it appears that immigrants are largely deprived of both the benefits and burdens of clinical research.

Related Topics

- ► Access to care
- ► Ethnic minority group
- ► Health care utilization
- ► Health services research
- ► Health services utilization
- ► Health status
- ► Racism
- ► Xenophobia

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Racial Disparities

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Racial disparities are the unfair, unjust, unequal, or unnecessary care or treatment of a group of people predicated on their race. To accurately define the term racial disparities, it is important to give a brief definition to each word. The term "*racial*" refers to a genetically distinguished group of people or to a characteristic of race or races. Race is a social construct, meaning, rather than being a biological construct; the definition is constructed and imposed collectively by a society. Race, refers to a social group – often that shares a cultural heritage and ancestry. Hence the historical definition of race is a distinct type or species, sharing manifest characteristics such as structure, temperament, and mental abilities. Race is considered a social classification that can influence health by reason of exposure to social factors including: socioeconomic position, lifestyle habits, and the use of health care.

An insidious social problem in the USA since the founding of the country, "*racism*" is the belief that members of one or more races are inferior to members of other races. Historically in the USA, the non-Hispanic White majority has singled out racial groups for differential and unequal treatment in the areas of housing, employment, education, and criminal justice. Racism can manifest institutionally, individually, and internally. Institutional racism transpires when statutes or laws, classifications, and practices have an unequal impact across racial groups. Individual racism arises as prejudicial beliefs and discriminatory behaviors are applied to individuals of a particular racial group. Internal racism occurs when persons from the same racial group adopt the beliefs, attitudes, and perspectives about their own race that other races believe.

A "*disparity*" implies an inequity or an injustice rather than simple inequality. In the context of health care, the Institute of Medicine refers to *disparities* predicated on race or ethnicity – not explainable by access-related factors, clinical needs, preferences, or appropriateness of interventions. The World Health Organization (WHO) describes disparities as differences in health that are avoidable unjust. Notably, the term "disparities" is used frequently in the United States; however, in many European countries the term is replaced with "inequities," placing greater emphasis on morality and fairness.

It is well documented worldwide that people of color suffer disproportionally across and within countries. Persons are treated differently for appearing distinctive from the majority, for example, possessing a dissimilar skin color, more pronounced features, etc. Frequently these individuals may not be offered the opportunity to receive an education, are not afforded the same opportunities, have a lower earning potential, may live in poorer areas and housing, have fewer resources, and may suffer more than their counterparts who are considered typical.

Racial disparities are the variances between groups after factors to which the difference could be attributed have been controlled for. For example, despite similarities between two people, such as educational background, location of residence, access to health care, salary, etc., one individual is treated differently due to racial group status. It is important to understand how this phenomenon manifests in day-to-day life and its implications for immigrants of color. Racial disparities can be found in a variety of systems, including: health care, social, economic, educational, environmental, and criminal justice – many overlapping in their presentation.

In the context of health care, "disparities" is the unequal treatment of patients, or a difference in health status between social groups (e.g., socioeconomic, racial, ethnic, and gender) that is unnecessary, avoidable, unfair, and unjust. Furthermore, this includes discrepancies in access to screening, treatment options, or the availability of culturally or linguistically knowledgeable and sensitive health personnel. A health disparity should be viewed as a chain of events signified by a difference in the following: (a) environment; (b) access to, utilization of, and quality of care; (c) health status; or (d) a particular health outcome that deserves scrutiny.

Connected to issues of social advantage, disparities are differences in health processes or outcomes between population groups, for instance, the average life span for certain racial groups, or that the incidence of diabetes and hypertension are more prevalent in Blacks and Latinos than in non-Hispanic Whites even when many characteristics are similar across groups – age, education, health insurance coverage. Racial health disparities are considered in terms of the social determinants of health.

Social determinants of health – the social conditions in which people live and work – must be examined to address racial health disparities. These conditions are influenced by income, education, employment, social and physical environment, and housing. The physical environment includes traditional environmental exposures and aspects of the environment constructed by humans, including land use, transportation, street design, features of urban design, public spaces, and access to health resources.

The social environment consists of the degree and nature of social connections between neighbors, the presence of social norms, levels of safety and violence, and various features of the social organization of places. Physical and social features of neighborhoods may affect health through constraints on, or enhancements of, health-related behaviors, or through mechanisms involving the experience of stress and the buffering effects of social support and social connections. Those with poor education may have decreased opportunities for employment, may be employed with a low income, may have poor or no health coverage, and may have less adequate housing. Socioeconomic deprivation is a key mechanism through which other bases of social disadvantage, particularly those linked to race and ethnicity, result in poorer health status.

Racial residential segregation is a fundamental cause of racial disparities in health. The physical separation of the races by enforced residence in certain areas is an institutional mechanism of racism that was designed to protect Whites from social interaction with Blacks. Long history exists in the United States of segregated or separation of housing based on race. Historically, persons of color, or the racial minority, generally resided in the urban areas of most cities in the USA. Living in a poor, deprived, or socioeconomically disadvantaged neighborhood is associated with poor health outcomes including greater mortality, poorer self-reported health, adverse mental health outcomes, greater prevalence of chronic disease risk factors, greater incidence of diseases, and adverse child health outcomes.

Over time, residential segregation has led to highly segregated elementary and high schools and is a fundamental cause of racial differences in the quality of education. In large part, community resources determine the quality of neighborhood schools. Access to quality education and adequate community resources will enhance the likelihood of high school graduates and increase the probability of enrollment in college.

Disparity in criminal justice refers to inequity of arrests and sentencing for certain groups of people; it nearly always refers to racial and ethnic disparity. Unequal treatment of people of color has been well established at each stage of the criminal justice continuum, from profiling to sentencing.

Racial disparity has been verified, though it may not always be related to intentional discrimination. Legitimate legal factors involved in racial disparity include severity of the offense and previous criminal record. One type of racial disparity occurs when there is a marked difference in the percentage of a racial group represented in the general population and the percentage of the same group represented in the criminal justice process. For example, African-Americans make up 12% of the US population but account for approximately: 40% of all arrests, 50% of the prison population, and 50% of the inmates on death row.

Another example of racial disparity in the criminal justice system appears when, as compared to other races, there are a significantly larger percentage of members of a racial group involved in any part of the criminal justice system. For instance, greater than 9% of African-American adult males are in jail, prison, on probation, or on parole, compared with not quite 2% of non-Hispanic White adult males. To cite another example, Blacks are four times as likely as Whites to be arrested on drug charges – even though the two groups use drugs at almost the same rate.

Related Topics

- ► Community-based participatory research
- ► Health disparities

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Suggested Resources

For information on racism. http://en.wikipedia.org/wiki/Racism

For information on disparity in criminal justice. http://www.ehow.com/facts_4855867_definition-disparity-criminal-justice.html

Racism

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Racism is the belief that all members of each race possess characteristics or abilities specific to that race, especially so as to distinguish it as inferior or superior to another race or races (Oxford English Dictionary). This definition applies in four primary contexts, namely, individual, institutional, internalized, and horizontal or cultural racism. Individual racism is the belief and attitude set as well as an individual's actions that support or perpetuate racism. Institutional racism is a term coined by Stokely Carmichael and is best described as the collective failure of an organization to provide appropriate and professional services to people because of their color, culture, or ethnicity. This concept covers government, universities, and private business, and is perhaps the bleakest kind of discrimination due to the numbers of individuals who are affected by institutional policies and mores. Internalized racism happens when an individual knows that stereotyping or certain racial constructs are inaccurate, but because cultural conditioning, family objections, and media accounts that portray individuals of color in accord with stereotypes and inaccurate constructs, the individual who remotely empathizes with derogatory cultural concepts is said to abide by a racist code. The last kind of racism, horizontal or cultural racism, happens when individuals of one minority group act to discriminate against or oppress other minorities. Horizontal racism can occur between members of the same minority group or between members of different minority groups.

Racism is a prominent form of social exclusion. Consequently, each of the four kinds of racism factors into the immigrant experience. Because the 2007 WHO Commission on the Social Determinants of Health ("SDOH") explicitly recognized racism as a contributor to socioeconomic position, racism is seen as a key structural determinant of health. Thus, if the goal is to improve the immigrant experience and poor immigrant health associated with the experience, we must discern which forces work against immigrant populations within each kind of racism and the socioeconomics of those forces.

Before we discuss the kinds of racism presently inculcating the immigration experience, we must first consider whether any racial barriers to immigrating exist. Based on the fact that the USA gives preference to employment-based immigration, we know that the majority of preferred individuals are either fluent in English, have some English training, or the means to employ a tutor and be educated. While English is arguably the most widely spoken language in the world, the body of speakers is still primarily Western, or at least Westernized. Thus, while it is open for debate, the USA's preference for immigrants based on employment is a racial preference that likely favors non-Hipanic White individuals. The counterargument to race-based immigration policy is that the USA prefers immigrants based on employment status as a means to promote economic progress. The economic argument, however, loses credibility, given the overwhelming number of immigrants who successfully enter the USA each year and who contribute substantially to the economic well-being of the country.

At the individual level, hospital staff, nurses, and doctors bear directly on an immigrant's patient care. The most obvious ways for medical personnel to demonstrate racist attitudes toward an immigrant involve overt language, a lesser quality of care, and outright refusals to treat the individual. It has been suggested that racialized group members are less likely to be admitted to the hospital compared to their non-racialized counterparts, although they are more likely to use a general practitioner and equally as likely to see a specialist. Individual racism also encompasses immigrant perceptions of racism. The concept of perceived racism is based on one's notion that he or she was treated unfairly or inequitably, was uncomfortable around or not accepted by others, or was not treated with the respect and dignity generally accorded in the individual's culture. Many immigrants cite disrespect of historical or cultural backgrounds, and beliefs in alternative health systems as additional race-based problems surrounding provider care. Consequently, these potential problems likely contribute to recent racial immigrants' increased risk of declining physical and mental health over a period of time.

At the institutional level, immigrants without citizenship status experience racism that helps deter racialized immigrants from accessing and receiving quality health care. Government, hospital systems, insurance companies, and universities all contribute to racism perpetuated against immigrants. In the USA, the government compromises multicultural aims with Federal law requirements which prohibit immigrants from participating in Medicare and State Children's Health Insurance Program (SCHIP) until they have lived in the USA for at least 5 years legally. This lag time forces many immigrants to forgo primary and preventive health services until they are eligible for government services, and fails to touch on the millions without legal status who will never have access to what few Federal health provisions exist. A damaging consequence of immigrants forgoing preventive health services is that, often, they arrive at emergency care facilities in critical condition.

While every emergency department in the USA has an obligation to accept individuals pursuant to the Emergency Medical Treatment and Active Labor Act ("EMTALA"), private hospitals, at a disproportionate rate, camouflage their emergency services. This camouflage results in high numbers of poor and underinsured individuals being taken to public and disproportionate share hospitals. The risk involved with emergency services defaulting to public and disproportionate share hospitals is that many ambulance services will automatically bring individuals they perceive to be low income to these hospitals based strictly on "a gut reaction" that poorer individuals tend to utilize public and county systems at a greater rate than the affluent. Where individuals are perceived to be poorer based on race or ethnic status, and where individuals who are perceived to be affluent are given a choice of emergency medical services, immigrants are discriminated against. While the decision to take immigrants to a county hospital over the area's private hospital may not ultimately affect their quality of care, a race-based decision, has, nonetheless been made. Similarly, immigrants and racialized groups may have a difficult time accessing preventive care; immigrants typically are less likely to use preventive cancer screening services and mental health services. The inability to access health services, particularly those that maintain health and prevent disease, increases long-term health risks and is associated with negative health outcomes over time.

Internalized racism manifests itself in the experience immigrants detail over time. Recent studies suggest that racialized immigrants' perceptions and experiences of discrimination increase over time due to increased exposure to discrimination and greater recognition of discriminatory behavior over time. Unfortunately, the Gulf War and recent warfare in Iraq, Afghanistan, and Iran have reignited previously outmoded Middle Eastern stereotypes. Consequently, many Middle Easterners, citizens and immigrants presently attest to the fact that they feel unwelcome and have difficulty finding employment.

Horizontal racism is essentially the reverse of the minority alliances we saw from, in the USA, the late 1950s and through the mid-1960s. This era gained civil rights for African Americans as a result of cooperation from Black America, the women's movement, and also gay and lesbian groups. Today, race wars, prison gang wars, and cultural imperialism fragment minority groups. This fragmentation contributes to the negative reflections of self.

The four kinds of racism discussed each contribute to multiple and intersecting pathways that negatively impact an individual's health status. The idea is that racism exposes an individual to an increased amount of stress, generally sustained over time. Thus, individuals discriminated against undergo prolonged stimulation of the human body's physiological stress response. As a result, racialized immigrants experience negative physical consequences such as breakdown in immune responses and negative emotional responses such as anxiety, depression, and lowered self-esteem/identity at markedly high rights. To cope with these negative responses, racialized immigrants often forgo health care and turn to dangerous coping mechanisms such as substance abuse and self-harm.

While the USA has made several attempts to safeguard against, or rather, make amends for past racism, the primary mode of reparations largely involves affirmative action. Where present racism is perpetuated against immigrants in the form of health and health-related services, the government and health-providing institutions need to rethink their strategy and the ways in which the system continues to perpetuate subordination of various races.

Related Topics

- ► Discrimination
- ► Health care
- ► Race
- ► Self-concept
- ► Stress

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Radicalization

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Radicalization, especially violent radicalization, is the process of converting an individual of normal beliefs into an individual who believes and follows an extreme ideology and feels justified in taking extreme actions, such as breaking the law, committing acts of violence or assisting in such acts, in order to obtain a goal related to their beliefs. When the term radicalization is used in the current global environment, it is usually used in the context of extreme religious beliefs (e.g., "Islamic fundamentalists/radicals"); however, an individual can also develop radical nonreligious political beliefs, as occurs in protests to G7 Economic Summits or occurred in the famous case of Patty Hearst, who was abducted by the Symbionese Liberation Army (a radical political group) and "brainwashed" into adopting their radical political beliefs and terrorist (bank robbery) tactics.

Radicalization can occur through many different pathways. As in the Patty Hearst case, an individual can be kidnapped, terrorized, brainwashed, or be radicalized by rage. For example, Patty Hearst at one point was angry against authorities because she perceived them as trying to kill her verse trying to free her. Rage against and perceived mistreatment by authority can also lead to radicalization or identification with groups who present themselves as anti-establishment and anti-repression as is the case with anarchy groups such as Black September, the Baader Meinhof Gang or The Red Brigade. Radicalization can come from the need to belong to a group for safety, as occurs in prisons, where individuals will join gangs such as The Aryan Nation, Black Brotherhood, or the Crips or Bloods. Immigrants may join ethnic gangs like MS13 for similar reasons. Prisons serve as fertile breeding grounds for radical religious recruitment because many prisoners turn toward groups and shared religion for solace in prison; harbor negative societal views; are vulnerable, confused, and frightened when first incarcerated; and are housed with ethnically and culturally similar individuals who proselytize their religious ideas to maintain their own social position in the prison. Malcolm X provides a good example of this type of jailhouse conversion and potential radicalization in his autobiography, where he describes how and why he converted to Islam while incarcerated.

Radicalization often occurs over a period of time, through social contacts, where individuals meet others at religious meeting places, charitable groups, neighborhood community centers, book stores, and rallies and slowly become indoctrinated in radical theologies and ideologies that they incorporate into their existing belief systems. They are "absorbed" and "inculcated" into those "reputable" groups or subgroups, which harbor hidden radical beliefs and "plans for action." Radicalization can also occur when individuals join cults. Here, individuals lose their identity and belief system and replace them with the cult leader's mission and direction. They are promised answers, safety, identity, and purpose if they just believe the right things and follow the often-charismatic leader. Deviation from the cult's purpose results in punishment or expulsion (i.e., Jim Jones in Guyana, David Koresh at Waco Texas).

The birth of the Internet opened a new pathway for mass radicalization. Individuals can now be exposed to radical Internet material. The radical ideas of a few can now be seen as acceptable and coming from a community of many. Individuals begin to radicalize themselves without direct human contact with any radical individual or group. This method of Internet self-radicalization usually occurs among individuals or a small group of friends, with each encouraging the other to believe the group, increase fervor, and eventually defining one member to lead their crusade.

However radicalization occurs, it is important to remember that an individual's susceptibility to radicalization may be increased following some dramatic national, international, or personal event; international strife; wars; police actions, reported mistreatment, or torture; bombing; terrorist attacks; national/local police abuse; or personal tragedy where the system is blamed. All mobilize zeal and cause a change in radicalized thought, new interest in religion and politics, and the need to recruit new members and act.

Immigrants are often the targets of radical groups who see them as needy, uncertain, and vulnerable. They are perceived as potential members who will join ethnic movements. Immigrants are sought because they often have a weaker support network in their new country, may potentially be disenchanted by prejudice or poverty in their new nation, and are, therefore, more likely to feel like second-class citizens. They are often isolated by language, culture, education, and assimilation into their new homeland. They need to belong. In general, the two classes of immigrants most likely to join a radical group are isolated first-generation immigrants or second- or third-generation "immigrants," who have failed to successfully assimilate.

The two other groups prone to radicalization, but harder to identify, are new and zealous religious converts from any group (e.g., Jihad Jane – American suburban resident who turned terrorist) and immigrants of any generation who have successfully assimilated but who repudiate their role in society, seeing instead a need to avenge the ill treatment of all their brethren through a radicalized reawakening of beliefs in their heritage or faith (e.g., Umar Farouk Abdulmutallab, aka the underwear bomber who came from a position of privilege). Immigrants are easily targeted through their social institutions, which they attend to obtain support in the new country. They gather at houses of worship, ethnic college and work clubs, political organizations based on religion or country of origin, charities, neighborhood meeting places, ethnic restaurants, and sporting events and facilities. Here, the disillusioned or religiously radical are recruited and trained.

Radicalized immigrants are important assets for radical groups. Once an immigrant has been radicalized, they may assist in recruiting additional members in the immigrant community. They provide important resources such as money, safe houses, and materials used to carry out the radical group's "mission." Legal immigrants have the same constitutional (government) rights as natural-born citizens in most countries. Thus, they provide an international radical group with additional agents and protectors who have constitutional protection from local authorities if apprehended. Naturalized immigrants also travel on the passport of their new country, which may help reduce suspicion, and make it easier for them to travel from country to country while engaging in "radical business." The radicalization of immigrants causes fear in the host country's population, induces xenophobia and other concerns about immigrants in general, and thus creates tension between the immigrant and native-born community, which further alienates immigrants and makes recruitment and radicalization of new recruits easier.

Traditionally, nations seek safety through government control when acts of terror occur. Thus, civil liberties are often reduced when governments become engaged in reactive policies to acts of terrorism brought about by radical groups. Recently, more nations are placing emphasis on preventing their citizens and new immigrants from becoming radicalized in the first place, as part of their counterterrorism strategies. In general, there are two broad approaches for preventing the radicalization of immigrants. The first is the promotion of multiculturism in the host country. This strategy attempts to allow immigrants to maintain their culture of origin while still feeling included in the larger umbrella of national identification within the host nation. Immigrants are made to feel valued, needed, and secure. In order for the multicultural approach to work, all groups need at least some shared common beliefs, such as respect for the system of justice, respect and acceptance of other cultures and customs, and maintaining and following the democratic rule of law. Often radical organizations, such as radical fundamentalist Islamic groups cannot be placated by a multicultural view of belonging due to their strong belief that Sharia law must be applied to all and that infidels who do not embrace their culture must be defeated. Jihad prevents inclusion! The multicultural assumption is that if society encourages and promotes a strong moderate community, that community will feel safe and included, reject extremist views, police itself, and work with the national authorities to identify radicals who do not subscribe to democratic rule of law.

The other government option is to place an emphasis on the assimilation of immigrants into the existing host nation's dominant culture, which prevents these immigrants from feeling outside society, rejected, or like second-class citizens. They give up their past and become "new" and like other members of their new country. This approach may help prevent already established immigrants from becoming radicalized, but is unlikely to soften the anger or isolation felt by individuals who have already become radicalized over what they perceive to be social prejudice. For this process to work, the accepting nation needs to have relatively secure borders, a low rate of immigration, funds to support active assimilation programs, some tolerance of other cultures, and a stable economy, which can absorb, benefit from and provide jobs to immigrants of all skill levels.

A third approach toward radicalization has been utilized by Great Britain. The British tried to prevent radicalization using a multicultural approach integrated with the acquisition of a strong national identity embracing democratic rule. The country also, however, actively observed, monitored, and infiltrated radical groups using counterespionage techniques and operations, took active measures to shut down terrorist cells and organizations before they caused death and destruction. This approach was born out of the many years of dealing with the terrorist threats posed by the IRA in both Northern Ireland and the home isles. This level of governmental observation of radical groups was highlighted in the aftermath of the December 25, 2009 "underpants bomber," when the British government announced it was monitoring ten universities that it felt to be potential recruiting grounds for radicalization. It is widely believed that the "underpants bomber" was radicalized while attending one of those universities, where he was the president of an Islamic student group. Therefore, the government actively monitored these institutions in order to learn who else had become radical, who their associates were, and to find any actionable information that could be useful to prevent radicals from engaging in further terroristic activities.

Related Topics

- ▶ Assimilation
- ▶ Cultural background
- ▶ Department of Homeland Security
- ▶ Gangs
- ▶ Stockholm syndrome
- ▶ Terrorism

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Rape

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Although rape is defined differently across various legal jurisdictions, it is generally conceived of as any forced or coerced genital contact or sexual penetration. This would include not only vaginal contact or penetration, but also anal and oral contact or penetration. Penetration can be effectuated with a genital organ (penis), another body part such as a hand, or an object.

Although rape can be committed against males and females, it is often used as a form of gender-based violence. Amnesty International has delineated three categories of gender-based violence: family violence, that is committed against a woman or girl by a family member, including marital rape; community violence, including rape committed in the context of prostitution or trafficking and rape committed by a stranger; and state violence, which includes rape that is committed or condoned by someone working for the government, such as a police officer, prison guard, soldier, or border official.

Rape has been and continues to be used as a weapon of warfare and genocide. As an example, women in Darfur who were members of the Fur, Masalit, and Zaghawa ethnic groups were systematically raped by members of Sudan's armed forces and security agents and tribal militia in an effort to dilute the blood of these ethnic groups and cause their extinction. The children borne from these rapes were often ostracized from their communities or, even worse, killed or abandoned to die.

Immigrants may become the scapegoats in their host country for groups that do not look favorably on individuals who appear different in any way. Immigrant men may be denounced in the media as the purveyors of rape. Women who attempt to cross national borders illegally may become the targets of vigilante groups, some of whose members may use rape as a tactic to "punish" them for crossing the border illegally. Men, women, and children who are trafficked illegally may be subject to rape by their traffickers, as a way of controlling them.

Immigrant women may be at particularly high risk of rape in some circumstances. In some countries, such as the USA, a citizen or permanent resident can petition for permanent residence for his wife to gain legal status in the country. Unless the law provides a mechanism for the woman to self-petition for legal status, she must depend on her marital partner to gain legal status. Consequently, even if her husband is abusive, she may feel that she has no choice but to tolerate the abuse, including rape, if she is to gain legal status. The US government recognized the injustice inherent in this situation and changed its immigration laws to allow battered women who are the wives of US citizens to self-petition for legal status under specified circumstances.

Immigrants whose primary language differs from that of their new host country or who are illegally present in their host country may face barriers in seeking medical treatment following a rape and/or in reporting a rape to law enforcement agencies. Women may have difficulties communicating to health care providers if they do not speak the language of the host country. Depending upon the norms of their culture or their religious beliefs, they may be reluctant to undergo a physical examination or to discuss a situation that is so highly personal and traumatic. Individuals who are undocumented may be afraid that the health care provider or law enforcement official will report them to immigration authorities and they will be deported, a situation that would further traumatize the rape victim.

Research suggests that the attitudes of individuals who migrate to more industrialized or Westernized countries from those that are less Westernized change over time. For example, one study conducted in Canada by Kennedy and colleagues found that the longer Asian immigrants had resided in that country, the less likely they were to tolerate myths about rape, for example, that women have an unconscious wish to be raped, and behavior that could be considered sexual harassment.

Related Topics

- ► Asylum
- ► Domestic violence
- ► Gender-based violence
- ► Genocide
- ► Torture
- ► Trafficking
- ► Violence

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Red Crescent

- ► Non-governmental organization
- ► Red Cross

Red Cross

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The International Red Cross and Red Crescent Movement is an international humanitarian movement which started to protect human life and health, to ensure respect for the human being, and to prevent and alleviate human suffering, without any discrimination based on nationality, race, sex, religious beliefs, class, or political opinions. The often-heard term *International Red Cross* is actually a misnomer, as no official organization as such exists bearing that name. In reality, the movement consists of several distinct organizations that are legally independent from each other, but are united within the Movement through common basic principles, objectives, symbols, statutes, and governing organs.

The International Committee of the Red Cross has a permanent mandate under international law to take impartial action for prisoners, the wounded and sick, and civilians affected by conflict. The International Committee of the Red Cross is headquartered in Geneva, Switzerland. The International Committee of the Red Cross is based in 80 countries and has a total of more than 12,000 staff. In situations of conflict the International Committee of the Red Cross coordinates the response by national Red Cross and Red Crescent societies and their International Federation. The International Committee of the Red Cross is at the origin of both the International Red Cross/Red Crescent Movement and of international humanitarian law, notably the Geneva Conventions.

The International Committee of the Red Cross' legal mandate is derived from two sources: (1) the 1949 Geneva Conventions, which task the International Committee of the Red Cross with visiting prisoners, organizing relief operations, reuniting separated families, and similar humanitarian activities during armed conflicts; and (2) the Statutes of the International Red Cross and Red Crescent Movement, which encourage the International Committee of the Red Cross to undertake similar work in situations of internal violence, where the Geneva Conventions do not apply. The Geneva Conventions are binding instruments of international law, applicable worldwide. The Statutes of the International Red Cross and Red Crescent Movement are adopted at the International Conference of the Red Cross and Red Crescent, which takes place every 4 years, and at which States that are party to the Geneva Conventions take part, thereby conferring a quasi-legal or “soft law” status on the Statutes.

The International Committee of the Red Cross has more than 1,400 people, both specialized staff and delegates, currently on field missions across the globe. This work is backed up by 11,000 local employees and supported and coordinated by 800 staff at the International Committee of the Red Cross' Geneva headquarters.

Related Topics

- ► Community health workers
- ► Global health
- ► Health care
- ► Human rights
- ► Nurse/Nurse practitioner

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Refugee

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According to the 1951 Refugee Convention, a refugee is someone who “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 his nationality, and is unable to, or owing to such fear, is unwilling to avail himself of the protection of that country.” The Convention also defines a refugee’s obligations to host governments and certain categories of persons, such as war criminals, who do not qualify for refugee status.

Even if half a century has passed since its adoption, the 1951 Convention is the most important document that articulates the international system for protecting refugees. While the Convention offers the legal definition of a refugee, history has shown that there is a need for more legislation to address current refugee issues.

Although the definition of “refugee” seems quite straightforward, establishing who is a refugee is a rather complicated issue. According to United Nation High Commissioner for Refugees (UNHCR), over 200 million people are living outside their homeland and only a small fraction of them would qualify under the standards imposed by the 1951 Convention relating to the Status of Refugees as a “refugee.” Established in 1951, UNHCR is the international agency in charge of offering assistance to refugees worldwide, at the request of a government or the United Nations. The agency offers protection and support to many other categories of people in need, such as asylum seekers, stateless persons, refugees who have returned to their homeland and need help to rebuild their lives, and internally displaced peoples (IDPs).

An “asylum seeker” is an individual who seeks international protection and whose refugee status has not been determined yet. Once refugee status is granted, a person usually enjoys specific protections. In the United States, refugees are eligible for a variety of Federal assistance programs that entitle them to medical assistance, cash assistance, and social service programs. Most of the EU Member States have a similar policy.

The term “asylee” is used in the United States to describe a person seeking “asylum.” This status is granted by the US Citizenship and Immigration Services to an alien residing in the United States as a result of persecution or a well-founded fear of persecution in the individual’s country because of race, religion, ethnic group, social group, or political opinion. This status is similar to refugee status. The difference is that refugees are granted their status abroad, while individuals seeking asylum apply after they enter the United States.

“Internally displaced persons” (IDPs) are individuals in a situation similar to that of refugees. IDPs are defined in the 1998 Guiding Principles on Internal Displacement as “persons and groups of persons who have been forced or obliged to flee or to leave their homes or places of habitual residence, in particular as a result of or in order to avoid the effects of armed conflict, situations of generalized violence, violations of human rights or natural or human-made disasters, and who have not crossed an internationally recognized state border.” Yet, even if IDPs have a similar situation as that of refugees, they are not subject of a universally adopted treaty and therefore are not offered similar protections and do not qualify for the same benefits as refugees.

According to international refugee law, all States have an obligation to protect all refugees that arrive on their territories and seek asylum. International refugee law is a set of rules that seeks to offer protection first, to all persons that seek asylum from persecution and second, to those recognized as refugees under the relevant instruments. The sources of refugee law are treaty law such as the 1951 Refugee Convention and the 1967 subsequent Protocol, and customary international law that applies to all States regardless of whether they have ratified these treaties or not. Several regional instruments offer further protection for refugees, notably the 1969 Organization of African Unity Convention (for African States) and the 1984 Cartagena Declaration (for Latin America). Under Article 33 of the 1951 Refugee Convention, all party States have a duty not to expel or return a refugee to their country or territory where he/she would be at risk of persecution or where his/her life or freedom would be threatened. This principle, which is known as “non-refoulement,” is considered a part of customary international law and therefore binding to all States. The principle is incorporated in other international human rights treaties, such as the 1984 Convention Against Torture, which prohibits the forcible removal of persons to a country where there is a real risk of torture.

Yet, it is the States that determine whether an individual or groups of individuals entering its territories are refugees, legal migrants, or illegal aliens. Since the procedures for determination of refugee status are not indicated in the 1951 Refugee Convention or in the 1967 Protocol, it is left to each State to establish the procedures that it considers most appropriate, taking into account its particular constitutional and administrative structure. For this reason, such procedures vary considerably: in some countries, refugee status is determined under a formal procedure specifically established for this purpose; in others, determining refugee status is considered within informal arrangements or on an ad hoc basis for specific purposes, such as the issuance of travel documents. Therefore, one country may recognize the refugee status of a group of asylum seekers while another would view the same group as illegal migrants, and treat them as illegal aliens.

Currently, there is a considerable movement of people from one country to another, many seeking better employment or educational opportunities and others trying to reunite with family members; only a small number are fleeing persecution, conflict, or violence in their home country. Faced with an increasing afflux of immigrants, officials across the world have a difficult challenge in discerning the status of this mobile population. Even if individuals who meet the legal definitions of refugees and asylum seekers account for only a small proportion of the global movement of people, they frequently travel alongside illegal migrants who may use similar stories in order to obtain legal status and additional benefits in a new country. Since these large movements of people are irregular, and because most travel without the requisite documentation or use unauthorized border crossing points (which may involve smugglers), many States perceive such movements as a threat to their sovereignty and security. Therefore, in spite of existing international regulations for the protection of refugees, there is no guarantee that an asylum seeker will be granted refugee status even if their claim is legitimate; in fact, many end up being deported to their native country.

Health Status

Most countries have compulsory medical exams for asylum seekers on their arrival, especially for contagious diseases. For example, people suffering from communicable diseases of public health significance, serious physical or mental disorders, or drug addiction are denied entrance to the United States. There are many studies that demonstrate that refugees and asylum seekers are prone to health problems, which are due to complex and wide-ranging causes. Asylum seekers are not a homogeneous population as they come from different countries and cultures. Yet, there are some common premigration factors, such as life experiences that have an impact on health and nutritional state, and traumatic experiences such as torture and acts of violence. In the host country, refugees may suffer from the effects of poverty, dependence, and lack of social support, which affect physical and mental health. Moreover, due to racial discrimination, they may face numerous obstacles in accessing health care services.

Refugees living in refugee camps may experience deterioration in their health because of a lack of resources to fulfill simple human needs, such as access to clean water, food, shelter, or medical services and drugs. They are particularly susceptible to illness since diseases can spread quickly throughout an entire camp population as a result of precarious living conditions. Most common are diarrheal diseases, cholera, measles, meningitis, tuberculosis, and malaria. Asylum seekers and refugees living outside refugee camps often encounter hardships in accessing medical systems due to language barriers, cultural differences, institutional obstacles, lack of material resources, and limited knowledge on how the medical system works. Another contributor to poor health status is the trauma resulting from the horrifying experiences they have been through during their flight to freedom, navigating through difficult and unfriendly asylum procedures, or simply from culture shock. There are many studies documenting various mental health problems due to the specific traumas encountered during and after their flight into asylum and eventual resettlement. In addition, factors such as separation from family, life events after exile, employment status, level of education, gender, and marital status may have a significant influence on a refugee's psychological status.

From a public health point of view, it is worth considering that refugees bring varied epidemiological profiles as they come from different environments and exposures to diseases in their countries of origin, and may fall ill as a result of their emigration experiences. As cultural beliefs and representation of illness and health may be different from those of the host country, cultural competency in health services is needed to meet the special physical and mental health needs of refugees.

Related Topics

- ▶ Communicable disease of public health significance
- ▶ Human rights
- ▶ Refugee camp
- ▶ Refugee health and screening
- ▶ Refugee resettlement
- ▶ Refugee status
- ▶ Trauma
- ▶ United Nations High Commissioner for Refugees

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▶ Refugee

Refugee Camp

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A refugee camp is a temporary shelter built to house people who have fled their homes due to conflict or natural disaster. Refugee camps are run by governments, the United Nations, international organizations, or nongovernmental organizations (NGOs). Most people who live in the camps are refugees who have fled their home country but can also be Internally Displaced Persons (IDPs); refugees and IDPs are civilians displaced by persecution, war, or violence. Approximately 67 million people have been forced to leave their homes due to conflict or natural disaster: 16 million are refugees and 51 million are IDPs.

When people flee their homes, they are usually forced to leave behind their belongings. The government or humanitarian agency running the refugee camp provides refugees with clean water, food, and basic health care, but depending on the location of the camp and the political climate of the country in which the camp is located, it may take weeks for the camp inhabitants to receive any assistance. Security for a refugee camp is usually the responsibility of the host country and is provided by the military or local police. The number of people living in the camp depends on the crisis from which they have fled. Camps are usually established on the outskirts of towns or cities, away from the border, in a secure area. Some countries mandate that camps be enclosed with barbed wire fence so the refugees do not interact with the local people.

There is a reception center where newly arrived refugees check in and are counted. This is important in order for aid agencies to keep track of the number of people in the camp, assess their needs, and provide enough food, water, and medical supplies. When a new refugee is registered, he/she is given relief items such as clothing, blankets, and cooking utensils.

Food is kept in a storage warehouse and is distributed to the women in the camp on a set schedule. Food is given to women since they are responsible for the cooking and will ensure everyone is fed. Rations that adhere to cultural diets are provided. The minimum recommended daily ration is 2,100 calories per adult. Breastfeeding mothers may receive additional food. Examples of the types of food distributed include rice, wheat, or maize; beans, lentils, or peas; vegetable oil or butter; a fortified blended food such as corn soya blend; sugar; and salt. The minimum amount of water each person in the camp should receive is one gallon per day in an emergency situation. The amount should increase to 6 gallons per day so people have enough water for cooking, personal hygiene, and washing clothes and dishes.

Though the camps are meant to be temporary solutions, giving people a place to live until they can return home, refugees and Internally Displaced Persons can live in camps for years while they await resettlement in other countries or, for IDPs, conflict to be resolved in their home countries. In some cases, camps have existed for decades and turn into permanent settlements or become part of the local community where the camp is located.

Related Topics

- ► Refugee
- ► Refugee health and screening
- ► Refugee resettlement
- ► Refugee status

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Refugee Health and Screening

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According to the United Nations High Commissioner for Refugees (UNHCR), there are currently 15.2 million refugees worldwide. Most refugees and displaced persons reside in urban areas or camps in the Global South. The health of refugees is a complex topic with important implications for policy and practice on a global scale. The complex humanitarian emergencies often associated with refugee flows pose significant challenges to the health of displaced peoples. In addition to morbidity and mortality directly resulting from war or other violence, disruption in infrastructure associated with humanitarian emergencies pose great challenges for public health and medical care. The process of migration from conflict or disaster can be associated with further injury and illness. Following migration, encamped refugees and those in urban settings of asylum experience a variety of health concerns as do the much smaller number of refugees who are resettled to places such as Europe, North America, or Australia.

Forced migration often occurs at times of massive social upheaval, such as war or disasters, which can include disruptions to water, food supply, shelter, and health care, all of which have implications for health. Precipitating factors and the often-stressful migration process, combined with factors in the place of asylum, influence refugees' health and well-being. Refugees and other forced migrants suffer from a wide range of health problems including chest, back, and stomach pain; psychological disorders; heart disease; hypertension; tuberculosis; diabetes; and nutritional problems, among others. Before the 1980s, refugee health and humanitarian aid were primarily understood in terms of necessities such as food, water, and basic medical care, but recently, refugee health has also been understood in terms of psychological trauma and psychosocial well-being. Research has demonstrated that refugees are vulnerable to a variety of health problems because of factors including poor living conditions, lack of access to health care, stressors related to the refugee experience, conflict between health beliefs in place of origin and displacement, and lack of financial resources for food and medicines.

Legal Aspects of Refugee Health

Refugees are defined under several conventions in international law as persons who have fled their country of origin because of a well-founded fear of persecution on the basis of race, religion, nationality, political opinion, or membership in a social group. Under the United Nations 1951 Refugee Convention and its 1967 Protocol, some aspects of refugee health are explicitly considered. Under Article 24 of the Convention, ratifying countries agree to treat refugees the same as nationals with respect to social security, including health and maternity care. Additional legal protection relevant to health is available under Articles 20, 21, and 23 which provide for refugees' rights to access rationing, housing, and public relief, respectively. Ratifying countries vary in the ways in which they implement these convention obligations. Other branches of international law, namely human rights law and humanitarian law, are also relevant to the health of refugees, and are particularly useful in cases when forced migrants may not meet the Convention definition of a refugee, as in the cases of internally displaced persons and non-Convention refugees. In many cases, the health status of Convention refugees and other forced migrants may be similar, but in some cases the health of forced migrants such as internally displaced persons (IDPs) may be worse because they may still be exposed to conflict zones, may be inaccessible to aid efforts, and have less protection under international law.

Refugee Health in Complex Humanitarian Emergencies

In complex humanitarian emergencies such as war or disaster, forced migration is associated with significant risk of increased morbidity and mortality. During or immediately following such disasters, when large numbers of people are in flight, rates of morbidity and mortality can be extremely high. In Asia and Africa, population migration and associated food shortages have been associated with more deaths than direct conflict. In times of social upheaval and war, health is threatened through limited access to health services, disruption of infrastructure, disturbances in the food supply, and problems with shelter in addition to injuries and trauma sustained from violence. The process of migration itself can pose threats to health, as can conditions in refugee camps or other places of asylum.

Measuring the health impacts of displacement under emergency conditions is challenging, with upheaval often leading to the underreporting of mortality and morbidity rates and an inability for observers to accurately document health conditions. The crude mortality rate is one measure that is often used to determine the impact of an emergency on a displaced population, and research shows that for mass population displacement, mortality rates are often highest immediately following arrival in a place of asylum such as a refugee camp. While mortality rates vary by population and over time, children under 5 years of age are at highest risk of death. The leading causes of mortality among refugees in humanitarian emergencies are infectious diseases, such as measles, malaria, acute respiratory infections, and diarrheal diseases.

For refugees housed in camps, a range of causes of morbidity and mortality have been documented. Among these, epidemics of diarrheal diseases are perhaps the most common, often attributable to contaminated water. In complex humanitarian emergencies, infectious disease rates typically increase. Measles is one of the leading causes of death for children in refugee camps as a result of low immunization rates combined with nutritional deficiencies. Protein-energy malnutrition, iron deficiency, vitamin A deficiency, pellagra, and other types of malnutrition have been documented in refugee camps and are often associated with insufficient food rations or food that is deficient in micronutrients. A high prevalence of acute respiratory infections in refugee camps, especially among young children, has been associated with poor conditions and crowding. Malaria occurs in refugee camps particularly when populations from areas of low endemicity migrate into areas where malaria is endemic. Elevated rates of meningitis, hepatitis, HIV/AIDS, and other sexually transmitted infections have also been documented among encamped refugee populations. With respect to HIV/AIDS, complex and protracted refugee situations can affect infection rates, challenge the treatment of those living with the disease, and affect prevention efforts by, for example, limiting a person's ability to access preventive care, such as family planning supplies, in a refugee camp.

Refugee Mental Health

Much of the literature on refugees and other forced migrants focuses on the psychological effects of displacement, particularly in terms of trauma, and on coping strategies. Migration does not necessarily lead to poor mental health. Instead, a number of forces and processes, including traumatic events, housing conditions, and others can threaten psychological well-being and lead to high rates of psychiatric trauma and stress-related disorders. Desjarlais et al. (1995) identify three key factors which influence a migrant's well-being. These are: (1) adaptation to the changes wrought by migration; (2) the environment in which the migrant resides; and (3) whether the migrant can live a meaningful, productive, and culturally integrated life. Most research on the health of forced migrants has considered the direct effects of violence on health. Some other, less discussed factors that influence forced migrants' health include the disruption of civil society and social relationships, flight, and separation from one's homeland.

Research demonstrates that depressive disorders, anxiety, and posttraumatic stress disorder are prevalent in refugee populations and that refugees have high levels of stress as well as other problems that affect their quality of life. Reported rates of PTSD vary widely in refugee populations, with the lowest rates observed in epidemiological studies, higher rates in studies employing convenience samples, and the highest rates being observed in clinic populations. PTSD is often associated with other disorders such as depression, anxiety, somatoform disorders, dissociative disorders, or substance abuse. A higher incidence of depressive disorders has been found in some displaced populations.

Somatization, or the cultural patterning of psychological and social disorders into physical ways of expressing distress, is widely observed in displaced populations. Refugees have been shown to have higher rates of somatization than immigrants in some cases. Given cultural differences in lay and professional disease classifications globally, it is perhaps not surprising that clinical encounters and diagnosis are issues of concern in the health of forced migrants. Western diagnostic criteria are overwhelmingly used to assess the health of displaced populations, although these are increasingly being validated for major forced migrant groups. The use of such standardized instruments, both for diagnosis and also for indices of concepts such as stress, well-being, or self-esteem may be inconsistent with local and indigenous classifications of health and ill health.

Health in Resettlement

Much research has considered the health of refugees resettled to the United States, Canada, Australia, and Europe. Conclusions about the health of resettled refugees vary. Some studies show continued rates of traumatization and stress, while others have shown a decrease in psychopathology over time. As refugees become acculturated to their new environment, patterns of disease and health habits may change. Rates of chronic diseases, such as cancer, coronary heart disease, diabetes, hypertension, and obesity may increase, as may health behaviors related to diet and substance use, for example. Refugees may also experience barriers to accessing medical care and preventive services in countries of resettlement.

The process of becoming acculturated to a new environment may in itself be a source of stress that affects health. While exposure to traumatic experience is the most consistent predictor of psychiatric disorder among refugee populations, other factors, such as social environment, living conditions, preexisting vulnerabilities, and demographic factors, also affect mental health. In contexts of resettlement, insecurity, low socioeconomic status, unemployment, and other post-migration stressors are associated with increased and prolonged psychopathology.

More research is needed in order to understand how to address the mental health needs of refugees and other forced migrants. Religion has been shown to have protective effects in some cases, as have political and ideological commitment. Social linkages and support have also been shown to be important for mental health. Social and personal factors mediate the risks for ill health among forced migrants in various contexts. In terms of scholarship, work that considers the mental health of forced migrants from a more holistic perspective is increasingly available. In asylum and resettlement, acculturation and social integration can pose challenges for health. These challenges include role reversal in families, downward mobility, loss of social support, and intergenerational conflict among others. The implications include loss of self-esteem, stress, and substance abuse. Loss and separation also pose challenges to health in resettlement.

Refugee Health Screening

Refugees are often required by law in countries of asylum to undergo a health assessment. In the United States, refugees accepted for resettlement are required to have a health screening in their country of first asylum before they can travel to the United States. The historical purpose of such assessments was to identify refugees who were afflicted with certain diseases, especially infectious diseases, for the purposes of potentially providing treatment before travel or, in some cases, for excluding a refugee from resettlement. Once resettled, refugees are usually offered a health screening. In the United States, refugees enter the country through an airport that has a quarantine station, where officials review their medical documents. In addition, a domestic health screening is recommended under the Refugee Act of 1980. The purpose of this screening is to address and treat health conditions that may have been identified in a pre-travel screening. Historically, health screening measures were primarily focused on infectious diseases of major importance for public health but now tend to be more comprehensive general health assessments. Refugee health screening is complicated by differences in the number and type of measurement and diagnostic instruments, and by issues of language and culture. However, refugee health screening is important as it often serves as an introduction between the refugee and the host country health care system, may provide refugees with access to treatment that can alleviate suffering and facilitate self-sufficiency, and identifies refugees with health conditions of public health importance.

Conclusion

Studies of populations of migrants around the world show that refugees tend to suffer from more mental health and medical problems than immigrants of other types. Refugees, by definition, have fled from persecution, which often may include traumatic experiences including war, violence, and physical or psychological torture. That refugees are vulnerable to health problems specifically related to displacement has been established in the literature. In terms of health concerns, significant attention has been paid to infectious diseases and forced migration, although the significance of these diseases largely depends on the population of interest. Increasingly, the mental health of refugees is a topic of considerable research and intervention. Refugees housed in urban areas or camps in developing countries have specific health concerns related to the conditions of their asylum. Most studies of refugee health consider the relatively small number of refugees who are resettled to North America, Europe, and Australia. With millions of people displaced by conflict around the world living in a wide range of conditions, refugee health varies from place to place, suggesting that interventions to improve refugee health should be based on rigorous assessment of local needs and concerns.

Related Topics

- ▶ Acculturation
- ▶ Acculturative stress
- ▶ Assimilation
- ▶ Barriers to care
- ▶ Border health
- ▶ Communicable disease of public health significance
- ▶ Depression
- ▶ Global health
- ▶ Health barriers
- ▶ Health beliefs
- ▶ Inadmissibility on health grounds
- ▶ Medical examination (for immigration)
- ▶ Mental health
- ▶ Panel physician
- ▶ Posttraumatic stress disorder
- ▶ Refugee
- ▶ Refugee camp
- ▶ Refugee resettlement
- ▶ Refugee status
- ▶ Refugee youth
- ▶ Resilience
- ▶ Somatic symptoms
- ▶ Torture
- ▶ Trauma exposure
- ▶ United Nations High Commissioner for Refugees

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Refugee Resettlement

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A refugee is a person fleeing his or her country because of persecution or a well-founded fear of persecution on account of race, religion, or nationality; membership in a particular social group; or political opinion. Refugees are different from other immigrants in that they do not have the choice to remain in their home country.

The refugee resettlement process varies from country to country, but all programs offer immediate aid including food and shelter. Longer-term services offered at refugee centers in resettlement host countries can include permanent housing, employment skills and job placement services, clothing, medical attention, education, language classes, and community orientation. Some refugee centers also provide day care, transportation, case management, translation services, assistance obtaining employment documents, and support during the process to become a permanent citizen.

According to the 2009 World Refugee Survey by the United States Committee for Refugees and Immigrants, as of December 31, 2008, the number of refugees and asylum seekers worldwide totaled 13,599,900, with the majority (6,343,800) located in the Middle East and North Africa. The report also notes that, of the worldwide total, only 86,460 refugees or asylum seekers were resettled in 2008. As a result of the discrepancy between the number of refugees and asylum seekers compared with the number actually resettled, most refugees live in camps. Though the camps are meant to be temporary solutions, refugees can live in the camps for many years. Most camp host countries do not allow freedom of movement, which is defined as the right to choose one's place of residence and move freely in the host country. As a result, refugees are "warehoused"; they are usually confined to camps or segregated settlements where they are dependent on humanitarian assistance.

There are 16 countries with formal refugee resettlement programs including Australia, Canada, Sweden, the USA, Norway, New Zealand, Finland, Iceland, Denmark, the Netherlands, Ireland, the UK, Chile, Argentina, Brazil, and Italy.

Related Topics

- ▶ Refugee
- ▶ Refugee camp
- ▶ Refugee health and screening
- ▶ Refugee status

Suggested Resources

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Refugee Status

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War, communal conflict, and persecution based on religious, ethnic, or political affiliation are the primary reasons that over 10 million people are considered to be refugees by the United Nations. According to both United Nations protocols and US immigration laws, the generally accepted definition of a "refugee" is a person who has fled across international borders because of a well-founded fear of being persecuted "for reasons of race, religion, nationality, membership of a particular social group, or political opinion." The UN Refugee Protocol of 1951 mandates the global community to give protection for those with a "well-founded fear of persecution" in their home country. Nevertheless, despite clear protections promised by widely accepted international law, refugees are frequently subjected to the vagaries of political self-interest. The reason for this is that refugees are an indicator that a state allows, either intentionally or unwillingly, the persecution of part of its population based on religious, ethnic, or political affiliations.

To maintain good political relationships, countries may be reluctant to accept asylum seekers from their allies. Thus, North Korean refugees in China are considered "economic migrants" and are forcibly repatriated (refoulement) back to their homeland despite the likelihood of imprisonment and capital punishment. Christians from Iraq were denied political asylum by the United States during the Iran–Iraq war (1980–1988) because American foreign policy at that time favored Iraq. Refugee status can also be rejected based on grounds that people are fleeing a poor economy rather than harm. Haitians intercepted by the US Coast Guard in international waters are considered "economic refugees" fleeing desperate poverty rather than persecution for their political or religious persuasions. Refugees therefore frequently experience the vulnerability of being "asylum seekers," who have not yet been given refugee status but are in the process of presenting their case of a "well-founded fear of persecution."

The United Nations High Commission for Refugees (UNHCR) was formed to protect refugees, coordinate international assistance, and work out long-term solutions, such as orderly resettlement to "third countries" or repatriation (return to home country). Providing emergency relief and shelter in countries of "first asylum" is considered a temporary arrangement but can mean years of uncertainty while waiting for protracted conflict situations to play out and resettlement options to be arranged. The approximately 2 million Iraqi exiles in first asylum countries of Syria, Jordan, and Lebanon have waited 5 years for conditions back home to improve, with no end in sight. Even UN-monitored refugees camps are not necessarily safe havens and may be vulnerable to raids by armed militias (current examples being Darfur and northern Uganda). Governments can also force the UNHCR and aid agencies to close camps, as the Ethiopian government did to camps housing Sudanese refugees in the late 1980s.

The USA routinely accepts more refugees for resettlement than any other country in the world. In 2009, the ceiling was set at 80,000, and 74,602 refugees were resettled that year. The US Refugee Act of 1980 aimed to eliminate the practice of granting asylum primarily to escapees from Communist controlled countries, although it continued to resettle large numbers of Vietnamese (759,482 from 1973 to 2002) and Cubans.

The US Refugee Admissions Program (USRAP) coordinates the admission of refugee applicants referred from the UNHCR and works with private voluntary organizations (such as International Rescue Committee and Catholic Charities) that sponsor refugees in the USA. Once given full refugee status, the US government provides cash and living assistance support for a given period of time; in California support is for about 8 months. Nonprofit agencies with both private and public funding may give additional assistance in the form of job training, language classes, health care, counseling, and cultural orientation. Scarcity of funding forces resettlement agencies to depend heavily on sponsoring or "anchor" families to help refugees get on their feet.

Besides the many difficult adjustments that all immigrants must make in a new society, finding jobs, changing careers, learning a new language, refugees face the additional strains of having experienced traumatic events in their lives. Many have faced dangerous journeys and witnessed family members and conationals killed, tortured, and raped. They often feel tremendous responsibility to family and friends left behind who are in danger or whose whereabouts are still unknown. They commonly channel a great deal of their resources, both financial and emotional, toward supporting and protecting family members who are still facing difficult and dangerous circumstances in their country of origin or refugee camp.

Related Topics

- ► Asylum
- ► Internally displaced persons
- ► Refugee
- ► Refugee camp
- ► Refugee resettlement
- ► Refugee youth
- ► Trauma exposure
- ► United Nations High Commissioner for Refugees

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Refugee Youth

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Refugee children and adolescents constitute over 45% of the refugee population worldwide. While a number of guidelines and standards have been developed to promote their protection and care, in practice, refugee youth are not always paid sufficient or adequate attention. Their needs and priorities have until recently been considered "on-the-sidelines" of core protection and aid programs, or else subsumed under those of their adult counterparts. One notable exception is the increasing focus on health issues, with a particular emphasis on mental health. Psychosocial research in the area of refugee youth mental health suggests a complex relationship between displacement and health. Studies also suggest that refugee youth have many of the same physical health issues or conditions seen in non-refugee children and adolescents, although with differing prevalence rates.

Mental Health

Refugees of all ages must not only contend with experiences of violence, persecution, and other potentially traumatic experiences. They also face additional long-term stressors related to displacement such as changes in language and culture, and loss of social and economic status. The conditions of chronic stress to which some refugee youth are subjected may manifest as physical symptoms including headaches, abdominal pain, indigestion, fatigue, or insomnia that have not clearly identifiable physical cause. Traumatized youngsters may experience depression, adjustment difficulties, posttraumatic stress syndrome, and other psychological disorders. In these cases, psychological and psychosocial interventions can be instrumental in helping refugee youth regain their mental health. Approaches that focus exclusively on mental problems, however, have been criticized for treating all young refugees' as a homogeneous, universally traumatized group, for disregarding the sociocultural dimensions of mental health, and for interpreting the responses of Non-Western youngsters by means of predetermined Western psychiatric categories and symptom checklists.

Physical Health

In addition to psychosocial factors, refugee youth may manifest a wide array of common physical health issues. Poor oral health (dental caries, gingivitis, and orthodontic issues related to cultural practices such as tooth extraction) is prevalent. Anemia and micronutrient deficiencies (particularly of iron, zinc, and vitamin A) are also common. Similarly, growth abnormalities, including low weight-for-height (an indicator of acute malnutrition) and low height-for-age (an indicator of chronic malnutrition) are more frequently found among refugee youth than among their non-refugee counterparts. Common infectious diseases include tuberculosis (typically in its latent or asymptomatic form), intestinal parasites, fungal skin infections, and hepatitis B among refugee youth from endemic countries.

Conclusions

The mental and physical health practices and beliefs of refugee populations are influenced by variables such as ethnic values, cultural orientation, religious beliefs, and linguistic considerations. Additional factors such as distrust of unfamiliar medical practices, lack of transportation, financial barriers, lack of health insurance, and lack of information may seriously affect refugee youth's access to health services. While the enormous challenges many young refugees face must be acknowledged, their resourcefulness and capacity to adapt to difficult circumstances must also be recognized. Whatever their country of origin or circumstances of arrival, a respectful and well-informed attitude toward their health beliefs, customs, and practices is likely to contribute to more effective and culturally appropriate health care options for refugee youth and their families.

Related Topics

- ► Adolescent Health
- ► Nutrition
- ► Nutrient intake
- ► Oral health
- ► Posttraumatic stress disorder
- ► Refugee health and screening
- ► Refugees
- ► Trauma exposure
- ► Tuberculosis
- ► Unaccompanied minors
- ► United Nations High Commissioner for Refugees

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Suggested Resources

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Bridging Refugee Youth and Children's Services. www.brycs.org

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Religion, Religiosity, and Spirituality

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Introduction and Overview

Social scientists have long been interested in the study of religion, human behavior, and well-being. In fact, scholarly writings on these issues trace back to the emergence of some disciplines. Influential works on religiosity include (among others) an early 1900s publication by William James, who is credited as laying the groundwork for American Psychology, as well as classic pieces on suicide published in the late 1890s by Emile Durkheim, the prominent sociologist whose work drew heavily on religious affiliation as a form of social cohesion. Despite the interest in religiosity generated by these early works, throughout the twentieth century, research on the topic dissipated with the growth of empiricism, behaviorism, and scientific paradigms grounded in biomedical models. These ideologies created barriers that forestalled and marginalized research on religiosity. Over the past few decades, however, dissatisfaction with the narrow focus of biomedical models paved the way for broader biopsychosocial paradigms. Due, in part, to the popularity of these biopsychosocial approaches, and sparked by research initiatives in the 1990s of the National Institutes of Health, which provided additional legitimacy to the topic, research on religiosity and health proliferated.

Negative effects of religion on health have been documented. For example, spiritual trials or "religious struggles" (which may involve questioning the existence of the divine, internal religious conflicts, or discord with others on spiritual matters) are associated with psychological distress and worse physical health outcomes (e.g., poor recovery). Nonetheless, several reviews of this growing literature conclude that, in general, there are beneficial effects of religiosity and spirituality on health. This body of work is not free of critiques, however. Criticisms center on such serious methodological problems as overreliance on cross-sectional studies, inadequate controls for confounding factors, and failure to adjust for multiple comparisons. In a review accounting for some of these concerns, Powell and colleagues concluded that the strongest and most consistent evidence for the effect of religiosity on health is found in research on religious involvement (e.g., church attendance) and all-cause mortality. However, they noted that the association between religiosity and health may be underestimated due to lack of precision in measures of religiosity and spirituality. Furthermore, there is a shortage of studies on spirituality and health.

A brief definition of terms and an overview of explanations or hypotheses posited to explain the association between religiosity and health are provided. It is important to note that very few studies focus on religiosity and health among immigrant populations. Nevertheless, particular focus is placed on describing models for which there is some research on immigrant populations in the United States. Although the entry draws mainly on studies from the U.S., in some instances, parallels are drawn to global findings. Following a biopsychosocial approach, this entry will highlight psychological, social, and cultural factors in the association between health and religion, religiosity, and spirituality. Specifically, we adopt the perspective that psychological variables at the level of the individual, such as cognitions, religious coping responses, and behaviors, influence and are influenced by broader social contexts that include interactions with other persons, groups, and institutions. Finally, individual and social factors operate within cultural contexts.

Definition of Terms

The terms religion, religiosity and spirituality often are used interchangeably. *Religion* refers most commonly to formal and institutional expressions of the sacred. Particular beliefs, practices, memberships, and social organizations characterize religions. *Religiosity* derives from the adherence to the religious doctrines (e.g., beliefs and practices) of formal institutions. The literature on religiosity sometimes distinguishes between "private" (e.g., prayer, reading the Bible) and "public" (e.g., attendance of religious services) forms of religiosity. *Spirituality*, on the other hand, generally refers to subjective experiences of that which is sacred in life, which may involve the search for essential meaning, transcendence, and connection with others, including nature and/or a supreme being. Spirituality may or may not include involvement in religious organizations or groups, or adherence to religious traditions. When considering the beliefs and practices of ethnically diverse communities and given their unique explanatory models of disease and indigenous views of health and illness, the distinction between religiosity and spirituality becomes more complex.

Despite the theoretical differences between religiosity and spirituality, in practice, there is a high degree of interrelationship among them. Therefore, some argue that it is misleading to uphold the theoretical separation between these terms. Moreover, distinguishing between the terms ignores the organized form in which all spiritual experience takes place, that is, the religious domain. Nevertheless, the distinction between spirituality and religiosity may be useful particularly with reference to the notion of spirit in non-Western philosophical perspectives. In the following sections describing the primary hypotheses concerning religiosity and health, the terms *religion*, *religiosity*, and *spirituality* are used interchangeably unless otherwise noted.

Hypotheses on Religiosity and Health

Various hypotheses are proposed to explain potential pathways or processes by which religiosity might impact health. The most prominent hypotheses, for which there is some research relevant to immigrant and ethnically diverse populations, fall into three broad categories: (1) individual-level explanations that focus on psychological factors, such as cognition and coping processes; and behavioral factors; (2) social explanations; and (3) culturally based explanations. Of note, these categories are not mutually exclusive. Moreover, the overlap among categories might involve interacting factors that produce various health outcomes. For example, social factors can interact with psychological coping processes, as when emotional support from fellow congregants leads to coping with stressful life events by praying, resulting in less psychological distress. The interaction among these factors is seldom, if ever, studied.

Despite the biopsychosocial approach adopted in this entry, biological models are omitted from the discussion below. There are few well-controlled studies on physiological pathways linking religiosity and health. The most conclusive evidence concerns studies on transcendental meditation, and none involved immigrant groups. The suggested readings and resources at the end of this entry provide more detailed discussion of these and the other hypotheses described in the following sections.

Individual-Level Explanations

Cognitive Processes

Spiritual belief systems could engender a sense of direction, purpose, comfort, and motivation and direction for living, especially during stressful periods. Because religious frameworks may offer a specific philosophy of life or world view, cognitive mechanisms may explain the relationship between religiosity and health. For example, religious beliefs (e.g., that prayer enhances closeness with God or divine intervention) may promote a sense of control over stressful events or generate strength to tolerate adversity. In addition, by providing a framework of a greater purpose or “grander plan,” some religious doctrines may render optimism, hope, and a sense of acceptance for situations or events that cannot be changed or controlled, helping individuals find meaning for troubling events or ongoing hardship.

Despite various hypotheses concerning potential cognitive mechanisms that may mediate the association between religiosity and health, there are only a few studies (of nonimmigrant populations) testing these effects, and they yielded mixed results. There are even fewer studies of immigrant or ethnically diverse samples. Simoni & Ortiz report that mastery (as well as self-esteem) mediated the relationship between religiosity and depressive symptoms among Puerto Rican women living with HIV. These results support the hypothesis that, in the context of a chronic illness, religiosity helps individuals to achieve a sense of self-efficacy, which, in turn, leads to enhanced psychological well-being.

Religiosity as a Coping Strategy

Religiosity may benefit health by providing a means of managing difficult life circumstances. Rooted, in part, on broader coping theory, *religious coping* refers to spiritual methods or strategies for dealing with the emotional and other demands of stressful events. Thus, it is distinct from global *religiosity* (e.g., intrinsic or self-rated religiousness, church attendance). Religious coping may involve cognitive (e.g., seeking comfort or strength from faith or God) or behavioral (e.g., praying) strategies based on religious beliefs or practices. Although research on immigrants and other culturally diverse groups is limited, there is evidence that ethnic minorities frequently rely on religious forms of coping (e.g., prayer) in response to difficult life circumstances, such as coping with chronic health conditions. The most consistent observation in the limited available literature is that rates of religiosity and religious coping are higher among racial and ethnic minorities as compared to Whites.

Compared with the broader literature on religiosity, research on religious coping is unique in its focus on both the positive and negative sides of coping. In response to stressful life circumstances, religious coping may involve negative reactions, such as anger towards or a sense of punishment by God. Compared with strategies that involve calling on God as a "partner" or benevolent being, these negative responses are associated with worse psychological and physical well-being. It is also interesting to note that conventional coping theory tends to conceive of religion as a passive form of coping, which is considered less effective than "active," behaviorally oriented strategies. Little evidence, however, supports the proposition that religious coping reflects passivity or avoidance. To the contrary, when viewing God as a partner, religious coping engenders a sense of personal power and efficacy.

Behavioral Explanations

Religiosity may lead to better health outcomes as a function of proscriptions against risky behaviors; internalized moral codes; or adherence to other religious, philosophical doctrines that influence health behaviors, such as the belief that, as a temple of the sacred (e.g., the Holy Spirit), the body's health should be maintained. As a result, behavioral explanations suggest that religious individuals engage in healthier activities and lifestyles than do those who are less religious. Supporting this hypothesis, rates of cardiovascular disease and lung cancer are lower among members of denominations with strong proscriptions against smoking (e.g., the Church of Jesus Christ of Latter Day Saints) compared with the general population. Smaller-scale studies provide mixed evidence of the hypothesis that religiosity is associated with healthy behaviors. More support for the hypothesis is found in larger-scale studies. A multiethnic, statewide probability sample of Texas adults found that, adjusting for potential confounders, religious involvement was associated with healthier behaviors, assessed as an index of 12 items that included exercising, not smoking, and visits to the dentist. Of note, the association was similar for men and women and for the various ethnic groups (Blacks, Mexicans, other race/ethnicity, or non-Hispanic Whites) in the study. In addition, large-scale studies show that, relative to those who attend religious services less frequently or not at all, individuals who attend weekly are more likely to quit smoking, become physically active, not become depressed, and increase social relationships.

Social Explanations

Social Support

One class of explanations for the association between religiosity and health focuses on social processes, more specifically, social support. An expansive body of evidence documents the effects of social support on physical and psychological well-being. Social support entails a variety of emotional, tangible, informational, and other resources made available from social relationships and networks. In addition to the direct benefits of social support on health (e.g., via the provision of instrumental assistance), social support may operate indirectly via several mechanisms, including the promotion of healthy behaviors, and other psychosocial processes.

Many religious denominations foster social networks through regular gatherings in places of worship (e.g., churches, synagogues, and mosques). Social explanations suggest that the social support derived from membership in these religious organizations accounts for the association between religiosity and health. Perhaps more than any other issue, critics of the literature on spirituality and health assert that the social processes inherent in these religious groups, chiefly among them social support, explains the beneficial effects of religiosity on health. In essence, the debate centers on the premise that it is the social – not religious – aspect of “religiosity” that confers health benefits. In at least two ways, however, religious support from congregation members, clergy, or other religious leaders might differ qualitatively from and provide added benefits over other sources of support. First, although individual members of a congregation might change, the institutional and social structures remain, providing stable sources of support throughout the life course. Second, the religious content of the support (e.g., being surrounded by individuals who share a similar philosophy of life or world view, or who offer prayers) might provide additional comfort or other psychological benefits. Given the psychological distress that they experience due to losses in their social networks, the social supportive functions of religious institutions might be particularly important for immigrants. There is a lack of research that explains the extent to and mechanisms by which religious organizations assist immigrants in rebuilding social networks.

Religious Involvement

A common method for testing the hypothesis that religiosity benefits health consists of assessing the association between a specific type of religiosity – religious involvement. Because religious involvement is measured often as participation in religious activities with other members of a religious group (e.g., attending church services), it occurs in a social context. A small number of epidemiologic studies of Latinos (predominantly Mexican Americans) provide evidence of the beneficial effects of religious involvement on health. One of these examined the effects of religious attendance on mortality over 8 years of follow-up data from the Hispanic Established Populations for Epidemiological Studies of the Elderly (the Hispanic EPESE), a study of over 3,000 Mexicans aged 65 or older who reside in the Southwestern section of the United States. After adjusting for numerous potential confounding variables at baseline (sociodemographic characteristics, cardiovascular health and risk factors, and functional and activity limitations), the mortality rate was approximately one-third lower among respondents who reported attending church or religious services once per week compared with those who never or almost never attend. Furthermore, this association held and remained virtually unchanged when a number of potential mediators were included in the analysis: social support, health behaviors (smoking and problem drinking), depression, cognitive impairment, and poor health. Of note is that the association between religious attendance and mortality occurred only among once-per-week attenders, not those who attended services yearly, monthly, or more than once per week. Overall, these findings are consistent with conclusions drawn by reviews of the literature that, by far, studies of religious service attendance and mortality provide the strongest evidence of a link between religiosity and health. However, that the association does not hold for attending services more than once per week runs counter to a dose–response effect.

Structural Explanations: Faith-Based Institutions

Structural explanations focus on the role of formal institutions, such as religious and faith-based institutions or organizations in promoting health and well-being. Faith-based organizations, such as churches, historically have offered critical mental and physical health care-related resources to immigrant and minority groups in the United States. By providing spiritual, material, and social assistance to newer and less integrated immigrants, as well as others in need, churches play pivotal roles in promoting the health and well-being of diverse immigrant groups and in protecting them against material deprivation and emotional distress. More recently, faith-based institutions of diverse denominational affiliations led significant political and grassroots initiatives aimed at protecting immigrants' rights, a growing phenomenon given the rising anti-immigrant environment in the United States.

Faith-based organizations also provide another important resource: clergy. Clergy are among the most frequently sought-after sources of help for psychological distress – particularly among minority groups, including immigrants. A growing literature documents the underutilization of mental health services among immigrants and their preference for religious substitutes for these services. Clergy have unique advantages in providing assistance with personal problems, including affordability and access. Their shared religious faith, particularly during stressful periods of social and individual accommodation to the recipient society, facilitates the ability of clergy to address the mental and emotional distress of their immigrant congregations. Clergy are the only professionals that most congregants encounter throughout their lifetimes, making them critical sources of counsel. In addition, clergy and other church leaders are key figures in some successful faith-based health programs.

Despite the key role of clergy in promoting well-being, they are seldom considered partners in healing by the medical profession. Such partnerships are hampered by dissimilar goals, philosophies and lack of resources. Thus, clergy provide mental health counseling that is seldom recognized by the medical profession or other organizations. Because most clergy do not receive extensive training in mental health counseling, they may deal with mental and social service problems that are beyond their level of expertise. Therefore, in general, there is little consensus on the role of clergy in service delivery and mental health counseling.

Culturally Based Spiritual and Folk-Healing Practices

In recent decades, what have been termed traditional healing or folk-healing practices have grown in popularity in the United States, spurred by the holistic health movement commencing in the 1970s and succeeded by the New Age movement, as well as the rise of the field of complementary and alternative medicine. Traditional healers of Latino origin, ranging from *curanderos* to *herberos*, are largely multidisciplinary practitioners who combine religious healing practices rooted in traditional-belief systems, predominantly *Santeria* and Spiritism. These religious-therapeutic movements share a common belief in communication with and possession by an array of incorporeal spirits.

Research by Viladrich reveals the role of *botánicas* as an entry to the concealed world of Latino healers. *Botánicas* provide health care products, informal health services, and referrals to informal and formal health care practitioners, and they function as community resource information hubs. They provide a physical and a social space to support informal faith-healing on the basis of religious belonging, connecting immigrants with alternative networks of care within a culturally meaningful explanatory model of disease and healing. The services that *botánicas* offer, healing practices that are low cost and highly available, provide a viable means for confronting the numerous barriers to health care that their largely uninsured immigrant and other clients face. Latino immigrants use *botánicas* and healers to obtain holistic care for emotional and psychological problems that extend beyond physical complaints. Healers combine natural and supernatural treatments while searching for cost-effective remedies for a variety of ailments, including stress-related conditions (e.g., *nervios* due to financial difficulties or undocumented status) and other chronic disorders. Most healers use diverse therapeutic methods, including referrals to professionals (e.g., psychotherapy, Western medicine), especially when clients' problems are evaluated as severe and beyond their expertise.

In a somewhat analogous fashion to that of clergy and the medical profession, healers hold strained relationships with biomedical providers in general and with mental health professionals in particular. Although healers acknowledge their limitations in treating serious mental illnesses (e.g., major depressive disorders), they criticize conventional medical practices, such as pharmacological treatments (perceived as the use and abuse of chemical substances), the limited reliance on verbal therapies, and the narrow scientific focus that ignores Latinos' spiritual and religious beliefs. Similar to religious healers in other countries, such as Uganda and Taiwan, Latino healers experience a lack of acceptance by organized medicine, which views them as charlatans or as mentally unstable. As a result, despite the visibility of *botánicas*, Latino traditional healers mostly remain a hidden population in urban settings, and conceal their identity to outsiders.

Given this hidden population, little work exists evaluating the effectiveness of traditional healing on physical and mental health. That healers tend to view emotional problems as normal indicators of stress may deter clients from seeking professional care when needed. Also unknown is the extent to which religious healing systems (e.g., *Santería* and Spiritism) disguise psychotic symptoms under the notion of spirit possession or intrusion. On the other hand, these same spiritual interpretations of distress may lead to misdiagnosis of psychotic illness. Finally, misunderstandings concerning *Santería,* often misconstrued as a cult related to witchcraft and Satanism, or other spiritual practices, may prevent practitioners of these faiths from seeking formal health services in the United States. Policies and practices that bridge Western and religious healing systems should be put in place to overcome the fear of retaliation that keep traditional practitioners, as well as their patients, from sharing their beliefs and practices with mainstream health professionals.

Conclusion

Interest in studying the relationship between religiosity and health continues to flourish. Although various hypotheses have been advanced to explain this association, there is a paucity of research on the processes and mechanisms by which religiosity might affect mental and physical health among general populations, and even less focusing on immigrants. Additional studies on biopsychosocial factors associated with religiosity and health among immigrant groups could provide important tests of existing hypotheses and models, and identify areas of divergence. In addition, given the lack of studies on spirituality among immigrant and nonimmigrant populations, future research should focus more closely on this issue. Also warranted is a closer look at the overlapping and complementary effects of religion and spirituality at individual, social, and institutional levels. Finally, interactions among individual and broader social and cultural factors should be examined. Such models offer the potential to advance our understanding of the pathways by which religiosity may lead to a variety of health outcomes.

Related Topics

- ▶ Alternative and complementary medicine
- ▶ Christianity
- ▶ Curandero
- ▶ Explanatory model of illness
- ▶ Islam
- ▶ Judaism
- ▶ Resilience
- ▶ Santería

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Reproductive Characteristics

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Reproductive characteristics are defined as the behaviors that are acceptable, unacceptable, and the societal expectations of a particular immigrant group as they relate to sexual activity, marriage, and childbearing.

Most countries recognize marriage as the societal norm, but many have been faced with teen and unwanted pregnancies which add to the burden of poverty. This is a growing problem in many countries as the result of the limited availability of contraceptive education and affordable options. Family planning and the availability of birth control still evade women as preventive methods to control unwanted pregnancies. The issue of reproductive rights still remains a topic that is not discussed in many communities.

The number of children that a couple conceives is usually not predetermined unless they are living in countries that limit the number of childbirths as an economic incentive. Many communities believe that a greater number of children conceived is a significant sign of religious blessings. This practice remains within many immigrant populations in spite of the significant challenges facing couples as they attempt to integrate into a new community.

Religious beliefs play a major role in the day-to-day lives of many immigrant populations. Although the Christian, Jewish, and Muslim faiths are frequently encountered, traditional healers and religious counselors remain a strong force. It is critical to incorporate traditional practice when appropriate to secure needed trust for optimal care delivery.

The inability to conceive or the loss of child may be interpreted by some individuals as a curse or missed blessing. Many times, this experience may result in family discord, loss of financial and social support, and major depressive disorders.

Infertility is a troublesome issue for all women. Although documented causes of infertility such as tubal disease and premature ovarian failure may be the root of many cases, unknown causes remain as the most common reason given to most couples.

The data on the psychological impact childbirth, loss, and infertility have on immigrant women are scarce. Although health care workers assist immigrants with the adjustment process, many women and their families continue to experience psychological stressors. Women who remain in countries away from their countries of origin for long periods of time have more documented anxiety and depressive disorder.

Lesbian relationships are rarely accepted and, as a consequence, may not be openly presented. Many women in lesbian relationships only rarely present for health care. Those that do seek health care are often given suboptimal care.

Workforce, persistent paternalist policies, and polygamy place demands on women that confuse reproductive choices. Shame and isolation may be common among women in communities that use these methods to control unacceptable societal behaviors. Battered women live in shame as they face issue of poor self-confidence and image. Many believe the abuse is warranted as they label themselves as failures. Unveiling this practice is very difficult and can often place the women in greater danger. In some countries, illegal abortions result in great loss of maternal wellness and life.

Menopause ("change of life") is a valued experience in many immigrant populations because it is perceived as a validation of maturity and wisdom. Many older women do not complain of many of the discomforts experienced during menopause. These women are at risk for osteoporosis and various reproductive cancers. Education that informs these populations of the hallmark warning signs of disease is essential.

The prudent health care provider must be culturally aware, if not culturally competent, to treat immigrants. Most immigrant women have a proud legacy of motherhood and family values. Understanding cultural and societal norms, religious practices, and self-healing practices will help a global provider give optimal care.

Related Topics

- ► Maternal dietary intake
- ► Menopause
- ► Pregnancy

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Reproductive Health

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Reproductive health has diverse definitions for women from various parts of the world and poses several challenges for practitioners. Reproductive health encompasses reproductive choice, sexuality, birth control, infertility, pregnancy loss, and general gynecologic health.

A discussion of reproductive health cannot be discussed without understanding the political and societal norms that dictate the level of importance or significance of women in a given society. These norms are an integral part of each woman's self-worth and may influence choices made that promote or inhibit optimal health.

Societal status often predicts what the role of the women often plays in a society. Age, sexual activity, and marriage in many communities are customs as well as rites of passage. Expectations of family and community often dictate when childbirth should occur in the lives of women who are often children themselves. It is interesting to monitor the change in gender equality and equity in developing countries. For centuries, the value of women has focused on their sexuality and their ability to have children. Protecting legacies as well as enriching the workforce through childbirth are a few examples of the role of women in many societies. The increasing number of women involved in parliament and policy development is increasing their value in many societies. This progressive development has opened doors to the education of females and potentially allows them to move away from hard labor as a way of life. This also gives them access to reproductive choices such as birth control and safe terminations. As immigrants, many women are finding access to choice a new but sometimes fearful phenomenon.

Family planning methods vary from the most highly advanced technology to the rhythm method, but infertility is an unwelcome subject in many groups. Family planning is almost nonexistent in many developing countries. Through many nonprofit organizations, limited birth control options are available including, birth control pills. Intrauterine devices and injectable contraceptives are also popular. These are convenient methods and allow many women to control their fertility in a non-visible confidential manner.

Abortion may be an option to many women but cost is almost always the limiting factor. Most women may purchase medication at a local pharmacy that initiates an abortion; such abortions may be complicated by hemorrhage and infection. Unsafe abortions still remain a major cause of unnecessary death among young women. Self-proclaimed health experts continue to attempt abortions without training. This practice cost the lives of many young women. Health practitioners have fallen victim to this controversial health care challenge with the threat of incarceration for delivering postabortion and/or life-saving care. Postabortion care has been funded by many philanthropic organizations in an effort to save lives.

Female genital cutting may also pose a significant problem to caregivers who have not cared for women with an obvious alteration in physical appearance and may challenge the implementation of contemporary medical practices. Rape is often commonplace and places both physical and psychological stressors on the victims whose perpetrators are often visible within the community. The victim may be held responsible for this violent behavior and may consequently be further victimized.

Related Topics

- ► Fertility
- ► Reproductive characteristics
- ► Women

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Research Ethics

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Research Ethics and Immigrants, Incorporating Community and Diversity Needs

Research ethics training is needed in many disciplines that engage immigrant groups and their communities in research or other intervention efforts. It is reported in several key articles that research ethics training is not adequate in student training, that human subjects training requires more extensive development than that provided by compulsory online training from federal agencies. Additionally, many academic professors are not fully trained in research ethics so that they report that their ability to cover in-depth ethical issues is inadequate. Researchers often will provide a standardized response to Institutional Review Board (IRB) applications that can be approved to ensure standard human subjects protections. Yet, some researchers and health professionals will go beyond standard protections and demonstrate innovative approaches to the ethics of research with very diverse groups, such as immigrant communities, in an effort to help their field gain sensitivity, cultural competence, and effective interventions with immigrant groups. These new sources of advice are worth compiling and examining periodically for the important lessons learned in the field. Additionally, it is worth being aware of some international codes of ethics and applied ethics articles that offer new advice to working with cultural groups, economically disadvantaged groups, and community-based research projects.

Considering both Individual and Community-Based Approaches to Human Subjects Protections

Many research practitioners have recommended the need to see individual persons as part of group identities or place-based communities. This expanded understanding of the individual human subject is not well taken up by research ethics boards for the emphasis is on the common morality on individual autonomy. The moral requirements of individual human subjects protections are based on these principles: beneficence, respect for autonomy and justice. For example, beneficence refers to the ethical obligation to maximize benefits and to minimize harms for the individual. The risks of research should be reasonable for the expected benefits. The beneficence principle has certain rules: The need for scientific veracity ensures the research design be sound, and investigators are competent both to conduct the research and to safeguard the welfare of the individual research subjects. Beneficence guards against the deliberate infliction of harm on individual persons, which can be expressed as a separate principle, nonmaleficence – the need to do no harm. Truthfulness, privacy, confidentiality, and fidelity are other rule obligations of beneficence and the respect for autonomy to the individual patient or research subject.

So, as of yet, there is not much authoritative advice on working ethically with individuals who are strongly tied to cultural identities, as immigrant groups may be, nor is there adequate authoritative advice on research subjects whose individual conditions are part of place-effects, such as an environmental threat to a whole geographic community or neighborhood or a prevalence of a disease that is tied to community-wide conditions.

In the past decade, new articles have been published on the need to consider the community or cultural group as a collective research subject and to provide the same ethical protections to the collective as one would to the individual. Some have written about the duty to protect the community, the need to understand how the community of study requires an assessment of risks and benefits as a whole collective. Many culturally diverse community leaders have become involved in research partnerships and collaborative projects in order to ensure that the research being proposed for the geographic community will have local benefits to community members. Some have stated that when a diverse community has economically disadvantaged conditions, the researchers are morally obligated to ensure that the community members have benefits from the research project.

Community-Based Beneficence

US research ethics committees will recommend that certain rules of beneficence be applied to the collective community of study. For example, a community of study should be consulted in terms of assessing risks and benefits. They do not require more than that for a researcher's obligation to the collective group. However, many practitioners of public health, housing, environmental, mental health, and other community research projects are utilizing community-based research (CBR) approaches in order to increase beneficence and provide more social justice for the disparities in economically disadvantaged and immigrant communities. CBR models are designed to create benefits on multiple levels for diverse community members that may alleviate multiple burdens affecting the community of study. Studies of asthma or pesticide exposure with CBR designs will provide capacity-building to local residents with research and health care needs. Community staff and advisors are trained in research skills, community outreach and education projects, and administrative activities, even grant-writing. Community members provide consultation on research actions/outcomes that benefit local residents (media venues, exhibits, radio shows, walkways, education programs, many more activities). These multiple benefits can meet the requirements of some international guidelines for research which require that a research project provide beneficial change to the community of study. Most of all, such benefits allow the community to have the skills and experience to take control of the health or environmental threat. This is essential to the sustainability of a research intervention.

Still, CBR practitioners and other researchers need to be aware of community-wide and cultural risks from research interventions and should consult community members and cultural representatives for this assessment. Such an assessment is new to research ethics but some researchers have done this in genetic research and also in environmental health and other studies. Members of immigrant communities can alert the research team that certain questions in a survey would bring harm to community members, that some research activities would be culturally inappropriate and cause distress to cultural groups, and that certain types of studies may not be effective and other approaches may be more worthwhile. Research teams need to spend some time eliciting this advice from community members and developing some community-based tools to adequately obtain this advice.

Some researchers have used an extensive interviewing process with a sample of community members to assess risks and benefits. Community advisory boards or research committees can review the research questions, designs, and methods with a research team and thoughtfully examine the impact of such activities with community members. In environmental health, it may be useful to examine the impact and outcomes of similar research designs/methods already published in case studies by reviewing how effective they were in other communities of study and how did those community members react to such studies.

Intercultural Research Designs/Methods

Another important extension of beneficence for immigrant communities is the creative design of intercultural research interventions. Postmodern ethics stresses the need to incorporate multiple voices and forms when dealing with groups that are marginalized; to overcome ethnocentric privilege and allow an expression of diversity or otherness in traditional or standardized models of research. Immigrant groups who are involved as research advocates, advisors, or community-based staff will want to see that a research team is willing to share power and not keep an oppressive technical control over the research process.

By working with immigrant community members to allow an expression of their culture, be it Vietnamese, Latino, Cape Verdean, Indian, or other groups, a research team can allow qualitative methods to be culturally based. There are examples in case studies of types of ceremonies, ritual gatherings, and storytelling projects that are integrated with data collection needs. These activities help to break forms of White or academic privilege by building up cultural identities while accomplishing research tasks. These activities can strengthen individuals and groups in the community with capacity-building, community cohesion, and a sense of solidarity for dealing with a health or environmental threat. By providing community-based funding and technical assistance, a research team will create more sustainability for an intervention that will be needed over time.

Respect for Persons and Informed Consent with Immigrant Communities

The principle of the respect for persons is of paramount importance in human subjects protections. Respect for persons involves two critical considerations. First, the respect for autonomy requires that each research subject or patient be capable of deliberation about their personal choices and be treated with respect for the right to self-determination. The second consideration is the protection of persons with impaired or diminished autonomy, which requires that those who are dependent or vulnerable be afforded security against harm or abuse.

The respect for persons is upheld in human subjects protections through informed consent. Informed consent requires an assessment of two key preconditions: competence and voluntariness. Competence requires that the individual subject or patient is psychologically, cognitively, and legally capable of adequate decision-making. Voluntariness is an assessment of substantial autonomous choice in the person's decision-making to consent or not to consent. It requires that all individual persons have adequate knowledge about an intervention or procedure and are free from controlling influences such as coercive force or undue persuasion in their decision-making.

In obtaining informed consent, a researcher or doctor must carry out these elements of consent: disclosure (complete and accurate information about the research or medical procedure), comprehension or also termed "understanding" (a complete and realistic comprehension of the procedure or research intervention being proposed), the voluntary decision (the substantial, autonomous decision to consent or not to consent to a medical procedure or research intervention), and consent (the actual authoritative act of consent, signing a written form or providing oral consent).

In obtaining advice about informed consent with immigrant communities, researchers in several recent case studies have recommended that beneficent approaches to informed consent be allowed. These researchers are advocating more of an ethics of care than just a standardized, rationalistic approach to obtaining informed consent from individuals. In the ethics of care, advocates of this ethical framework are concerned about the need to build relationships, to have empathy and compassion with patients and research subjects and not just value neutral approaches to individual autonomy (using a standardized consent form in an impersonal approach to the subject). Such advocates will be respectful of immigrant cultural traditions that may require the need to share individual decisions as a family. Such empathy does not mean that the individual's consent will not be obtained but that researchers will strive to accommodate special needs around gaining that consent with care. It may mean allowing the family to make the decision with the individual if that has been a longtime tradition, yet the individual will still sign the form. If individuals and their families fear official forms, there are forms of oral consent that are acceptable to IRBs.

Practitioners may need to be aware of cultural attitudes about communicating health or environmental adversities. Different uses of language and the meanings of words, such as illness or harm to the body require a culturally based understanding. Cultural competence training (gaining cultural skill, knowledge, and humility) can help practitioners be more sensitive to these cultural needs. Researchers may need to be familiar with the spiritual beliefs of different cultures in preparing for the consent process – the symbolic meanings of physical and environmental harms and adversities. Many academic and medical practitioners prefer to avoid spiritual beliefs but this may deeply offend some immigrant communities. It is better to work with cultural liaisons than to ignore these needs.

Nonetheless, the approach to obtaining informed consent still must be adequate. Research violations occur when informed consents are found to be inadequate and researchers did not assess preconditions for competence and voluntariness and follow all the rules of disclosure, comprehension, decision, and consent. In conducting research with some elderly immigrants or new immigrants, be aware that researchers and doctors are intimidating agents to them. They may quickly agree to participate out of a fear of authority or retribution. Some immigrants are very fearful of government officials or those with a sense of authority. It is essential that researchers realize that they cannot secure this consent without allowing the subject, free, autonomous, and noncontrolling voluntary choice. Efforts at persuasion, manipulation, or coercion violate the standards for obtaining consent and these controlling factors are easily used with some immigrant communities.

Researchers must make every effort to fully disclose their interventions to immigrant groups who may need special help in understanding procedures for themselves or for an intervention for the community as a whole. Ethicists recommend that researchers realize what pictures are in the mind of participants as they confirm that they understand a research procedure. Make sure that the pictures are appropriate. Time must be spent with adequate understanding for the intervention. Comprehension is a rule that requires some literacy and training for research subjects on complex topics. Translators, visual graphics, and videos are common now for informed consent preparation. Immigrant communities may be helped by community advisory boards or cultural liaisons (community health/other workers) as community staff/advisors can help other community members understand interventions that are for individuals or the whole community.

Justice Needs with Immigrant Communities

The principle of justice within human subjects protections requires a fair distribution of benefits and burdens from research. These protections explicitly require fair selection and recruitment of subjects for research and an assurance that vulnerable subjects are not used for exploitation. The justice principle will require that those who have power and resources do not benefit from interventions where the less powerful are burdened by such interventions. With immigrant communities, researchers often need to do more to ensure fair subject recruitment and selection. Often researchers may not have adequate demographic information about the places where they are selecting subjects and will not have a representative group from their research recruitment process. Immigrant communities require special outreach mechanisms. Often, many do not have access to clinical trials or other research projects because of hardships such a lack of health care coverage which prevents them from using clinic services or having local physicians. There are articles written about low disease screening of immigrant groups. Some groups fear racist attitudes, intimidation, and discriminatory practices. Evidence of these negative practices by researchers and physicians do exist. Many individuals need translators for their health care. Some have no transportation, day care, or special support to seek health services.

Again, community-based outreach and research projects have had some success with these barriers. In some reports, researchers recommend the need to conduct research efforts with the partnership of a church, an immigrant center, or other social support group. Culturally based activities are used to recruit immigrant residents to research-related recruitment or engagement activities. Much new training is being undertaken to provide a cadre of community health workers who are local community members, known to many other immigrant community members. They are able to enter their homes and assist immigrants with much-needed support services.

One last rule of justice is the need to ensure that benefits are provided to economically disadvantaged groups in a research activity that also stands to benefit researchers and other well-off social groups. Too many researchers have conducted research in low-income, disadvantaged communities, burdening the local people and not providing any benefits back to these communities and not reporting results back to them.

The recent reports from community-based research provide many innovative forms of research benefits that researchers can consider for their projects.

Related Topics

- ► Community-based participatory research
- ► Council for International Organizations of Medical Sciences
- ► Cross-cultural health
- ► Ethical issues in research with immigrants and refugees
- ► Helsinki Declarations
- ► Methodological issues in immigrant health research
- ► Nuremberg Code

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Resilience

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In the social sciences, resilience is commonly used to describe a person or community's ability to withstand and rebound from adversity. Resilience is a complex idea, and so when people measure it, they tend to measure factors that describe the adversity in question (abuse, violence, war, torture, migration, etc.), and then to use markers that describe success. For example, much of the early research on resilience focused on academic achievement in school children, and what the differences were that allowed some young people who had faced significant challenges to do well in school, while other young people that had similar experiences struggled in school. Research on resilience in adults often focuses on mental health status after difficult events, and measures things like depression, posttraumatic stress disorder (PTSD), and other mental health concerns.

Many studies on resilience tend to focus on which factors grouped together among those people that were successful by the markers of the society they lived in – for example, they achieved in school, went to or completed college, did not use drugs or participate in the street economy, did not get pregnant if they were teenage girls, etc. Then, researchers have measured factors which are risks for being less successful by societal standards – these things have tended to be factors like living in poverty, having an incarcerated parent, having a parent not in the home, or not being connected to extended family.

Additional research on resilience is about persons that have been through particular sorts of difficult events – torture, physical or sexual abuse, war, or other forms of violence. Researchers that study these events look for which persons survived them and continued on with life in a way that is approved by the society in which they live.

This same framework is often used to study resilience in immigrants. Immigration is often a tremendously difficult experience, and immigrants may experience adversity in their countries of origin that provokes immigration such as violence, abuse, persecution, and war, difficulty during the actual process of immigration such as difficulty crossing borders or attaining documentation for legal immigration, and difficulty adjusting to the new culture where they live – both the culture of the immigrant community where they reside if there is one, and adjustment to the new country where they live – language, customs, expectations, services, government, policing, and general cultural expectations. Often, these adversities are interlocking and multilayered, so researchers look for the individual and community characteristics that allow immigrants and their children to adjust and thrive in the new society where they live.

Studies that have looked at resilience among refugees and asylum seekers have looked at the impact that traumatic events in parents have in the lives of their children. A study of refugees in Sweden looked at those who had survived torture in Iraq versus refugees from other parts of the world who had not experienced torture. The children of the torture survivors were more successful in adjusting to Swedish life when they had good emotional expression, supportive family relations, good peer relations, and more outgoing behaviors. Other studies in different immigrant groups have had similar results – those children that have supportive parents, are more connected to communities, are more outgoing, and feel comfortable asking for help when they need it and are also independent thinkers tend to weather the multigenerational trauma from their parents as well as the stress of migration more easily. The difficulty with these studies is that children that had more support at home may generally be from more economically and culturally resourced backgrounds, and thus had more concrete tools, as well as psychological tools, to help them adjust to life in a new place.

Scholastic achievement in general has also been studied in the children of immigrants. Immigrant youth face multiple challenges in school. They may face difficulties in language access, social interaction, poor treatment from peers and school authorities, and difficulty in negotiating school policies in a new country. Coming from a home where the primary language was something different than the language spoken in school has been described as a risk factor in many different studies on resilience, but children from immigrant families that have been described as resilient consistently achieve in school. Personal characteristics of young people that emerged across studies that predicted greater resilience and success academically are having a sense of purpose and a future, good social skills, personal autonomy, good problem solving skills, and a personal belief in their own academic skills. Parental qualities that help children of immigrants be successful are having parents in the household, having parents that are invested in their children being successful in school, having parents involved in community or school activities, and having parental approval for success in school. These issues become difficult when parents of immigrant children may speak a different language from the one spoken at school, or may have job commitments that do not permit them the level of involvement with their children's schooling that they might like. Immigrant children may live separately from their parents, and so supportive family networks, which also help to increase resilience, become even more critical for those young people. For those children from racial or ethnic minority backgrounds, having ethnic pride relates strongly to success in school, and to the capability to withstand a racist society. Additionally, the immigrant children's skill at acculturation, or understanding the values and norms of the culture in which they live are also related to success in school.

Supportive communities also emerged as a factor that encouraged student success. If young people could access activities, mentorship, and support from other people in the community they tended to be more successful in school. The environmental risk of racism was also a significant factor in evaluating the potential for student success. Community-based resilience is one of the emerging topics in research on resilience in general, and in immigrants in particular. Research on this topic looks at resilience from an ecological or community-based model, in order to try and capture the context that produces successful children. This angle at research on resilience in immigrants looks to examine factors that are beyond the individual in order to help build success.

Research about resilience in immigrant adults focuses on the process of acculturation, mental health status after migration, and the stresses of both immigration and acculturation. Successful acculturation is a mark of resilience, because it means that the person in question has fully adjusted to the new society, and is able to earn a living, negotiate state and government systems, and live successfully in the new country. Additionally, markers of mental health like depression and posttraumatic stress disorder (PTSD) are used to study resilience because these conditions are unusually high in immigrant populations. This may be due to the stressful nature of migration; groups that become immigrants tend to do so because of unacceptable conditions in their home country due to economic opportunity, war, and other stressors. Additionally, immigrant families often have fewer resources available to them, less money for which to avail themselves of resources, mistrust of resources that are available, and sometimes a lack of awareness of the resources that are available. Research on these topics tends to show that some of the same factors that help children to succeed in school are the same things that help adults to succeed with acculturation and to treat mental health problems – strong relationships with family, a large network of community members, a community to which they belong (including both religious and secular communities), a personal notion that they can overcome adversity, an ability to ask for help when they need it, a strong community where they resettled, and ethnic pride all seemed to support acculturation. In addition, language fluency in the new language, income, and the ability to do the same work as they were doing in their home country have been found to be associated with lower rates of depression and other mental health concerns. Mental health concerns are explained in many different ways internationally by different immigrant groups, so different groups have different strategies for coping. Immigrants from nations where psychological counseling is not a part of society, or is stigmatized within it, may be less likely to seek out therapy as a method of coping with immigration-related stress. However, they may seek out traditional healers, community leaders, religious resources, and utilize other strategies to deal with their own mental health concerns. Additionally, they may frame these concerns as a normal extended mourning resulting from forced migration and other forms of trauma.

These alternate readings of their own situations begin to call into question some of the historical ways that people have researched resilience. Some researchers are beginning to respond to that alternate understanding by conducting resilience research in a different way. These researchers question the notion that success, as defined by mainstream values in the new society, is or should be a goal of new cultural groups. This sort of research asks people in those groups how they frame resilience, and often manages to reframe previously stigmatized activities, such as gang membership, as resilient behavior – the notion that belonging to a gang may provide some degree of safety, security, and survival in the new society that was not felt before joining. Mental health may be framed differently in nations where immigrants are coming from and where they are going to, and so the notion of resilience becomes more complicated when notions of what "health" is are different. In addition, the focus on mental health has left a hole wherein resilience might be studied as it relates to physical health. As models of community health are developed, the physical health of persons in resilient communities is a potential topic for research and discovery – currently, not much is known.

Related Topics

- ► Child
- ► Culture shock
- ► Education
- ► Health status
- ► Social integration

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Respeto

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Among Hispanics, *respeto* (respect) refers to a way of relating to others that acknowledges differences in social status. These differences include age, gender, socioeconomic class, and occupation. While *respeto* often entails deferential treatment toward a higher status person, as a cultural ideal in Hispanic communities, *respeto* is a necessary quality of many social encounters. Therefore, while *respeto* may require that a lower status person defer to the actions and wishes of a higher status person, *respeto* compels people to behave in ways that protect the dignity of participants in an interaction, regardless of their social position. Given this, politeness and discretion are important ways to express *respeto* in social interactions.

Traditional Hispanic cultural expectations dictate that women defer to men, youth to elders, employees to employers, and children to parents. Between individuals of equal status, *respeto* may be expected in first-time meetings or in acquaintanceships where intimacy or comfort has not been established. Appropriate displays of *respeto* may include using polite titles or greetings, avoiding eye contact, and withholding questions that may be perceived as a challenge to a person's authority. Failure to use formal *usted* (you) when speaking to an authority figure in Spanish may be taken as a face-threatening act.

In healthcare contexts, knowledge about the unspoken rules of *respeto* is important for a culturally competent approach to work with Hispanic patients. The power differences inherent in the patient–provider relationship lead Hispanic patients to assume a submissive role as a way to show *respeto.* For example, Hispanics may view questioning a doctor as disrespectful. Providers could misconstrue silent nodding as a show of understanding or agreement when in fact it could indicate the Hispanic patient's lack of understanding or reluctance to show disagreement. Hispanic patients may not admit deviations from treatment plans, such as taking medication irregularly, for fear of offending a provider. Where a Hispanic patient may view formality as polite, a provider unfamiliar with the concept of *respeto* may read formality as impersonal or a patient's way to maintain a distance.

Even as a Hispanic patient is deferential to a provider during a healthcare encounter, a provider's respect is expected. Greater formality, such as in the use of polite terms of address, is an appropriate way for younger providers to show *respeto* to older Hispanic patients. In demonstrating *respeto* to parents, pediatric providers should be mindful to not undermine parental authority in their interactions with a child patient. Such missteps could lead to patient dissatisfaction with care, treatment under adherence, or termination of medical care.

While behavioral norms and attitudes associated with *respeto* apply generally to Hispanics, it should not be assumed to apply uniformly and to the same extent within different Hispanic subgroups. Hispanic subgroups can differ in the importance placed on proper displays of *respeto* or deference to high status individuals. Hispanic immigrants from countries with less hierarchical power structures and greater levels of equality, such as Costa Rica, will differ in the importance placed on status differences when compared to Hispanic immigrants from countries where the opposite is true, such as Mexico. Overall, it is important to keep in mind that the value attached to *respeto* and how it is defined can change across immigrant generations, with exposure to new norms, or as a result of assimilation.

Related Topics

- ► Confianza
- ► Cultural competence
- ► Hispanics
- ► Physician–patient communication

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Reverse Migration

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In current patterns of international migration, an often-overlooked dynamic is the practice of a sizable number of people who sooner or later return to their respective countries of origin. This was one of the observations made about earlier waves of migration by Michael J. Piore in his book *Birds of Passage*. Less attention is given to practices of reverse migration, that is, on those returning home. Most data collected in the USA focuses on the sheer numbers of people who enter a country as immigrants, their national origins, and their patterns of settlement. But immigrants rarely follow stable patterns of settlement. Many move to other regions of a country (secondary migration) as employment, housing, education, and better opportunities for advancement dictate. Refugees may be sponsored and settled in a particular city, but later decide to relocate closer to co-ethnic social networks. Little attention is paid to immigrants who actually return home, either temporarily, as is common for transmigrants engaged in a pattern of circular movement, or on a more permanent basis.

Various factors come into play in influencing the behavior of immigrants who choose to return home. In cases of voluntary migration, it is often assumed that economic conditions are the dominant influence in the overall calculus of choice. Beginning in 2008, the impact of the “great recession” in the USA has indeed caused some immigrants to return home. Labor migrants such as those in construction or manufacturing, like their native counterparts, are in sectors of the economy highly vulnerable to recessionary effects. Research on communities that have historically been recipients of large numbers of labor migrants from Mexico have documented a considerable downturn in new arrivals, and some evidence of people leaving. For example, interviews with educators and human service professionals in Indiana (US Midwest) communities most severely affected by the demise of manufacturing, reveals that some families have returned to Mexico, and families who have stayed are trying to cope with the emotional and financial stress of less employment and reduced incomes.

However, the impact of economic conditions on migrants’ decisions to leave or stay may be overestimated. Immigration policy in the USA is primarily based on family unification, and secondly on government determinations of labor market needs, primarily in occupations that require certain high levels of specialization and education, such as software engineers, physicians, nurses, and other technical fields. These types of professions may be less vulnerable to downturns in the economy.

The other major factor in reverse migration is when geopolitical events precipitate changes to policy and the forceful deportation immigrants. For example, in 1992, after the first Gulf War, Jordanians working in the oil-rich countries of Saudi Arabia, Kuwait, and UAE had their work permits revoked and were forced to return home. Jordan's support for the Iraqi regime which had invaded Kuwait angered many of Kuwait's allies, prompting those countries to expel Jordanian expat workers.

Other forms of forced reverse migration are when domestic politics shapes the way existing immigration policy is enforced. Mexican migrants in the USA have recently faced greater threats of deportation as ICE (Immigration Customs and Enforcement) officials have targeted raids on workplaces (meatpacking plants, food processing) known to hire undocumented persons. An economic slowdown in Spain also led to renewals of fewer work permits for immigrants who had been drawn there by labor needs in its previously booming economy.

Whether forced or voluntary, all types of reverse migration have social, economic, and psychosocial consequences for individuals and families. Because of their sudden nature, deportations frequently cause family dislocation and trauma, as parents or guardians are arrested and deported, or detained in facilities far away from relatives and children, their whereabouts unknown. All migration affects families in some substantial way. Each of the conditions and contexts of reverse migration may affect families in different ways, but it will have some kind of substantial impact. Children are the most vulnerable, since they may be going to cultures and countries for which they have very little cultural affinity, albeit considered "home" to their parents. Having grown up in one society in which they consider home, reverse migration may bring them to a society where they have very little language ability or cultural competency. Likewise, the return migrants bring their own cultural influences in the form of new ideas and values back to home communities, what Peggy Levitt terms "cultural remittances."

Another impact of reverse migration is the economic impact of a migrant's return to their home country. For many years, research suggested that return migrants brought back few real substantial new skills to support economic and social development. This was because the skills acquired by immigrants were not necessarily significant or relevant to home communities. For example, a physician from Mexico who migrates to the USA to do agricultural labor brings very little back to his/her home community in the form of new skills. Or a recent graduate from university who migrates to do factory work likewise returns without any significant human capital investment that will affect economic development.

The impact of investment capital is another matter. Recent research from the Mexican Migration Project has documented that many migrants return home with substantial savings that is invested in new business start or community infrastructure. Similar patterns are emerging around the world, as in India, where reverse migration is playing a significant role in new investment and entrepreneurial initiatives.

Related Topics

- ► First generation immigrants
- ► Guest worker
- ► Labor migration
- ► Transnational community

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Risk Factors for Disease

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A risk factor is something that increases your chances of getting a disease. The factors can be environmental, behavioral, or biologic in nature. If these factors are present, it increases the probability of a disease occurring. In research terminology, risk factors are exposures that are statistically related in some way to an outcome. Biologic risk factors are hereditary and genetic features such as age, race, or gender. These factors cannot be altered. Behavioral risk factors include smoking, overeating, and lack of exercise, among others. These factors can be modified to some extent to prevent a disease from occurring.

Environmental risk factors include air and water pollution and poor sanitation. The World Health Organization (WHO) reports that many diseases could be prevented through better management of the environment. Studies by WHO have examined the impact of environmental risks on diseases and injuries. It has been estimated that one quarter of the world's diseases and injuries can be attributed to environmental causes. The environmental disease burden is greater in developing countries. Immigrants may therefore develop diseases not commonly seen in their new home country due to exposures to the risk factors in their country of origin. Immigrants also tend to take jobs that are unattractive to the local work force. Many of the available jobs in mining, manufacturing, and agriculture have poor environmental conditions and lack proper safety equipment. For example, the number of industrial accidents in France and Germany is much higher among migrants than citizens and 30% of all accidents resulting in permanent disabilities involve nonnationals. In the agricultural sector, unprotected exposure to pesticides in migrant workers in Spain has been linked to higher rates of depression, neurologic disorders, and miscarriages.

The U.S. Centers for Disease Control and Prevention (CDC) describe chronic illnesses as common and costly health problems. These illnesses are responsible for approximately 70% of the deaths in the United States and one trillion dollars in health care costs annually. Approximately half of all Americans live with at least one chronic illness such as heart disease, diabetes, cancer, obesity, and arthritis. These diseases affect people's activity, work, and quality of life. Although chronic diseases are common, many are also preventable to some degree by controlling the risk factors for the disease.

Heart disease is a leading cause of death in the United States. Many studies have identified specific factors that increase the risk of developing heart disease. Some of these risk factors can be controlled while others cannot. Risk factors that cannot be changed include advancing age, race, gender, and heredity. Some risk factors can be treated or controlled by changing one's lifestyle or taking medications. Risk factors that can be modified include smoking, high blood pressure, cholesterol intake, obesity, sedentary lifestyle, and diabetes mellitus. High blood pressure, cholesterol levels, and diabetes mellitus can be controlled with medications. Regular exercise, weight loss, and a diet low in animal fats and high in fruits and vegetables may lower cholesterol levels. Smoking cessation is essential for lowering the risk of heart disease as cigarette smokers have two to four times the risk of developing heart disease as nonsmokers. Immigrants to the United States that adopt the American sedentary lifestyle and fatty diet are at greater risk of heart disease.

Many believe there is a strong relationship between socioeconomic status and risk factors for chronic disease. Socioeconomic status includes education, income, and occupation. Although all these factors are important predictors of disease, the strongest socioeconomic risk factor appears to be education. Education develops positive social and psychological skills which influence health care choices. Therefore, education may be key to the prevention of chronic illness through the control of risk factors in immigrant populations.

Related Topics

- ► Built environment
- ► Cancer health disparities
- ► Cardiovascular disease
- ► Chronic disease
- ► Health determinants
- ► Racial disparities

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Risk Perception

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"Risk" is a term used to define a situation that might have an undesirable outcome and that we would likely prefer to avoid. The same term can be associated with others like: peril, threat, harm, injury, jeopardy, and unsafe. We can talk about financial risks, health risks, and life threatening risks. In order to quantify "the risk" we confer *levels* such as minimal risk or increased risk to describe the intensity of the real danger someone is, or might be in. A risk can be described as being foreseeable or unforeseeable, avoidable or imminent; it can be minimized or uncontrolled due to various unpredictable factors. It also can be exacerbated by the concurrence of other threatening factors.

Risk perception differs with age, culture, state of mind, awareness, consciousness, culture, and many other variable elements that can be involved in making individual level assessments of a situation. In general, people will perceive a risk and take measures to avoid increasing its level. We can speak about social risk judged within the context of personal, individual, or communities' achieved values. Natural instincts lead us to develop strategies to avoid exposure to risks; Darwin's principle of "survival of the fittest" offers a good explanation of this ability.

Avoidance of risks can be studied at individual, community, or worldwide levels because not only do individuals take measures to protect themselves, but also communities acting like unitary groups. The fact that risks are everywhere is more or less acknowledged. We can describe them as everyday risks, minimal risks, or extremely high risks. Differences, in determining what is a risk and its level, are evident between individuals and cultures. What can be seen as being extremely harmful for one person or society can be acceptable or not even be considered a threat to another. Research participation may be seen as more risky to healthy persons than a sick patient, who thinks he/she has nothing to lose.

Appropriate risk perception prevents avoidable exposure to the harmful situation. It may also save the life of individuals. For instance, drug use is frequently cited when discussing factors that diminish or increase risk perception. Studies of the degree of influence have shown that among nonusers of marijuana, perception of risk of drug-related consequences was greater than for those who reported marijuana use and, in turn, were more likely to have actually experienced a drug-related consequence. Among marijuana users, risk perception was not influenced by the frequency of marijuana use nor by the actual experience of a drug-related consequence. Individuals who drink alcohol also seem unable to assess risk in appropriate ways. Agostinelli and Miller report that abstainers or light drinkers were more likely to perceive that daily heavy drinking would put a person at higher risk for health problems or accidental injury than did heavy drinkers. They suggest that the distinction in risk perception results from either self-protective motives that are aroused when potentially harmful or damaging self-information is apparent, or self-enhancing motives that are aroused when desirable self-information is available. Thus, it is likely that one minimizes perceived risk as one is exposed to or experiences the negative consequences of alcohol use. Another study showed that smokers are more likely to try to quit if they are confronted with serious health issues than smokers who are apparently healthy. Smokers who are depressed also seem more aware of the dangers they expose themselves to by smoking.

In addition to the everyday risks discussed above, guidelines have been developed which require research projects to assess the risks to which study subjects may be exposed and under which situations. Designing appropriate informed consent processes presupposes the need to offer research participants information in steps adapted to their ability to understand the information, allow enough time for them to evaluate their risk of participation, and make an informed decision. The existence of Institutional Review Boards, Ethics Committees and human subjects' protection guidelines is reinforced worldwide. The creation of such oversight bodies highlights the important aim of preventing human exploitation and exposure to unforeseeable, unavoidable, imminent, and uncontrollable risks. These bodies and guidelines specifically focus on vulnerable groups' exposure to risk as the ways members of a vulnerable population perceive foreseeable risks might differ. For instance, mentally impaired individuals such as those with paranoid schizophrenia may perceive everything as being dangerous to them while children, due to their lack of experience might be unaware of the danger they are exposed to; hence the need for special protection of these groups. For immigrants coming from different parts of the world, harsh living situations may have exposed them to illnesses without their awareness or due to a lack of education and information on how to protect themselves from the risk of disease. Therefore, not only is risk assessment important but also the management of risk; the development of strategies to avoid risk exposure and methods to address misinformation and misperceptions about the risks are necessary.

Related Topics

► Research ethics
► Risk factors for disease
► Vulnerable populations

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Risk Reduction

► Health promotion

Rodino, Peter

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Congressman Peter W. Rodino, Jr., (1909–2005), who famously presided over the Watergate hearings, helped to shape immigration policy during his 40 year tenure in the House of Representatives. Born and raised in Newark, New Jersey, Congressman Rodino represented the state's Tenth District and, for a number of years, chaired the House of Representatives' Committee on the Judiciary. Before entering Congress, he served in the US Army. After retiring from Congress, Congressman Rodino taught at Seton Hall University School of Law until several months before his death in 2005.

Congressman Rodino held the Preamble to the US Constitution in the highest esteem, regarding it as providing a set of guiding principles. He labored to weave the Preamble's goals into the legislation he proposed. A shining example of his Preamble-centric philosophy came during the hearings on the Social Security Act of 1965, which provided for Medicaid and Medicare. In a statement in support of the legislation, Congressman Rodino expressed his belief that the bill should not be seen as "a radical proposal," but rather as "simply just the next step in providing services and finances to select groups of those who are in need."

This same philosophy carried over to his work on immigration reform. Congressman Rodino had a unique, personal experience, as his father and stepmother – the Congressman's mother passed away in 1913 – were both Italian immigrants, an upbringing that undoubtedly gave him a rich perspective on and empathy for the challenges immigrants faced. His work in the area of immigration policy is varied and great, but several examples are especially noteworthy. For instance, Congressman Rodino believed that the national quota system, which had been in place since the Immigration Act of 1924, fostered discrimination and did not appropriately embody the welcoming message intended by the Founding Fathers in the Preamble. From his first session in Congress, he repeatedly introduced legislation aimed at ending the national origin quota system.

Progress finally came in 1965 on the heels of the Civil Right Act of 1964. Congressman Rodino drafted a provision of the Immigration Act of 1965 that read, in language mirroring that of the Civil Rights Act, “no person shall receive any preference or priority or be discriminated against in the issuance of an immigrant visa because of his race, sex, nationality, place of birth, or place of residence. . .” (Rodino Jr 1990, p. 693 (quoting § 2 of act)). The act effectively ended the national quota system and recognized immigrants for the “dignity of the individual,” regardless of their country of origin.

Additionally, Congressman Rodino worked hard to ensure that the same principles and ideals were reflected in the Immigration Reform and Control Act of 1986 and that the pattern of discrimination pervasive during the first half of the twentieth century did not reappear.

Throughout his congressional career, relying on the language of the Preamble as his guide, Congressman Rodino fought for immigration reform and to improve quality of life for immigrants. The spirit of his initiatives inspired and informed the inclusion of immigrants within the ambit of essential services including access to quality health care.

Related Topics

- ► Health policy
- ► Immigration status
- ► Immigration Act of 1924 (U.S.)
- ► Immigration and Nationality Act Amendments of 1965 (U.S.)
- ► Immigration Reform and Control Act of 1986 (U.S.)

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Roma

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Roma, or Romani people (often referred to as “Gypsies,” a term considered to be pejorative), are considered European, but originate from the northern part of India. They migrated out of India approximately 1,000 years ago and first settled in the Balkans (Southeastern Europe), then moved to the Carpathians (Central and Eastern Europe), and from there to Greece, Finland, Russia, and into Western Europe (Spain, Portugal, France, Germany, and the United Kingdom). Now, Roma live throughout all of Europe, in Canada and the United States. In Europe alone, there are 10–12 million Roma, with the largest populations in Romania and Bulgaria; Canada reports an estimated 80,000 Roma as of 2008; and approximately one million Roma reside in the United States. It is important to note that these numbers are estimates: there is no official count of Roma anywhere they reside because Roma do not record births or deaths, they are undercounted in national census, they often do not identify themselves as Roma due to their long history of persecution, and there is no “Roma” category identified in most census counts.

Roma were traditionally nomadic, but they adopted a more sedentary lifestyle during the fourteenth century and up through the 1850s in the area of Moldavia and Walachia (now Romania) where they were enslaved. Roma have experienced waves of migration to different parts of Europe due primarily to political and economic upheavals, and armed conflicts and wars in their host countries. One of the latest waves of migration for the Romani people occurred in the 1990s when the former Yugoslavia was engaged in a regional war. Prior to the beginning of the war, Albanians living in Serbia, which was part of the Yugoslav Republic of Croatia, began a secession movement and this event turned out to be one of the precursors of this war. Roma, who lived in various parts of Yugoslavia, but also in the Albanian areas of Serbia, ended up fleeing in large numbers in fear of persecution and genocide by the Serbs who considered them allies of their Albanian enemies. In the aftermath of the war, the migration of Roma continued as the entire region experienced fundamental changes from government-run economic systems to market-based economies. Roma, who live in extreme poverty throughout Europe, had made some social and financial gains under the former communist and socialist governments of Europe. However, the new market-based economies, in conjunction with the systemic discrimination Roma commonly experience, lead to severe socioeconomic declines for Roma. After the end of the conflict in the former Yugoslavia, Roma experienced 80–100% unemployment.

Roma are not ethnically or religiously homogeneous, but are made up of distinct groups who often assume the nationality and religion of their host country. The Romani language has been influenced by Greek, Arabic, Slavic and Sanskrit, and the language and dialects vary from group to group.

Roma have very distinct cultural norms, especially from those of Western societies. Large extended families are the core of their social organization and family devotion is extremely important. Both men and women marry young; the average age for men is 18, and for women it is 15.5. Most marriages are arranged within the Roma community, although young Roma are beginning to marry outside of their ethnic communities. Family customs call for young mothers to defer to their mothers-in-law in regards to child rearing and any health care–related decisions. Much of Romas' social behavior has been traditionally restricted by "purity laws," although these rules are becoming more lax in younger generations. Purity laws regulate many behaviors including how certain body parts are treated. For example, the lower body, especially the genitals, is considered impure and clothes worn on the lower body must be washed separately from other clothing. The Roma believe that good health is the equivalent of good luck and that weight is a reflection of both. Therefore, the more a person weighs the healthier and luckier he or she is. Some Roma have very strong objections to immunizations and prefer to place their faith in traditional medicine and healing rituals. Roma are not convinced that bacteria and viruses cause certain diseases, but instead attribute disease and illness to impurities and dirty places.

Roma have suffered from extreme forms of discrimination and persecution throughout their history and they have been, and continue to be, one of the most misunderstood and mistreated groups of people. They are commonly referred to as Gypsies, which they consider to be offensive and derogatory. The word "gypsy" is often associated with swindling or theft. During World War II, the Nazis judged Roma as racially inferior and historians estimate that 25% of all European Roma were killed by the Nazi regime. It was not until 1979 that the Federal Republic of Germany recognized that Roma were persecuted based on race during the Holocaust. Examples of racism against Roma still exist today. There are numerous news accounts coming out of Europe citing examples of Roma as victims of racially motivated violence, with few perpetrators of that violence being prosecuted due in great part to prejudice against Roma which often permeates the law enforcement and legal systems. In fact, police abuses of Roma are well documented. Roma are also overrepresented in various poverty crimes, especially theft, and are more likely to receive harsher sentencing than non-Roma who are convicted of the same crimes. This pervasive discrimination can be attributed in great part to the negative perceptions about Roma, their culture, values, and traditions. Roma are socially, politically, and economically excluded from mainstream society and therefore unable to fully participate in it. In 2008, Amnesty International expressed alarming concerns about the treatment of Roma in Italy. Italy is home to 170,000 Roma, half of whom are also Italian citizens. At the time of the Amnesty International report, Italian authorities and media had begun making anti-Roma statements in public, using anti-Roma rhetoric in political campaigns, and some elected officials proposed that during the next Italian census, all Roma individuals, including children, should be fingerprinted for security purposes. Mayors of various Italian cities had also signed Security Pacts, with the aim of addressing security threats, including those reportedly posed by the presence of Roma communities. The Security Pacts proposed to unlawfully force the evictions of Romani communities and specifically designated four Romani camps outside of the city of Rome. Furthermore, these communities would be under surveillance by up to 100 law enforcement officials. Forced evictions of a number of Roma communities had already taken place without prior notice to the Romani people living there. These evictions also included the complete destruction of their settlements. No housing alternative had been planned nor was offered to those evicted. Similar events also occurred in the cities of Milan and Turin. The Amnesty International report cited aggressive and stigmatizing rhetoric against Roma by politicians and the media, creating an atmosphere in which vigilante style attacks against Romani settlements were becoming increasingly frequent and tolerated.

In Kosovo, Roma communities are described as shanty towns with faulty electrical systems, inadequate sewage facilities, and very scarce water availability. Homes are constructed out of any available materials such as wood boards, metal and plastic sheeting, and cardboard. Residents often search through garbage for food and reusable items. The living conditions of Roma are similar in much of Europe. Their socioeconomic situation is often dire and rates of illiteracy range from 26% to 40%. A 2005 survey of Roma in Albania, Bosnia and Herzegovina, Bulgaria, Croatia, Hungary, Macedonia, Romania, Serbia and Montenegro, Slovakia, and Kosovo showed that only two out of ten Roma had completed primary education. School enrollment for Roma children averages less than 80% and for 15-year-olds, the enrollment level drops to 40% – even though surveys show that Roma, especially Roma mothers, agree that school attendance for children is very important.

Rates of unemployment for Roma are very high, some places reporting at 100%. For those who are employed, 80% work in informal employment sectors (also known as underground or black market jobs). This is due primarily to Romas' low job skill levels, low literacy levels, and pervasive discrimination. They have little or no advantages when it comes to competing for jobs. Even among Roma with higher education and literacy levels, the rate of unemployment falls much more slowly compared to the non-Roma population wherever they live. This may also suggest, at least in part, why Roma remain in school for less time than young people from surrounding non-Roma populations. Since the gains from education are more limited for Roma, the incentives to remain in school are clearly less.

The poor living conditions of Roma have a profound effect on their health status, yet there is a lack of information regarding their specific health issues. Their cultural norms regarding health create additional barriers to improved health outcomes. For example, many Roma prefer to adhere to traditional health remedies that include the use of healers, magic, prayer, or herbal remedies for illnesses. They often delay seeking medical help until all other methods fail. Roma refuse immunizations because they believe that this will cause sterilization of their children. There is a general mistrust of the medical community, with Roma often believing that health care workers want to harm them. On the part of health care providers, there are many instances reported by both medical personnel and Roma individuals of doctors turning down requests by Roma patients for medical services. Doctors, nurses, and others have claimed that Roma are "difficult" to deal with, they are not able to communicate effectively about their health and treatment, and their customs and practices bring a "negative" element to the medical facilities they visit. For example, Romas' traditional extended family structure often means that when a Roma individual visits a doctor or has a medical procedure, he or she often arrives with many members of his or her extended family. This type of behavior is often in direct conflict with the ways medical services are generally organized and offered, which tend to be geared toward privacy, rules for patient visits, and a general desire for quiet in hospitals and other medical facilities.

Extreme poverty, lack of information regarding health issues in general, and discrimination encountered by Roma combine to bring about some of the worst health outcomes of any group of people. Access to preventive and curative health care services is very low. Roma often live on the outskirts of town far from medical facilities with few or no transportation options. Medical personnel admit that they do not like to go into Roma communities, citing security concerns and a general dislike for Roma people. Among the scarce information that has been published on specific health issues of Roma, indications are that they tend to have high rates of diabetes, high cholesterol, coronary artery disease, obesity, and respiratory diseases. Obesity, and the diseases that often accompany it, are likely caused by poor nutrition coupled with the cultural belief that the more a person weighs, the more good luck he or she has. Among Roma, weight is considered a sign of affluence and good health. Compounding these health issues is the fact that the Roma are excessive smokers. Although there is very little data on smoking rates among Roma, they are known to be very heavy smokers, often beginning to smoke in early childhood. Smoking is considered part of family life and part of their ethnic identity. Where efforts to convince Roma to quit smoking or to implement smoking cessation programs have been attempted, there has been very little measurable success.

Studies of life expectancy rates among the Roma living in Bulgaria, Ireland, and the Czech Republic, show that Roma men live on average to 61 years and women to 63 years. This is 10–15 years less for each compared to non-Roma in the same countries. Rates of infant mortality are very high, averaging 72.8 per 1,000 live births of Roma living in Romania compared to 15 per 1,000 live births in Romania among the general population; it is double that of non-Roma in the Czech Republic; and in Italy, it is three times higher compared to non-Roma. There is little use of birth control, only about 10%. Mistrust of doctors and medicine, lack of knowledge about birth control, and the burden on women who are solely responsible for its use, contribute to this low rate. Where birth control usage is low, abortion rates, however, are high. A survey of Roma women in Albania found that 56% had had one abortion and 77% had had two or more. Seventeen percent of those women reported performing their own abortion. Other health issues facing Roma include widespread infectious diseases such as tuberculosis. Drug abuse and smoking, especially among Roma youth, are also significant.

There are many obstacles to better health outcomes for Roma yet the efforts to promote the health of Roma populations often do not confront the social structures that shape health in the first place: inequity and discrimination in education, employment and housing; poor access to clean water and sanitation; lack of social integration; minimal or no political participation; poor access to food; and disparities in income distribution. In most places where Roma live, there is, at best, inadequate public response to minority health issues and at worst, outright discrimination by health care providers who refuse to see or treat Roma patients. Roma often lack information about the health care reforms that affect them either by increasing their access to medical care, or restricting and/or denying it. Efforts and recommendations to turn the tide on the dismal health status of Roma wherever they reside, include: (1) involvement of Roma women in the development of policies and programs since they are responsible for many health care–related decisions in Roma families; (2) facilitation of school attendance by Roma youth not only to ensure better literacy rates, but also to take advantage of a captive audience and provide more information in schools about hygiene, nutrition, disease prevention, and access to the health system; (3) improvement of Roma housing conditions and the cessation of illegal evictions; (4) increasing access to medical services to the Roma via mobile health clinics; (5) ensuring that Roma communities are well informed of the health care services available to them; (6) utilization of health mediators between medical professionals and Roma patients to facilitate better communication and to establish trust; and (7) the inclusion of Roma in health policy development and implementation. There is a significant effort in place in Europe to help change the dire fate of the Roma called "The Decade of Roma Inclusion 2005–2015." This is a multinational effort to change the prejudicial and discriminatory attitudes against Roma people and improve their socioeconomic status and social inclusion by focusing on the improvement of several priority areas including health, housing, education, and employment. In addition, The Decade of Roma Inclusion campaign includes numerous media efforts to promote Roma culture positively and celebrate its rich heritage and history in an effort to educate the general public about Roma as a people and turn the current pervasive discriminatory attitudes toward the Romani into an appreciation for their rich culture and diversity.

Related Topics

- ► Barriers to care
- ► Cultural competence

► Discrimination
► Education
► Health beliefs
► Health care utilization
► Health disparities
► Infant mortality
► Life expectancy
► Physician–patient communication
► Poverty
► Prejudice
► Violence

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Romania

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Romania is an East European country, with a total surface of 237,500 km^2 and a population of 21,680,974 inhabitants according to the 2002 census. The capital of Romania is Bucharest. Romania is bordered by Ukraine and Republic of Moldavia to the North-East, Bulgaria to the South, Hungary to the North-West, and Serbia to the South-West.

Before 1989, Romania was under a communist regime. Ceauşescu's dictatorship isolated Romania not only politically and culturally, but also economically.

In the 1980s, the Romanian borders were strictly controlled. During the communist regime those who had the opportunity to leave the country immigrated mostly to Germany, Hungary, and Israel. The poor living conditions during communism caused the population to revolt against the regime in 1989. In December 1989, the communist regime collapsed and a democratic regime has been established and the gate to individual freedom was widely opened. The initial happiness of the Romanian population of being free, transformed rapidly into desperation, confusion, disappointment, and fear. The guaranteed jobs and the protection of the jobs disappeared and Romania was confronted with a new phenomenon that greatly differentiated between social classes. People started to experience unemployment and insecure living conditions.

Before 1989, internal migration, i.e., migration of force labor from rural to urban sites was the dominant phenomenon in Romania. After 1989, the trends changed as the internal migration decreased and external immigration in search of professional accomplishments and better living conditions increased.

The increase of international immigration is facilitated by the relaxation of the Romanian legal system regarding the free circulation of individuals across Romanian borders. After 1992, the number of legal immigrants increased continually due to the existing option of working temporary across the borders.

Figures of March 2002 showed a number of about 360,000 people as temporary immigrants from Romania. For a country of 21,680,000 people, this means a temporary emigration rate of about 17%.

After 1996, the dominant streams were those directed toward the United States and Canada. In 2003 immigration became more dispersed, with relatively equal streams going to Germany, Canada, the United States, Italy, Spain, and Hungary. The settlement of relatives in different countries facilitated migration.

In 2004 the official figure of Romanian legal immigrants in Italy, was 62,300, which made Romanians the largest immigrant nationality in this country. Romanian migration to Italy started in the early 1990s (after the fall of Ceaușescu's regime in 1989), and according to Organization for Economic Cooperation and Development (OECD, 2007) Romanian immigrants have now become the largest ethnic community in this country (48.4% of the total number of immigrants during 1990–2004 and 56.6% of the total number of immigrants in 2005). Regarding the qualifications of the Romanian immigrants, the statistics showed that of 15,000 foreign doctors working in Italy, 555 are Romanians and 25% of the foreign nurses (8,479 individuals out of 35,000) are Romanian immigrants.

In Spain, from 1998 through 2007, Romanians ranked as the second largest immigrant group (2,000 immigrants in 1998, 208,000 in 2004, and 527,000 in 2007) and become the first in 2008 (716,000 Romanian immigrants).

The main causes of migration from Romania are the increasing levels of unemployment along with the low paid jobs and high expenses of daily life. Related to age, the statistics show that 45% of the immigrants are over 35 years old, 35% are 25–35 years old, and approximately 20% are 18–25 years old. Therefore, the profile of the Romanian immigrant is male, 35 years old, married, with different levels of qualifications coming from areas with high unemployment levels and very low incomes. According to the National Employment Agency the targeted domains in the destination countries are construction, agriculture, and hotel industry. These trends suggest that migration has become a phenomenon of highly skilled and educated individuals who are trying to find professional opportunities in the field in which they were trained.

In the last years, the "brain hunting" phenomenon heavily influenced the process of immigration. The "brain hunting" is oriented to individuals between the ages of 18 and 24 years old, who graduated or are enrolled in the last years of school. In this way, graduates represent 10–12% of all the individuals that legally immigrate. Most of the jobs obtained by the Romanian immigrants are temporary.

Some of the countries, such as Germany, Great Britain, Ireland, France, Austria, Belgium, Italy, Luxemburg, Holland, and Malta are imposing restrictions related to force circulation. The immigration of Romanians to these countries is permitted due to the bilateral agreements between countries but they need to possess work permits. Spain, Portugal, Greece, and Hungary decided that Romanians do not need a work permit starting with January 1, 2009. Beginning May 1, 2009, Denmark allowed Romanians to immigrate on the same terms as other citizens of the European Union.

Related Topics

- ▶ Brain drain
- ▶ Illegal immigration
- ▶ Italy
- ▶ Labor migration

Suggested Resources

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Russia

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As the largest independent state in the former Soviet Union, Russia – or the Russian Federation, as it is properly known – is the largest country in the world, at almost 6,600,000 square miles. It has a wide range of geographical features and climates. It shares borders with almost a dozen other countries, including Norway, the Baltic States (Latvia, Estonia, and Lithuania), Belarus, Kazakhstan, China, and North Korea. Russia has enormous quantities of natural resources, including oil, natural gas, forests, and approximately a quarter of the world's fresh water. Russia's population is about 140,000,000, although it has been on the decline due to a high mortality rate, especially among males, from a variety of causes such as a high rate of alcohol abuse and tobacco use. The literacy rate in Russia is one of the best in the world, at 99.4%, and the majority of Russian citizens are urban dwellers.

The Russian Federation has struggled to transition from the centrally planned Soviet-era economy to a market economy, and the transition has only been partially successful. Particularly in the early 1990s, when price controls were abolished, many Russians were suddenly impoverished after two episodes of hyperinflation. In 1998, the Russian economy collapsed, but has rebounded substantially under President Vladimir Putin's management of oil and gas revenues in the early 2000s. Politically, Russia has reversed many of its democratic gains and is currently viewed as a semi-authoritarian regime, although without the overt repression that characterized the Soviet period. Russia was hit hard by the economic crisis that began in late 2008, but at the time of this writing, appears to be rebounding – again with oil and natural gas revenues driving the recovery.

There have been several waves of emigration from Russia. The first and main wave of emigration was from Czarist Russia in the late nineteenth and early twentieth centuries. Key destinations for émigrés were Western Europe, particularly France, the United States, and, since the 1970s, Israel. The majority of Russian immigration happened before and after the Soviet period, because in the Soviet era it was considerably difficult even to travel abroad as a private citizen. Between 1890 and 1920, approximately 2.5 million Russians immigrated to the United States, making this period by far the largest influx of Russians to the USA.

This first wave of immigration to the United States occurred in the late 1800s and in the years immediately following the 1905 and 1917 revolutions in Russia. The persecution of Russian Jews by the czarist regime, and political turmoil associated with the revolutions provided the impetus for many Russians to leave the country. Prior to the First World War, 1.6 million Russians immigrated to the United States alone. After the start of the war, and with the Russian revolution in full swing, some 921,000 Russians managed to immigrate to the United States.

In contrast to the relative ease of emigrating from Russia in the early twentieth century, the Bolsheviks' consolidation of power and their heavy-handed utilization of the newly formed security services shut the Russian borders almost completely. During the time of the Cheka – the first political police in the new Soviet state – in the 1920s, only 62,000 Russians arrived in the United States. In the time of the Cheka's successor organization, the NKVD – made infamous as the tool of Stalin's terror in the 1930s – this number dropped to only 1,400.

By the late 1970s, the plight of Russian Jews living in the Soviet Union became a political issue in the United States and a cause for Jewish organizations who wished them to be permitted to emigrate. Political pressure by the USA was brought to bear on the Brezhnev regime, which was seeking increased trade with the United States at the time, and substantial numbers of Russian Jews and non-Jewish dissidents were allowed to emigrate from the Soviet Union. While many of these immigrated to the United States, Israel was also a key destination because of the special status of Russian Jews in the eyes of the Israeli government (Israel has an "open-door" immigration policy for Jews, whatever their nationality). The choice of Israel as a destination was also due to changes in US immigration policy in the 1980s which made it more difficult for Russian Jews from the former Soviet Union to enter the United States.

In the 1990s, there was a large wave of immigration to Israel from Russia. Substantial movement of Russians to other countries occur red due to the removal of many emigration restrictions under Soviet Premier Mikhail Gorbachev in the late 1980s, and the subsequent collapse of the USSR in 1991. From 1990 to 1997, almost a million Russian Jews immigrated to Israel.

At the same time, US lawmakers passed the Immigration Reform Act of 1990, which loosened the restrictions on immigration to the USA from Russia that had been laid out in the 1980s. The new law allowed an increased number of up to 50,000 refugees from the former Soviet Union to enter the USA per year. Additionally, the US government actively sought to attract former Soviet engineers, physicists, and other scientists who were disenchanted with economic conditions in the former Soviet Union. Wage arrears and salaries that now amounted to almost nothing following several economic crises in Russia combined to make the West highly attractive to those with advanced technical and scientific know-how. The number of Russian Jews who arrived in America during the period mentioned above, 1990–1997, was approximately a quarter of a million.

The opportunity to earn higher wages, however, came at the expense of leaving the familiarity of one's homeland to start over again in a country very different from the country with which one was accustomed. A new language must be learned, and new social customs must be picked up.

The "culture shock" experienced by many immigrants to the United States is certainly not unique to Russians. To be sure, dramatic changes in surroundings can have an alienating effect on anyone. However, in the case of immigrants from the former Soviet Union, they experienced drastic changes on many levels. Economically, change from Soviet to Western culture meant a drastic difference in the availability of consumer items in a market capitalist society, as compared to what was available under the centrally planned Soviet economy. The availability of foodstuffs and consumer goods in the West was almost overwhelming to many Russians.

The difference between the political systems was also an important adjustment for Russian immigrants to make. Political ideology in the Soviet Union was a pervasive, almost ubiquitous presence in the daily lives of Soviet citizens. To some, if not most, Soviets, however, the ideology was bankrupt even before Gorbachev's policy of glasnost opened the floodgates to criticism of Marxism–Leninism. Nonetheless, the change from a closed society in an authoritarian system to an open society in a liberal democracy created problems for some Russian immigrants to the USA.

Additionally, Western nations have familial structures that are very different than what is customary in Russia. In Russia, family members are dependent on one another to a much greater extent than is customary in Western nations. It is common to find multigenerational households in Russia, and adult children traditionally assume the role of caring for aging parents. This level of familial interdependence is not common in the USA, a nation in which independence is highly valued. During the 1990s, many older Russians came to the USA to reunite with children who had immigrated to the country to take professional jobs. After moving to the USA many of these older Russian immigrants felt as though relying on their children to help them settle and assimilate, which would have been a reasonable expectation in Russia, would be unacceptably burdensome. Therefore, for Russians, the adjustment to the Western customs regarding family structure involved learning to decrease one's reliance on the people who would traditionally have been one's greatest sources of support, at a time when the need for support and guidance is extremely high.

Yet another adjustment that had to be made by Russian immigrants was an adjustment to health care systems that differed greatly from the system that they had depended on for health care when living in Russia. Russian immigrants have to learn to navigate foreign medical systems to meet their health care needs, which can be a very daunting task in the Western countries where the immigrants settled. Russian immigrants in both the USA and Israel have the disadvantage of not being familiar with Western medical interventions. This unfamiliarity can interfere with Russian immigrants' access to services from which they could benefit. Additionally, Russians, who come from an authority-oriented country, are at a disadvantage in Western health care systems which place great emphasis on patient autonomy.

Immigrants who moved from Russia, a country with a universal health care system, to the United States, where the health care system is multilayered and does not guarantee universal access, can have a lot of difficulties navigating the medical system in their new country. Phenomenological research has shown that Russian immigrants see the US health care system as extremely complex. Russians also see the US health care system as cold. In Russia, physicians are modestly paid individuals who make house calls as part of their routine practices. Therefore, Russian immigrants are put off when they learn that it is the custom in America to deliver health care primarily through prearranged office visits performed by doctors who are of elevated social status.

Furthermore, since the acquisition of a new language is one of the most difficult – if not the most difficult – task for immigrants, Russians experience language barriers when seeking health care in their new countries. Unfortunately, it is not common for doctor's offices in the United States to have Russian language translators readily available. Immigrants who do not yet have good command of the English language are therefore forced to rely on family members to translate their physical symptoms to doctors, and translate the doctors' questions and recommendations to them. A main problem with the practice of relying on family members to translate is that Russian immigrants are reluctant to ask their relatives to accompany them to appointments, because immigrants who are adjusting to American expectations of social independence do not want to over-rely on their families. Immigrants' reluctance to ask for help can lead them to delay seeking medical care because of language barriers. Russian immigrants in Israel also face language barriers when attempting to visit health care professionals.

The Russian concept of health is being free of illness, and Russians equate being ill with being in pain. Because they have this conception of health, Russian immigrants seek medical care when they are obviously ill or in physical pain. In Western nations, a high priority is placed on preventive care, and patients of the health care systems in Western countries are expected to attend routine well care visits and take proactive measures to achieve a state of health that involves more than just the absence of illness or disease. This dramatic difference in the country-based expectations of how citizens seeking medical care should interact with the health care system presents yet another adjustment for Russian immigrants.

It has been shown that Russian immigrants participate in routine health visits and disease screening to a lesser degree than citizens of Western countries. Data from Israel show that Russian immigrants are less likely to have pap smears as recommended. They are less likely to have mammograms, which are recommended for early detection of breast cancer. They are less likely to have their cholesterol levels checked and have their blood pressures screened. Interestingly, it has also been found that Russian immigrants to Israel had lower rates of compliance with cancer screening than Russian citizens who remained in their home country.

Research shows that Russian immigrants visit Western doctors primarily when they are ill. When they do visit the doctor they voice many complaints, and are often seen by doctors as exaggerating their symptoms or somatizing. Unfortunately, this culture clash often leads to less than ideal medical treatment of Russian immigrants.

It has also been demonstrated that Russian immigrants are very suspicious of health messages (public service announcements) portrayed through the media. They suspect that health messages are projected to the public for political agendas rather than because of a genuine effort to improve the nation's health. Russian immigrants have been known to lose the benefit that they could gain from following media advice about healthy eating, for example, because of commonly held suspicion that the message is intended to increase sales of a particular type of crop.

Difficulties navigating Western health care systems are likely to partially explain why Russian immigrants have worse life expectancy and higher infant mortality rates than native citizens of Western nations. The following data provide a comparison of the health of citizens in Russia and those of the countries where Russians primarily settled during the most recent wave of immigration from Russia. In 1990, men in the Soviet Union could expect to live between 60 and 68 years, whereas men in the USA could expect to live approximately 72 years on average. Soviet women had a life expectancy between 68 and 75 years, while women born in the USA lived nearly 79 years on average. The average life expectancy for citizens of Israel was 76 years of age. The infant mortality rate in the Soviet Union was likely over 35 per 1,000 live births; in the USA and Israel alike, about 10 infants per 1,000 born died within the first year of life. Life expectancy and infant mortality data for Russian immigrants in the USA and Israel fall in line with the health statistics for Russia, rather than with the statistics for the Western nations in which the immigrants are living.

Another reason why Russian immigrants are not as healthy as the citizens of the countries in which they settle is that people who have lived in Russia commonly have poor health practices. In Russia, it is common for citizens to smoke very heavily. Physical fitness is not a national priority in Russia, nor is the development of healthy eating habits. When Russians immigrate to new countries, they take their unhealthy lifestyles with them. As a result, Russian immigrants have high rates of obesity. Many suffer from diabetes and hypertension. Furthermore, there are very high rates of cardiovascular disease among Russian immigrant populations in both the United States and Israel.

A habit that carries particularly serious health consequences, and one that is very common among Russians, is heavy alcohol consumption. In Russia, heavy alcohol use is commonplace, and it is a major determinant of mortality among the country's citizens. Russians who consume alcohol heavily die of accidents, violence, and alcohol poisoning. They also die of complications owing to long-term alcohol use, namely heart disease, liver cancer, and pancreatic disease, as well as infectious diseases, such as tuberculosis, that chronic heavy alcohol users are at higher risk of contracting. Russian immigrants to Israel, a country whose citizens have a relatively low rate of alcohol consumption, continue drinking as if they were still living in Russia. They report higher rates of drinking and higher rates of drinking to the point of intoxication than native citizens of Israel report. Alcoholism is also very common among Russian immigrants in the USA, and the same health consequences are seen in the Russian immigrant populations of Western nations as are seen in the general population of Russia.

Russian immigrants are also shown to suffer from depression at rates that are significantly higher than rates of depression among the general population of the countries in which they are living. US studies have shown that depression rates among Russian immigrants approach 10%. Unfortunately, despite the availability of effective treatment for depression in Western countries, Russian immigrants have very high rates of untreated depression because they have a great degree of mistrust of psychiatry. This stems from the historical Soviet practice of psychiatric detention, in which anyone who disagreed with the government, or acted in a way which was not approved of by the government, was labeled insane, detained in prison-like hospitals, and forcibly and excessively medicated. Russian immigrants' reluctance to seek psychiatric care, although understandable given the historical context of their past experiences, leads to morbidity and mortality from depression as well as from alcoholism.

Related Topics

► Alcohol use disorders
► Culture shock
► Depression
► Jewish migration
► Language

Suggested Readings

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Safety

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Safety is an important issue for immigrants and includes safety in health care. All patients have the right to expect that the health services they receive will be safe, reliable and of high quality, and that they will be kept free of the dangers and risks of preventable injury when receiving hospital and other forms of health care. Although modern health care systems generally provide safe high-quality services, sometimes things can go wrong. And when things go wrong, patients can sometimes suffer preventable harm, including death.

In contexts involving the health care of immigrant patients of minority language and cultural backgrounds, the risk of things going wrong can be disproportionately high compared to patients whose language and culture are congruent with the majority population and health service providers. Despite this imbalance, immigrant disparities in patient safety (more commonly referred to as "ethnic disparities in patient safety") have received relatively little attention in the international patient safety literature.

Due to a lack of research into patient safety events in minority immigrant populations, their true incidence and impact are unknown. What is known of their incidence and impact is probably an underestimation of what has occurred. The absence of "gold standard" research into immigrant disparities in patient safety (e.g., the kind of patient safety events that occur, their incidence, impact, and contributing factors) arguably stands as one of the most significant barriers to reducing and preventing their occurrence in real terms. This is because: "*What is not known about cannot be fixed.*"

Risk of Harm in Health Care

The risk of patients experiencing adverse events in health care is significant. Since the mid-1990s, various reports published, respectively, in the United States, Australia, the United Kingdom, Canada, New Zealand, and other countries have suggested that between 4% and 16.6% of patients have suffered some kind of harm, including permanent disability or death, while in hospital. These reports further suggested that around 50% of the harmful outcomes recorded could have been prevented, that is, were *preventable adverse events.*

Adverse Events

An adverse event is generally defined as an unintended injury or complication, which results in disability, death, or prolonged hospital stay and is caused by the *health care management* of the patient rather than the patient's disease. Although commonly attributed to human error (e.g., mistaken judgments or conduct) not all adverse events are the result of errors. Conversely, not all errors result in harmful outcomes or adverse events for patients. For example, a patient with no known drug allergies may suffer a severe adverse reaction after being administered a correctly prescribed drug. Although obviously an "adverse event," it was not the result of a mistake being made. In contrast, a patient may be given the wrong drug or an incorrect drug dose, yet suffer no serious consequences.

It is widely accepted that the risk of error and threats to patient safety have multiple causes. Chief among them are what have been termed: "active failures," events usually due to human factors; and "latent failures" mainly caused by *underlying organizational problems or "gaps" in the system* and which predispose individuals to making mistakes (active errors). Contrary to common belief, the vast majority of adverse

Sana Loue & Martha Sajatovic (eds.), *Encyclopedia of Immigrant Health*, DOI 10.1007/978-1-4419-5659-0,

events in health care are not the result of a single act by an individual. Rather they are usually the end result of failings in *complex systems of care*.

Human Factors

Human factors encompass all those factors that can influence people and their behavior. In a health care context, these factors encompass the environmental, organizational, and job factors, as well as the individual characteristics (e.g., an individual's culture, personality, character), which influence a person's behavior at work. Human factors are commonly implicated in human error (active failures) and contribute the most common threats to patient safety. Although sudden and unexpected failures in equipment also contribute a threat to patient safety, such events tend to be rare.

When caring for immigrant patients of minority language and cultural backgrounds, the risk of making a mistake can be compounded in instances where, because of language and cultural barriers between the providers and the recipients of health care, critical information about a patient is not obtained. Ethnic stereotyping, ethnocentrism, bias, and discrimination can also contribute to unsafe patient care.

System Processes

System processes encompass underlying organizational problems or "gaps" in the system, which predispose to unsafe patient care. These gaps are sometimes referred to as "accidents waiting to happen." Like a dormant volcano, these gaps can erupt in the system at any time. While one gap alone (e.g., understaffing, the lack of credentialed on-site interpreters, a poor mix of skilled and experienced hospital staff, the supply of outmoded equipment, poor drug package labeling, and so on) may not result in an error, *were all the gaps or flaws in the system to align* – even for just a moment – then there is a high probability that an "accident" (active error) will occur – e.g., the administration of a therapeutic drug to the wrong patient, or the wrong assessment and related misdiagnosis of a patient. Had even one of the gaps been detected (e.g., failure to use a credentialed health interpreter) and a system defense activated to "interrupt" the trajectory of accident opportunity (e.g., check list prompting language needs assessment), then the adverse event may not have occurred.

Global Patient Safety Movement

In 2002, the World Health Organization acknowledged that the incidence of preventable adverse events was a challenge to quality of care, caused significant avoidable human suffering, and had a high toll in terms of financial loss and cost opportunities to health services. This resulted in the World Health Assembly adopting a resolution on patient safety that set the stage for the development of global standards and guidelines for patient safety and quality care, and encourage research into this fledgling area. The resolution highlighted a range of strategies including preventive action, implementation of system measures to reduce risks, promotion of evidence-based policies and practice, fostering a culture of safety within health care organizations, and the development of mechanisms for recognizing benchmarks for excellence in patient safety internationally.

The adoption of this resolution resulted in patient safety being recognized on a global scale for the first time. In response to this resolution and mindful of the financial, social, and political implications of the costs caused by adverse events, governments and health services around the world took unprecedented action to develop and implement robust patient safety programs with the specific aim of improving the safety and quality of hospital and related health care services.

Patient Safety

Patient safety is fundamentally concerned with reducing the incidence and impact of preventable adverse events associated with patient care and treatment. In keeping with this concern, patient safety programs encompass the collective efforts made by patient safety organizations, health service providers, policy makers, health consumers, and other stakeholders to reduce to an "acceptable minimum" the incidence and impact of unnecessary harm associated with health care. According to the World Health Organization, an "acceptable minimum" in the incidence and impact of harmful events is determined by current best available knowledge, the resources available, and the context in which care was delivered weighed against the risk of nontreatment or alternative treatment.

To help prevent things from going wrong and to improve patient safety outcomes, health care organizations are now required to have in place a system that will enable them to continuously improve the quality and safety of patient care. Such a system is expected to minimally include processes:

- For identifying deficiencies (gaps) in the system that could allow or have allowed adverse events to occur, and acting to address the deficiencies identified
- For managing risks and minimizing the harm from adverse events should they occur
- For supporting generally a culture of safety and excellence in patient care.

Immigrant and Ethnic Disparities in Patient Safety

There is emerging evidence that, despite the internationalization of patient safety initiatives, patient safety events occur more often in immigrant than nonimmigrant populations, and that patients who do not have language and cultural congruence with their health care providers may be at disproportionate risk of experiencing harmful outcomes compared to patient groups who have language and cultural congruence with their health service providers. Immigrants (like ethnic minority patients) have been identified as being more prone to patient safety incidents such as medication errors and adverse drug events, postoperative complications, nosocomial or hospital acquired infections, and “failure to be rescued” by health care providers when things are going or have gone wrong.

In the United States, pilot research has shown that immigrant patients with limited English proficiency (i.e., patients whose spoken or written English is insufficient to enable them to negotiate the health care system or to interact effectively with their health service providers) are almost twice as likely as proficient English speakers to experience physical harm from an adverse event (49.1% compared to 29.5%) and are almost twice as likely to experience physical harm at a level ranging from *moderate temporary harm* to *death* compared with proficient English speakers (46.8% compared to 24.4%). Research has suggested that patients with limited English proficiency are also more likely to experience an adverse event related to communication errors than are patients who speak English proficiently (52.4% compared to 35.9%).

Ethnic minority patients have been found to be similarly at risk. For example, pilot research in the United States has shown that Black patients are 20% more likely to experience a patient safety event than are White patients. Studies outside of the United States have similarly identified immigrant and ethnic disparities in patient safety events, including wrong-site surgery, omission of prescribed pain relief, and misdiagnoses with related delays in treatment leading to irreversible harmful outcomes, including permanent disability and death. Language barriers and errors in communication have been implicated in these patient safety incidents.

Contributing Factors to Immigrant Disparities in Patient Safety

Socioeconomic and health access issues are known to contribute to health and patient safety disparities in both immigrant and nonimmigrant populations. Immigrant and ethnic disparities in health and patient safety outcomes, however, are not always explained by socioeconomic or other health care system variables. US data show that when adjustments are made to account for these variables, not only do the disparities remain, but are remarkably consistent across a range of illnesses and health services. Some commentators have concluded that racial/ethnic bias, stereotyping and discrimination leading to inappropriate responses, and the provision of inappropriate/ineffective care are significant contributors to immigrant and ethnic disparities in health and patients’ safety outcomes.

Other factors contributing to immigrant and ethnic disparities in patient safety include a lack of cultural competency among health service providers at both an individual practitioner and whole-of-organization level; ineffective cross-cultural communication; failure to capture and include immigrant/ethnic minority viewpoints about safety and quality in health care in patient safety programs; and an embedded organizational culture of “getting by” instead of safety being accorded a high priority. Each of these factors contribute to cultural misunderstandings, misperceptions, and expectations concerning health, illness, care, and treatment which, unless addressed, unnecessarily expose immigrant and ethnic minority patients to care pathways that are rife with the risk of “an accident waiting to happen.”

Communication Errors and Patient Safety

Patient safety research has revealed that the two most significant factors contributing to preventable adverse event occurrence in health care are *failures in communication* and *failures in team work* (noting that effective team work is also inextricably linked to effective communication).

Communication has long been recognized as "the tool" by which all interactions in the hospital environment are governed. Today, effective communication is widely regarded as *the* core component of health care. Oral and written communication between members of the health care team, the patient, and the patient's family are vital to the proper assessment of patients, and to the effective planning, implementation, and evaluation of their care and treatment.

There is a strong link between "communication failures" and poor patient safety outcomes. The US Joint Commission on Accreditation of Healthcare Organizations (JCAHO) has identified communication failure as a pivotal factor in around 70% of over 3,000 sentinel (catastrophic) event reports since 1995. The US Veteran Affairs National Center for Patient Safety has similarly implicated communication failure in almost 80% of more than 6,000 Root Causes Analysis reports to its agency.

There is increasing recognition that if communication errors are a threat to patient safety in the general (majority) patient population, then patients of minority language and cultural backgrounds are in "double jeopardy" of communication errors and their associated risks to the safety and quality of patient care. This recognition has led to heightened calls for "communicative competence" to be used as a framework for understanding and redressing language and cultural barriers to patient safety in hospital and other health care domains.

Communicative Competence and Patient Safety

Effective cross-cultural communication between patients, their families/friends, and health service providers is critical to the delivery of safe patient care. Such communication does not always occur, however, because of language and cultural differences between health care providers (e.g., doctors, nurses, hospital receptionists, administration staff, and so on) and patients, and low health literacy among some patient groups. So significant are these variables that the JCAHO has identified "effective communication," which takes into account language difference, cultural difference, and health literacy as a fundamental prerequisite to safe health care.

Language Differences

Language differences (oral and written) between patients and health service providers have been systematically identified as being a key barrier to effective communication. In some cases, the misinterpretation of just one word has led to a catastrophic outcome for the patient, which might otherwise have been avoided had the communication needs and requirements in the clinical encounter been properly assessed and responded to (notably by engaging the services of a qualified health interpreter).

Research is demonstrating that *language differences as a barrier to effective communication* and hence patient safety is not always immediately apparent and tends to be underrecognized and underestimated by the providers and recipients of health care alike. Professional caregivers (doctors, nurses, and allied health professionals), patients, and their families/friends have all been found to overestimate their "second language" proficiency and underestimate their capacity for making mistakes in health communication. Compounding this oversight is the underrecognition (and even denial) of the nature and harmful impact of language prejudice (a form of racism) on the clinical encounter and related patient safety outcomes.

Cultural Differences

Cultural differences between health service providers and their patients have been systematically identified as being a significant barrier to effective communication. Although commonly associated with language differences, cultural differences entail considerably more than mere differences in a spoken sound or use of conventional symbols. As can be readily demonstrated, two people from different cultural backgrounds may speak a common language, yet lack shared cultural knowledge and understanding of the meanings of particular words and of what is being communicated. For example, a bilingual physician may use the correct words when interpreting a cancer diagnosis to a patient, yet totally miss (and underestimate) the cultural meanings which the patient attributes to the word "cancer" and the harmful consequences of using this "conventional" term. Although the frank disclosure of the cancer diagnosis may well have been congruent with mainstream medical and lay cultural practices, in the context of the cultural worldview held by the patient such an action may be tantamount to "cultural imposition," a violation of the patient's right to cultural liberty, and ultimately clinically ineffective and even "toxic" (harmful) care.

What is not always understood in the health care environment is that intercultural communication requires not just an exchange of words, but also an exchange of *shared meanings*. Thus, to be effective, interpreters and bilingual staff must not only "translate words," but establish and verify their "shared meanings." This requires knowledge and skills not only in speaking a second language, but cultural knowledge and skills to ensure the "cultural appropriateness" of health communication in the clinical encounter. Without this understanding there is a risk not only of communication errors occurring, but of them going undetected, which in either case could result in preventable harm to patients.

Health Literacy in Relation to Patient Care

Health literacy, to be distinguished from "general" literacy (i.e., the ability to read and write proficiently), is a discrete form of literacy. Although the subject of various definitions, the term is widely accepted and used to refer to an individual's capacity to obtain, understand, and use information relating to health and health care services to make appropriate decisions concerning their health, disease prevention, treatment and management, safety and accident prevention, and to generally promote and maintain good health.

Low health literacy is a recognized barrier to effective communication with immigrant patients of minority language and cultural backgrounds. Although *any* patient who is functionally illiterate may have low health literacy, patients of minority language and cultural backgrounds face particular disadvantage in contexts where pertinent health information is available only in a country's "official" language. For example, in English-speaking countries, patients and their families who do not speak, read, or write in English – and who may also be functionally illiterate in their own native language – are at significant risk of experiencing disparities and inequities in health and health care. US research, for example, has shown that non-English speaking Latinos (8% versus 51%) and Asians (11% versus 51%) were less likely to receive needed health services than did their English-speaking counterparts.

Although the identification of language and cultural barriers may alert clinicians to the possibility that their patients may have low health literacy, this may be overlooked if the patient or family members fail to ask questions, and assumptions are made by attending health care providers that the patient "understands" the care and treatment information he or she has been given, and has the capacity to act on that information, when in fact the patient does not.

Cultural Patient Safety

Some commentators have suggested that conventional contemporary patient safety theory and practice are inadequate to the task of improving and achieving health care safety for racial/ethnic minority patients and their families. Moreover, what ethnic minority patients and families regard as "preventable harms" and "safety priorities" in health may vary from traditional patient safety typologies. An example of this can be found in a small US study, which suggested that patients were more likely to report psychological and emotional harms (manifest as anger, frustration, belittlement, loss of relationship, and trust in the clinician) occasioned by racist treatment by health care providers, than they were to report harms related to adverse drug events and surgical mishaps.

To redress the inadequacy of conventional patient safety processes across diverse populations, a cross-cultural model of "cultural patient safety" (to be distinguished from cultural competency) has been proposed. Cross-cultural patient safety takes a distinctive patient-centered approach to health care safety. Among the core risk factors it aims to address are *linguistic issues* (e.g., the potential for miscommunication), *cultural issues* (e.g., potential for cultural misunderstanding), *medical literacy* (e.g., taking into account that native languages do not always include conventional medical or related terminology which thus cannot be translated meaningfully; inability of patients to navigate the health care system), *practice issues* (e.g., where conventional services may contrast or clash with traditional healing practices), *contextual issues* (e.g., potential for misunderstanding due to differences in cultural knowledge or cultural habits), *systemic issues* (e.g., access and availability issues), *genetics* (e.g., failure to take into account issues specific to certain racial/ethnic populations), and *racism/discrimination* (e.g., manifest as prejudice, indifference, intolerance, unjust differential provision of health services).

Cross-cultural patient safety is depicted as extending beyond and being distinguishable from a more conventional model of patient safety. The basis upon which cultural patient safety is distinguished from conventional patient safety lies in its apparent emphasis on the safe and successful delivery of health care services *across cultural, linguistic, and related barriers* to the understanding and identification of racial/ethnic minority patient needs. To this end, cross-cultural patient safety is heralded by its proponents as encompassing a broader set of processes than those which are conventionally associated with patient safety, such as adverse events, medication errors, hospital-acquired infections, falls, and other patient safety incidents. Under a cross-cultural patient safety model, psychological and emotional harms causally related to cultural imposition, cultural insensitivity, racist and prejudicial treatment, the failure to observe traditional healing practices, and the like, would also be included in patient safety taxonomies.

The main objective of a cross-cultural patient safety model is to achieve the enrichment and empowerment of minority group *culture* and the protection of *traditional cultural practices* (e.g., cupping, herbal remedies, massage and other health practices, shown not to be harmful) in conventional health care contexts. Whether cultural patient safety has the capacity to achieve patient safety outcomes independently of, and more effectively than, conventional patient safety programs, however, has yet to be shown.

Redressing Immigrant Disparities in Patient Safety

Formally identifying the cultural and linguistic needs of immigrant patients and taking a systemic response to ensuring the provision of culturally and linguistically responsive health care are being increasingly recognized by patient safety agencies, governments, health service providers, health consumer advocacy groups, and other stakeholders as a key domain for patient safety. This recognition is seeing unprecedented emphasis being placed on the need for broad screening for potential safety events in immigrant (and ethnic minority) patient groups, evidence-based assessment of health interpreter needs, and systemic cultural responsiveness. Unprecedented emphasis is also being placed on the need to develop a health care workforce which has appropriate qualifications and experience to provide safe, high-quality care to patients of diverse cultural and language backgrounds, encouraging immigrant and ethnic minority patients to actively participate in care processes, engaging clinicians in redesigning systems and processes aimed at improving patient safety outcomes for immigrant and ethnic minority patients, and the full integration of "cultural diversity" services into the health care system and associated clinical risk management programs.

The adoption of a policy-orientated approach to cultural responsiveness in health care has underscored the need for a "systems approach" to improving the safety of health care services for immigrant patients. Currently little is known about risk perception, preferences, reasoning, and decision-making, and the complex interplay of variables that may influence these processes in contexts involving the health care of immigrant and ethnic minority patients. Comparative research investigating immigrant and ethnic disparities in patient safety is required.

Related Topics

- ► Cultural competence
- ► Cultural humility
- ► Discrimination
- ► Ethnicity
- ► Health literacy
- ► Language
- ► Limited English proficiency
- ► Telephone interpretation services

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Same-Sex Marriage

► Marriage

Sampling Method

► Methodological issues in immigrant health research

Sanctuary

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Sanctuary originally meant "a sacred place" – as the holy of holies in the innermost temple of Solomon (Judaism) or The Noble Sanctuary at Al-Haram al-Sharif in Jerusalem (Islam) or, in the Christian church, the place around the altar. Sanctuary also meant a place to be safe from arrest, as in a church or temple. The earliest mention of sanctuary was in an English code of law (AD 600), confined to the church itself. It was later expanded but ecclesiastical right of sanctuary ceased after the Reformation.

The Sanctuary movement in modern times began in the 1980s as part of a broader antiwar movement. By 1987, 440 sites were open to migrants escaping the civil wars in Central America. The sites included churches and university campuses for migrants facing deportation in Europe, Australia, Canada, and the United States. The "New Sanctuary Movement" organization estimated at least 600,000 people in the United States had at least one family member in danger of deportation. At its heart, the movement was to protect refugees and immigrants who were in realistic danger if forced to return to their own country.

The United Nations spelled out specific rights that nations should offer refugees and asylum seekers. Its provisions were put into US law in 1980. Having a legal way for protection and obtaining asylum has lessened the need for the sanctuary movement. However, since 9/11, laws require that anyone providing "material support" for terrorists be refused asylum. The sanctuary movement predated the ongoing American tension regarding immigration. The current tension divides the American population between those who, on the one hand, hold the historical position of providing safety for those immigrants who have been persecuted and tortured and those who, on the other hand, want to limit immigration to protest illegal immigrants and protect the country against potential "terrorists."

Related Topics

- ► Illegal immigration
- ► Refugee
- ► Torture
- ► Trauma
- ► Trauma exposure

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Sangue Dormido

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Sleeping blood or *sangue dormido* is listed in the American Psychiatric Association's DSM-IV-TR manual as an example of a "culture-bound syndrome" found among Portuguese Cape Verde Islanders (and immigrants from that area to the United States). Individuals affected with this syndrome are described as having "pain, numbness, tremor, paralysis, convulsions, stroke, blindness, heart attack, and miscarriage." Cited over 1,000 times on Google, *sangue dormido* has been reprinted in many languages and is typically listed alongside such well-documented culture-bound syndromes as *ataque de nervios*, *susto*, *amok*, and *pibloktoq*.

The condition was originally described by the authors in the journal *Culture, Medicine, and Psychiatry* (1981) in a single clinical case report of a 48-year-old Crioulo-speaking Cape Verdean woman who was admitted to Massachusetts General Hospital in Boston for further diagnostic evaluation and treatment of resistant right arm paralysis, numbness, pain, and tremor. The patient had sustained bilateral Colles' wrist fractures and subsequently developed the above symptoms which failed to respond to 2 years of conventional medical treatment and physiotherapy. An extensive diagnostic work-up including laboratory testing and imaging studies did not reveal any definitive organic neurologic pathology. A psychiatric diagnosis of conversion disorder (DSM 300.11) was made.

In order to develop a therapeutic alliance and negotiate a culturally sensitive treatment plan, the clinicians elicited what Dr. Arthur Kleinman and other medical anthropologists have termed the patient's "illness explanatory model" (i.e., her personal perspective about the cause, onset, name, course, fears, impact, and treatment of her condition). The patient shared her beliefs that a jealous family member or neighbor may have caused her original fall, wrist fractures, and resulting neurological symptoms through the evil eye (*mal olhar*) or witchcraft (*feitiçaria*). She further elaborated on this explanation by describing a belief held by the inhabitants of the Cape Verdean village where she had been raised. In her view, "living blood" (*sangue vivo*) could be caused by injuries such as the wrist fracture she had previously sustained to leak into the skin, blacken, and become "sleeping blood" (*sangue dormido*) or "dead blood" (*sangue morto*). If not removed, the blood's expansion over time in response to diet, climatic conditions, or temperature changes, could result in terrible consequences including pain, numbness, tremor, paralysis, convulsion, stroke, blindness, heart attack, infection, miscarriage, and mental illness. She was also a devout Catholic and believed that perhaps her condition was a divine punishment (*castigo*) for "bad thoughts" that she had about her family member and neighbor.

The patient described the following traditional treatment approach from her homeland: administration of a calming medication, making an incision in the shape of a cross to remove the sleeping blood, and offering a prayer for healing. After negotiating with the patient and with medical authorities, a procedure modified sufficiently to allow for implementation within a major metropolitan teaching hospital, the clinicians gave her an intramuscular injection of 5 mg of diazepam intramuscularly; drew 12 cc of blood from a wrist vein, a portion of which was sent for laboratory testing, and the rest was shown to her as coagulated blood in a cup; and stayed with her as she offered a prayer for divine assistance. The patient's tremor completely resolved the following day. Her paralysis, however, remained but slowly improved following discharge with outpatient physical therapy and psychosocial support over the next 5 months.

A subsequent interview with the patient's family during a home visit provided further background linking blood injury beliefs to adverse medical outcomes and suggested that concerns about *sangue dormido* were a common reason for visits to healers and physicians in their Cape Verdean village. A careful search of English-language citations, however, has failed to identify any empirical or ethnographic evidence of this condition that appears separate from the original case report, though it is possible (as one Internet discussion claims) that the original sources are in Portuguese.

The concept of "culture-specific" or "culture-bound syndromes" is a controversial one in psychiatry and medical anthropology requiring additional research, and is currently being reexamined in the planned revisions to DSM-V. Based on this single case report, the authors believe that *sangue dormido* should be seen as representing this individual patient's "illness attribution" and "idiom of distress" relating to beliefs about the connection between blood injury and illness. Community-based studies with Cape Verdean populations are needed to determine if these beliefs are more widely held. The inclusion of *sangue dormido* among evidence-based "culture-bound syndromes," is no longer appropriate and represents a powerful example of "disease reification" in an age of global electronic information dissemination. It is urged that this "syndrome" be eliminated from future DSM listings and allowed to rest in peace.

Related Topics

- ▶ Cultural competence
- ▶ Cultural humility
- ▶ Culture-specific diagnoses
- ▶ Explanatory model of illness
- ▶ Mental illness
- ▶ Physician–patient communication
- ▶ Somatic symptoms
- ▶ Transcultural psychiatry

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Sanitation

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Historically, the immigration experience is often associated with unsanitary living situations. This concern has divided recent immigrants from the rest of the population because their tendency to reside in more urban, densely populated areas has pitted them as the unhygienic "other." Sanitation concerns not only stem from close living quarters but also from exposure to various diseases either in the arrival nation or in the nation of origin due to hygienic practices. In the nineteenth and early twentieth centuries, immigrants tended to migrate from poor sanitary conditions to better sanitary conditions, but as the migrant population diversified to include the very poor and the very affluent, sanitation concerns have also varied in response. Immigrants can be from higher socioeconomic status who choose to migrate or are refugees escaping persecution in their land of origin. This wide spectrum of reasons for immigration makes it difficult, if not impossible, to simply declare that sanitation issues are applicable to all.

In nations where cleanliness is commonplace, sanitation not only divides the clean from the unclean but may also play a role in social stratification. Because it can be an important social value, observable sanitation conditions become physical embodiments of the stark contrast in socioeconomic status between the upper and lower classes. Members of the upper class who value cleanliness and can afford to maintain hygienic practices may view members of the lower class as inferior or even dangerous because they do not share these values, and this difference in priorities and ability to adhere to these norms make sanitation a perpetuator of class differentiation as well as a potential cause of mental trauma due to membership in a lower social class.

In the early 1900s New York City, in an attempt to battle the lack of sanitation in immigrant homes, used its public schools as an instrument of health reform by implementing a series of curricular changes to include physical education (which included all aspects of physical health) and home economics. The idea behind this reform was that the children of immigrants who attended these schools would then bring these newly learned skills regarding health and sanitation back to their homes and teach them to their families.

Immigrants who transition from poor sanitary conditions in their homeland to better conditions at their destination are faced with the need to conform to US standards of hygiene. Among the many items marketed toward a hygiene- and health-cautious audience is bottled water, which is internationally touted as the symbol of clean water. Depending on the brand of water, each company's water may be filtered more or less than tap water, which is often regulated in terms of contaminants. Fluoride, which helps combat tooth decay to maintain oral health, is found naturally in or is added to many water sources. However, bottled water may not have much fluoride. A study found that in a largely immigrant neighborhood in the USA, the immigrant residents tended to drink more bottled water than their American counterparts, possibly as a result of easier access to this icon of cleanliness than in their homeland. As a result, their oral health may not be as good as their American counterparts. Maintaining oral health is important because it is linked to the individual's diet – oral discomfort can lead to a selective, imbalanced diet, which could then create other health-related issues.

However, immigrants' experiences in poorer sanitary conditions may not necessarily be detrimental to their health. The hygiene hypothesis posits that immigrants who are exposed to certain infectious diseases in their native home due to unsanitary or underdeveloped conditions may be less likely to develop certain diseases that are prevalent in the USA, such as asthma and allergic rhinitis.

Immigrants also transition from good sanitary conditions to poor sanitary conditions upon arrival to the USA. Some individuals might have chosen to relocate with or without family members from comfortable accommodations to tenement-style living in the USA in hopes of starting better lives. In these cases, personal hygienic practices may still be employed, but many of these individuals ultimately find occupations where they labor in unsanitary conditions (such as garbage collection or janitorial services). They may be stuck in these jobs due to language, lack of specialized skills, or inability to transfer academic degrees.

This transition from good to poor conditions may even occur before arriving on US soil. Some individuals who might have been considered wealthy in their native country were compelled to relocate to refugee camps in order to avoid persecution. Refugee camps are notorious for their crowdedness and lack of sanitary facilities, which create a breeding ground for a host of diseases that can be easily spread due to the cramped quarters. The state of refugee camps and their lack of resources also pose particular health concerns for women. Most camps are ill prepared for childbirth, with facilities so lacking that many women choose to give birth within the privacy of their own quarters. Sanitary napkins and other menstruation needs are also deficient in quantity and quality.

Individual health may also be a factor in whether immigration is an option. The "healthy migrant" theory suggests that many contemporary immigrants tend to be healthier than the citizens of the destination country because the healthiest individuals choose or are selected to make the journey. However, studies have shown that although these immigrants are healthier than their nonimmigrant counterparts, their health, both physical and mental, deteriorates with increasing years residing in the new country. This observation is known as the acculturation hypothesis, and it could be a result of a variety of factors such as less than ideal occupations, acculturation to poor American diets and habits, and crowded housing situations where sanitation regulations are lax.

Because new immigrants tend to not be familiar with housing regulations in the USA, some landlords are able to take advantage of them. New immigrants, especially refugees, are less likely to report poor living conditions to officials because of their undocumented status and fear of deportation if discovered. This combination of inattention and hesitation to report negligence creates a cycle that usually is not broken until the residents relocate. Such residences tend to be filled quickly by other recent immigrants.

Throughout immigrant history, many new immigrants have found respite in urban ethnic enclaves that tend to be closer to their workplaces or to immigrant services. But living in urban or industrial conditions often brings with it exposure to tobacco smoke, smog, vehicle exhaust, and lack of sanitation, all of which can be detrimental to personal health and can lead to various cardiovascular, respiratory, and infectious diseases.

With increasing numbers of immigrants, it is imperative that clinicians and doctors be aware of issues of sanitary conditions and the prevalence of diseases that are not common in the rest of the population. Immigrants' crowded living conditions (refugee camps, tenement-style living, etc.) elevate their risk of contracting infectious diseases such as tuberculosis or hepatitis B. Densely populated quarters create an environment where infectious bacteria can be easily spread, and because vaccines may not be readily available for immigrants due to a lack of resources or access to health care, this population may be at increased risk for diseases that are less common in the native born population.

Related Topics

- ► Air pollution
- ► Asthma
- ► Dietary patterns
- ► Education
- ► Environmental exposure
- ► Health literacy
- ► Healthy immigrant
- ► Intestinal parasites
- ► Occupational health
- ► Smoking
- ► Water

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Santería

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Santería, meaning the way of the saints or worship of saints, is a religious tradition stemming from West African and Caribbean origin. Santería began in the nineteenth century in Cuba when hundreds of thousands of captives from Africa were brought to the New World to work in the sugar plantations. The slaves brought over their African religious beliefs and practices and transformed them by blending their traditions with ideas borrowed from Catholicism and spiritism.

Origins and History

The religion known today as Santería was brought to Cuba by the Yoruba-speaking tribes of Southwest Africa (today known as Nigeria) and the Bantu from Congo. From the sixteenth to the nineteenth century, hundreds of thousands of captive Africans arrived in Cuba as part of the Atlantic Slave trade with the majority of Yoruba-speaking people arriving in the mid-1800s. During this time, Cuba's sugar commodity had become popular worldwide increasing the demand for laborers. Practice of the traditional African religion known as *Regla de Ocha* or *Lukumi* was discouraged and often prohibited by the slave masters in Cuba. Santería is one of many West African and Caribbean religions being practiced in both developed and developing countries. Other religions with Yoruba roots also took hold in Cuba and elsewhere in Latin America including Palo Mayombe and Vodou. Each of these religions is distinct but may share some of the Yoruba itan, or the sum of Yoruba religious beliefs, songs, stories, and cultural practices.

Despite the constraints of their oppression, the slaves persisted in their worship and began to transform their beliefs by incorporating elements of Catholicism. Upon arriving in Cuba, the slaves became aware of similarities between their African religion and Roman Catholicism. Both religions believed in a high god and creator as well as a pantheon of intermediaries between the high god and those who worshipped him. They recognized that the Catholic saints embodied characteristics similar to the orisha gods of the slaves and they began to pair each orisha god with a saint. For example, the god of thunder and lightening, Chango, was worshipped using the image of Saint Barbara, whose father was struck by lightening as he killed her for her faith.

Santería is the fusion of the African religion of the slaves, the Catholic saints of their masters, and a third influence known as spiritism developed in France by Allan Kardec in the 1850s. The combination of two or more belief systems into a single system is known as syncretism. The Yoruba culture is known to have been open and flexible about its religious belief system and so it worked to their advantage to combine traditions in a way that allowed them to continue to practice. Santería expanded to the USA and outside of Cuba in two major waves. The first was after the Cuban revolution in 1959. The second consisted of approximately 125,000 Cubans who came in the 1980 Mariel boat lift, a mass exodus from Cuba to the USA.

The terminology used in the practice of Santería includes a mix of Yoruba, a creole version of Yoruba known as Lucumi, Spanish, and Congolese words. Ceremonial songs are sung in Yoruba and communication with orishas is usually done in Yoruba as well. The term "Santería" itself is somewhat controversial. Also known as *La Regla de Ocha* (the rule or law of orisha), a mixed Yoruba-Spanish phrase, or *La Regla de Lucumi* (sometimes spelled Lukumi), the term *Santería* was developed in the mid-1930s by an Afro-Cuban scholar named Rómula Lachatañeré. Some consider the term Santería to be a misnomer, Eurocentric, and derogatory and prefer to use the more neutral term "Ocha" which is a derivative of orisha.

Beliefs and Rituals

The Yoruba in Africa believed in a high god, Olodumare, who was thought to remain distant from the everyday lives of his worshippers. Instead, secondary deities known as orishas serve as the divine intermediaries between devotees and the high god. Santería revolves around orisha worship. It is estimated that the Yoruba in Africa recognized between 400 and 1,700 orisha. Today only 16 major orishas are recognized. Each orisha is paired with a Catholic saint and is believed to control certain aspects of life; each represents an aspect of nature and a human characteristic. Some speculate that orishas were originally paired with saints as a way to disguise or mask the ongoing worship. Whether this was true or not, the transculturation of the orisha had strong appeal for the White Cuban population. Over time, the orishas lost some of their original characteristics and assumed some of the personality, attributes, and powers of the saints.

Divination is utilized when a Santería devotee seeks advice or solutions for the problems they find most troubling such as illness, financial issues, employment, love, or friendship. Various forms of divination are used and are performed by a *santero* (priests) or *babalawo* (high priest). Each diviner uses specific objects: *oguele*, a divining chain; *obi,* coconut pieces; *dilogun*, cowry shells; or *ikin*, palm nuts. The diviner must also commit to memory the many patterns and corresponding verses which will determine a suitable remedy to solve the client's problem.

Devotees respond to the assistance they find in divination from the orishas by expressing gratitude through sacrifices and offerings. A specific food offering is associated with each orisha such as fruit, stew, cake, and drinks. Live animal sacrifices are practiced to cleanse the soul and give strength. These rituals are performed quickly and cleanly in accordance with ritual rules. The blood of the animals is poured on the heads of new adherents during initiation ceremonies or sprinkled on sacred stones which symbolize the heads of the orishas. The sacrificed animal is cooked and the food offerings are eaten by the participants after they have been offered to the orishas.

Santería involves an elaborate system of rituals. Followers believe that the powers of the orishas reside inside stones. Water is thought to be a powerful defense against evil. Santeros may advise devotees to keep a bowl of water under the bed, to throw it out when no one is looking, and to change it every day. Another method of eliminating evil is to burn brown sugar and garlic skins and allow the smoke to permeate all corners and closets where it is believed evil spirits hide. Followers may also wear necklaces and bracelets given to them by santeros as protection against evil.

Dance and drum festivals, known as *bembe*, *guemileres*, or *tambores*, are held to honor the orishas and invite them to join by playing specific drums, performing dance, and acting out the behavior of the orishas in pantomime. Each orisha is associated with a specific drum rhythm and dance posture. These dances are used to attain a trancelike state of consciousness or spirit possession as a means to receiving the orishas' presence and to hear their advice, cautions, and reprimands.

Santería as a Health Care System

During the colonial period (sixteenth to nineteenth centuries), Cuba was a poor and undereducated country and sources of health care were scarce. Spanish and African folk healers and their pharmacopeias were the only sources of medicine available for the majority of the population, both Black and White. During the Cuban Republic (1902–1959), education and health care became more widespread. As a result of the new reliance on more traditional medicine, the Afro-Cuban practices shifted toward the treatment of personal crises and emotional problems.

Santería is still a source of health and healing for followers today. Santero and santera priests are consulted to advise on ailments ranging from physical to personal. The Santería model of disease espouses the connection between body and mind but also physical and social environment. In other words, causation for ailment may be blamed on harmful energies from friends, relatives, or wandering spirits seeking a host. During a consultation, Santero/a priests will seek assistance from the orishas to reach a diagnosis. The priest will then direct the client to eat certain fruits, vegetables, or plants to find relief.

Botánicas are often the source of health care products and informal health care services for followers of Santería as well as practitioners of other folk religions or healing such as spiritism or reiki. Sweet and bitter herbs sold in botánicas are usually prescribed by a healer and are used in teas, baths, or rubbing formula. Botánicas may have a separate room in which a healer provides consultations for clients. Santería as a health care system may be especially appealing to immigrants who adapt their practices through exposure to multicultural contexts, particularly in large cities where such services are available and affordable. Further, immigrants and followers of Santería may find health care through botánicas more accessible in contrast to the barriers of formal health care.

Today, there are more practitioners of Santería outside of Nigeria where now the majority of the population is either Christian or Muslim. High concentrations of Santería followers can be found in global cities throughout Europe, in North American locales such as New York and South Florida, as well as Puerto Rico, Venezuela, and Cuba. Santería is practiced by people of African and Latin descent and over the years has attracted new followers from diverse racial backgrounds and socioeconomic standing. It is difficult to determine accurately how many followers exist today. Santería has a long history of secrecy due to oppression and misunderstanding. Santería worship is mostly home-based and private although practitioners are slowly and cautiously practicing more openly. Many immigrants, especially Latin American and Caribbean, may find Santería to fulfill their need for a religious community. The beliefs and practice of Santería continue to evolve as some regions take on new characteristics such as Puerto Rican spiritism and ethical principles of Christianity.

Related Topics

- ► Alternative and complementary medicine
- ► Health beliefs
- ► Health care
- ► Religion, religiosity, and spirituality

Suggested Readings

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Scale Validation

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Scales that measure various components of health are an important manner through which to gain insight into the nature of underlying constructs that are of interest in evaluating health outcomes. Self-reported or rater-scored surveys can be used to measure a wide range of constructs, such as quality of life, health beliefs, depression or anxiety, etc. Scales are generally most appropriate for constructs that can be viewed or summarized as being unidimensional, in the sense that the possible conditions or states within the construct can be meaningfully represented as a range of scale scores within some interval. Further, there should exist some type of ordering between the states or conditions that should be reflected by the values. For instance, if measuring some aspect of quality of life, those with relatively high quality of life should have higher scale scores than those with lower quality of life. Generally, scale scores are derived from item responses that are individually scored in some manner, resulting in a summary score that reflects the relative state or condition within the construct.

Once a collection of survey items for a particular health construct has been developed, a scoring scheme must be in place for responses. This can be built in, such as by using Likert scales, with responses being associated with numerical values (e.g., "1" is "poor,"... ,"5" is "excellent"). Scale scores generally represent a summary of the item responses, such as total sum of item scores. Certainly, there can be more complex scoring schemes, like those used in advanced psychometric methods such as Item Response Theory, where item response scores are differentially weighted when estimating a score value. Once items and a scoring scheme have been developed for a scale, it then becomes essential to validate important psychometric properties of this instrument. These include establishing whether the scores are stable across administrations of the scale given that the condition or state of the subject has not changed, verifying that the underlying construct is actually being measured by the scale, and determining whether the scale is sensitive enough to reflect that a subject's state or condition has changed. These key properties are respectively referred to as reliability, construct, and discriminant validity. Once a first version of a scale is developed, the next step in formal validation will be to administer it to individuals, and analyze response data to assess its psychometric properties. This process may be iterative (repeated several times), with items and/or scoring schemes adjusted to improve psychometric aspects of the scale. These properties can be assessed as follows.

Reliability involves studying the measurement variability associated with the scale. For instance, when the state or condition associated with a construct is stable, it is desirable for similar scores to arise from measurement. This would indicate that the measurement score does not have large within-subject variability. To establish this, the associated survey is administered on at least two occasions to the same people within an appropriate time frame, keeping all sources of variability to a minimum, such as ensuring that a participant's state is stable and making the environment is similar during both occasions. One can then determine the reliability of the scale by gauging the variability between these same subject measurements. Given a same construct being measured, larger number of items administered should lead to more reliable measurement.

Construct validity relates to the degree to which a scale measures the target construct (Does the scale measure what it is supposed to measure?). There are various possible approaches in establishing this. One approach is to link scores to an observable variable that is hypothesized to be related to the construct. Higher (or lower) values of the variable are expected for those at higher levels of the construct. A common variable for comparison is a legacy measure (a measure that has already been developed and used) that was designed to measure a related construct. Also, clinically available information may be useful when studying populations affected by particular health conditions. For instance, an assumption can be made for a quality of life measure that the greater the severity of a particular disease the more diminished the individual's level of quality of life. It will be of interest to establish this statistically by examining the relationship between scale scores and clinical indicators of disease severity. If the expected relationship appears to exist, construct validity for the scale is supported.

Internal consistency is the extent to which a collection of items measures a same construct. A high level of internal consistency, expressed statistically, for instance, by a statistic called Cronbach's Alpha or correlations, is anticipated when all the items comprising the scale measure a single, unidimensional construct. Establishing high internal consistency is an indirect form of construct validity, in that it gives indication that a scale is measuring a single construct. Groupings of items to be associated with a particular construct can be identified through exploratory factor analysis or by expert opinion.

The responsiveness of a scale is a property that refers to its ability to detect changes in a state or condition that are clinically important. Again, a measure is administered on two occasions at an appropriate time frame, so that a number of subjects will undergo a change in state or condition. It becomes very much of interest to see if respective scale scores change as well, particularly in relation to the variability of within subject measurements. If a scale is to be used as a primary outcome measure in clinical studies, then determining a minimally significant difference in scores that reflects meaningful clinical change is useful. For example, this value can be used in identifying a target effect size for power analyses.

A potentially important application in scale validation for immigrant health research is the translation of an existing measure into another language. In these situations, the same validation issues as discussed previously arise. Further, one may also want to equate the scores on a translated measure to those of the original measure. An area of psychometrics called equating deals with understanding how to convert scores on one measure to psychometrically equivalent scores for another measure. As a final note, the scope of validity of a scale should be recognized, and this relates to the understanding the population characteristics from which responses were sampled. For instance, if item responses and scale scores from participants with a particular health condition are used in validation, then the scale's validity is established for that particular population and may not hold more generally.

Related Topics

► Methodological issues in immigrant health research

Suggested Readings

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Suggested Resources

http://faculty.chass.ncsu.edu/garson/PA765/statnote.htm

Schizophrenia

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Schizophrenia is a chronic enduring mental illness falling under the psychiatric classification of the *psychoses*. Psychoses are mental illnesses in which the person's organization of his or her thoughts and the person's ability to recognize reality are severely impaired. Schizophrenia is characterized by disturbances in perception, thought, and behavior, with features of hallucinations (false sensory perceptions), delusions (fixed, false beliefs), bizarre thought and behavior. Schizophrenia begins most commonly in adolescence or early adulthood. Without appropriate treatment it often progresses into a chronic enduring condition characterized by significant social and cognitive impairment. The pioneering scientific study linking the increased occurrence of schizophrenia in White Norwegian migrants to Minneapolis in the USA was published in 1932. The dramatic increase of migration to First World countries in the past century has catalyzed the plethora of studies of migration and mental illness. A review in 1987 of the findings of more than 100 studies of migration and psychopathology identified an increased rate of schizophrenia in migrants by a factor of 2, over the native population of the host country. (The annual incidence of schizophrenia ranges from 0.5 to 5 per 10,000.)

Significant resources have been invested in the research study of schizophrenia in migrant populations particularly in Europe. A recent review of the studies reported the excess incidence of psychosis in African-Caribbean migrants to the United Kingdom, confirming the reported risk ratios of 2–18 times the rate of schizophrenia of these Black immigrants and their second and third generation offsprings. Unlike the initial study of White migrants to a White country, the risk ratio for schizophrenia in second and third generation African-Caribbean migrants to Britain was increased rather than decreased. A meta-analysis in 2005 of 12 studies from the UK, three from Holland, one from Sweden, and one from Denmark estimated the relative risk of schizophrenia associated with immigration to be 2.7 (95% CI: 2.3–3.2) for first generation immigrants and 4.5 (95% CI: 1.5–13.1) for second generation immigrants compared with the native-born population. Another meta-analysis in 2010 also suggested that immigrants had an increased risk for schizophrenia in countries of longstanding immigration, but with lower risk for those of recent immigration. This study suggested that the risk was higher in Black immigrants and in the Black population living in the United States.

The elevated risk ratios of schizophrenia in Black immigrants to the UK were reported in the 1980s and 1990s, with the wide-ranging speculation as to the cause of this finding leading to the watershed study of the incidence of schizophrenia in Jamaica. Hickling & Rodgers-Johnson demonstrated an age-corrected schizophrenia incidence rate for Jamaicans of 2.09 per 10,000 and suggested that the findings of the British studies for Blacks in the UK are either a methodological artifact or are due to major etiological factors specific to African-Caribbean people living in the UK. The 2010 meta-analysis indicated that the three studies in the English-speaking Caribbean countries of Jamaica, Trinidad, and Barbados, using the same methodology as that used in the British studies, found similar rates to those observed in native White British in the UK. This meta-analysis also reported that the two studies in the Dutch-speaking Netherlands Antilles identified rates comparable to those observed in native Holland.

A study in 1996 in Jamaica compared the psychiatric diagnoses of White mentally ill immigrants to that country with the diagnoses of a sample of Jamaicans matched for age, sex, and social class, who had never migrated. This study reported that White mentally ill immigrants to Jamaica did not develop schizophrenia at a higher rate than the native-born. This result runs contrary to the consistent finding of increased rates of schizophrenia in immigrant populations. This study also showed that for this cohort of White immigrants, migration created a condition of immediate and marked upward social mobility in the host country, Jamaica, a factor which rarely if ever occurs for immigrants, whether Black or White, to White First World countries.

All of the meta-analytic studies that have emerged from White European or North American countries have suggested a hidden epidemic of schizophrenia in the immigrant populations of Europe and North America. These studies have given rise to a plethora of possible etiologic reasons for this putative epidemic. McGrath, in a guest editorial, agreed that migration is a stressful event, and that stigma and racism can contribute to adverse health. The editorial also supported the suggestion that the possible etiologic cause of this acknowledged epidemic of schizophrenia in Black immigrants in predominantly White countries perhaps lies in the neurodevelopment deficiency of vitamin D for Blacks living in predominantly White countries. It was suggested that it is time to examine through clinical trials the efficacy of vitamin D supplements in the prevention of schizophrenia.

The hypothesis advanced following the only study of White immigration to a predominantly Black country was alternatively linked to socio-political stress as the more favored etiologic factor. This study suggested that political/economic system in predominantly Black post-colonial countries like Jamaica protects White immigrants from the social stress of migration, which is associated with schizophrenia in migrant groups in predominantly White societies. It was suggested that the converse may also be true, namely, that the socio-economic and political structure of White First World countries may contain built-in conditions which predispose both Black and White migrants to downward social mobility, creating a psychosocial stress factor which is predisposing to the development of schizophrenia.

Related Topics

- ► Acculturation
- ► Mood disorders

Suggested Readings

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Screening

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Screening refers to a test that identifies factors associated with a certain medical condition or predisposition to diseases or that can lead to diseases for offspring. Basically it is done in order to determine whether a condition exists even before any symptoms begin.

Screening in the Clinical Context

In the context of clinical care, it is often conducted to assess the risk of breast cancer and cervical cancer, prostate cancer, colorectal cancer, high blood pressure, metabolic diseases such as diabetes and high cholesterol, and genetically transmitted diseases. Screening will be increased if the screening test is valid, easy, accessible, and noninvasive and if it is not costly.

Screening will distinguish between persons who have a specified disease, those who have a possibility to have it in the future, and those who are healthy carriers of a gene that they may pass to their children, who may then be at elevated risk of developing that disease. Screening can also be utilized to establish the prevalence of a certain condition in general population.

The screening process can be divided into three phases: preparing the patient or participant for the test, sample analysis, and interpretation of test results and information management. The patient will receive information regarding the disease (*How serious is it? What is the mode of transmission* (*autosomal dominant or recessive*)*? What are the complications? What is the significance of carrier status? What are the possibilities of treatment, if any?*; test procedures; issues related to the test (the test validity, sensitivity, and predictive value); and information on the implications of a positive or negative result. The patient will also receive information about the likelihood of correct predictions, the individual and family implications of test results, the availability of alternative tests, the potential risks and benefits of tests, and potential implications of the tests for insurance.

Analysis of the test samples depends on the type of disease for which the test is being conducted. The samples to be collected vary depending on the disease. For example, blood is taken for genetic tests and metabolic disorders and biopsies are conducted for cancer. The interpretation of test results and information management is done by a specialist in the particular medical specialty. Depending upon the particular situation, the specialist may discuss with the patient the possibility of treatment, only monitoring the patient, or pregnancy or abortion. Sometimes genetic counseling may be necessary as well.

Screening programs have many advantages and disadvantages. Many are very expensive and require significant resources, such as medical staff and laboratory technology, but they are clearly necessary. This is particularly true when the disease can be diagnosed before birth, the disease occurs frequently and is severe, and when there is the possibility of effective and acceptable treatment. Disadvantages also include the possibility of false-positive and false-negative results and the costs associated with their use by large numbers of individuals who may not be at risk for the particular disease and who will not need treatment. Additional concerns include the adverse effects associated with undergoing screening procedures, such as stress, anxiety, discomfort, radiation exposure, and chemical exposure.

The greatest advantage of screening may be the detection of medical conditions at an early stage before symptoms occur while treatment is more effective or when preventive measures can be applied. Screening can detect medical conditions of parents that can be transmitted to their children. In this case, future parents can make informed decisions regarding their procreative actions. In some cases, screening results can influence decisions about marriage for some communities, for example, Tay Sachs disease in the case of Askenazic Jews.

Screening may be recommended at varying points in time. It can be prenatal, as in pregnant women over the age of 35 years to detect neural tube defects or Down syndrome in the fetus; neonatal for phenylketonuria, congenital hypothyroidism, and galactosemia; and in adults, for multifactorial diseases such as osteoporosis and cancer. Screening for diseases such as Down syndrome, phenylketonuria, and galactosemia is not mandatory in most of the countries.

Screening in the Immigration Context

Many countries have implemented screening procedures in the immigration context to screen prospective immigrants for specified diseases. Most frequently, such screening is conducted for syphilis, tuberculosis, and HIV. As an example, the USA, Canada, and the UK screen individuals seeking permanent resident status for tuberculosis and syphilis. At one time, the USA also screened prospective immigrants for HIV. Depending upon the particular country to which someone intends to immigrate, the individual may also be screened for a variety of other infectious diseases, including schistosomiasis, filariasis, and strongyloidiasis.

Many countries are also concerned about whether an illness may impact a prospective immigrant's ability to earn a living and support himself or herself. For example, New Zealand's immigration forms include the question: "*Do you have any physical/mental/communication/developmental/intellectual disabilities which may affect your ability to earn a living or take full care of yourself?*" The USA asks a similar question of individuals intending to immigrate to the country.

Related Topics

- ► Communicable disease of public health significance
- ► Exclusion
- ► Immigrant visa status

Suggested Readings

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Suggested Resources

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UK National Screening Committee. (2009). Criteria for appraising the viability, effectiveness and appropriateness of a screening programme. Retrieved April 22, 2009, from http://www.library.nhs.uk/screening/ViewResource.aspx?resID= 314462

Secondary Data Analysis

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Secondary data analysis involves the reanalysis of existing data to study research questions that were not necessarily foreseen when the data was collected. In contrast, obtaining primary data involves the researcher collecting data directly from subjects. Secondary data is available in many forms, and offers an important way to advance research and knowledge. A major example of a data set that has been used for secondary analysis is the US Census. Other important data sets are collected at the US Federal government level. For instance, through the National Council on Health Statistics, publicly available data are collected on vital records, and surveys are collected on a range of important health and health care policy issues. With the advent and importance placed on electronic data collection, electronic medical records have become another source of large-scale data. A constraint in immigrant health research using secondary data is whether or not immigration status can be ascertained.

There are several attractive aspects to secondary data analysis. First, extensive and rich data can be readily available, at little or no cost. Also, sample sizes may be very large, so that important patterns of specialized interest such as ethnic minorities may be detectable. In contrast, primary data collection usually involves careful design, exhaustive and time-consuming effort, and is often expensive. Sample sizes are generally not large, due to financial constraints, and access to subjects that satisfy specific inclusion criteria and are agreeable to participate in a study can be limited as well.

There are also possible drawbacks and pitfalls to secondary data analysis. For instance, specific types or precision levels of data that may be important for an analysis may not be available. While proxy variables may be identified, this may require accepting compromises in terms of preferred exactness. A related issue is the identification of the scope of sampling that was conducted for the data. It must be determined if populations of interest are included in a data set, and can be identified. Also, sampling schemes may be complicated, with data collected from the same families or through community networks. Data records from subjects may thus not be statistically independent, but rather a correlated cluster structure exists. Ignoring this type of correlation could have serious consequences for the validity of the statistical inferences, so they must be identified, if it all possible from the secondary data set. Further, some subgroups may be oversampled relative to their population frequency, so that the data are not representative of the target population of interest. Weighting schemes for the samples may need to be implemented.

Advantages for primary data collection include being able to implement measurement approaches specifically tailored for the research questions of interest. Data can be collected in a range of manners considered best suited for the study, such as through surveys, structured interviews, or careful review of medical records. Specific variables of interest can be targeted, and issues in dealing with immigrant populations, such as language barriers, can be addressed. Sampling designs can be carefully considered, and correlated cluster structures easily identified and accounted for in analyses. Also, careful safeguards can be put in place to monitor data quality, and overseen firsthand. For secondary data, it may be unclear how rigorously data checking mechanisms were implemented, or how missing data arose.

In sum, secondary analysis can be a useful approach to answering research questions and may be a particularly useful way of evaluating health outcomes among immigrant or ethnic minority groups who are represented in large databases. It may be especially useful for allowing exploratory analysis of hypotheses before primary data collection is conducted. It also can be used for comparison with analyses based on primary data.

Related Topics

▶ Methodological issues in immigrant health research

Suggested Readings

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Suggested Resources

http://www.census.gov

Secondary Education

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Immigrant students are among the fastest growing population in public schools in the United States. If current immigration patterns continue, it is estimated that immigrant youth will make up 30% of the nation's school population by 2015.

Immigrant youth face a number of developmental and health challenges during their secondary education. In the United States, a number of immunizations are required for school entry, including diphtheria, tetanus, pertussis, measles, mumps, rubella, and polio. Obtaining these immunizations, or proof of these immunizations, may be difficult for newly arrived families with limited access to health care and language difficulties. Schools also usually require a general physical examination, as well as vision and hearing screening, which again could be difficult for families to obtain.

Immigrant youth have higher rates of poverty – over a third of immigrant families have difficulty affording food. Hungry students have difficulty concentrating. Immigrant adolescents may have higher rates of sleep disorders, anxiety, and depression – all of which can interfere with learning. Depending on the quality of medical care and education services in their country of origin, immigrant youth may arrive at secondary schools with undiagnosed learning disabilities.

Even before arriving at school, immigrant youth face challenges to their education. Many immigrant youth arrive with significant gaps in their formal schooling. They may have been out of school because of war, natural disasters, or time spent in refugee camps. Female youth may be from countries where girls were not provided with an education. These students may not be literate in their native language, making English literacy even more difficult.

Cognitively, younger adolescents are initially capable of mainly concrete thought and are unable to perceive the long-range consequences of their decisions. As their brains develop, they establish abstract thought processes and become more focused on the future. Immigrant youth must accomplish this developmental task while learning a new language. Becoming proficient in English – the biggest education challenge – can take 5–7 years. Studies show that immigrant youth who perceive themselves as not speaking English well are more likely to drop out of school. Immigrant adolescents must not only learn English, but they are also expected to master more complex academic content to keep up with their peers. Immigrant youth who live in homes with limited English proficiency are less likely to develop proficiency themselves and are more likely to leave school, to be behind a grade or more, or to never have been enrolled in school at all.

Despite these disadvantages, one strong advantage immigrant youth have is the high educational goals immigrant parents tend to have for their children and the high value they place on the educational opportunities offered to their children in the United States. However, parents themselves may have little formal education and may have difficulty helping with schoolwork. Parents also may place less value on the theoretical ideas learned in high school and question why more practical skills are not being taught. They also can be intimidated by the school system; that intimidation, combined with language difficulties and a work schedule that may not allow them to participate in parent–teacher conferences, can make advocating for their child difficult.

Immigrant youth must often be their own advocates. Adolescence is a time of physical and psychosocial maturation, and as youth become adults they begin to develop independence. Immigrant adolescents must adjust to a new culture and acquire a new language. In doing so, they begin the separation from their parents and their original culture. Achieving independence and a coherent sense of self can be more challenging for immigrant adolescents because they feel like they are leaving behind their old world as they enter a new one.

Immigrant youth also use school to develop peer groups. In early and middle adolescence, peer groups appear to take precedence over family as adolescents look to friends to help with self-image and behavioral codes. For immigrant youth, peer groups offer a sense of belonging. Those who do not find friends feel excluded and are vulnerable to bullying. Many immigrant parents do not understand the importance of peer groups or of extracurricular activities. They expect their adolescents to be working at jobs or to be home taking care of the smaller children.

Many alternative programs exist to address the unique challenges in educating immigrant youth. Typical ESL (English as a Second Language) programs can alienate immigrant youth and increase the likelihood of discrimination. Newcomer centers, flexible schooling, and transitional high schools are some of the more recent options that exist for secondary education of immigrant youth.

Related Topics

- ► Adolescent health
- ► Education
- ► Youth

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Segregation

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Humankind's phenomenal progress over the last 50 years has literally made the world a smaller place – technological advancement and accessibility as well as political momentum and change have played a large role in the development of global communities. This migration has resulted in a surge of large ethnically diverse migrant communities in most metropolitan cities. This in turn has placed a burden on government services and the ability of governments to adapt and cater to the needs of a much more diverse population.

With this ethnic and cultural diversity are intertwined the associated issues of segregation and acculturation. Segregation is defined as the separation of people based on race, religion, ethnic group, sex, or social class. Acculturation is the assimilation of one culture into a dominant culture. It has been considered that such acculturation may have certain benefits for society by minimizing inherent differences and a first step to consistent service provision methodology and policy. However, the acculturation of migrants to domestic culture has proven to be a slow and costly process and within certain xenophobic cultures the problem is exacerbated. This results in disparity of service provision to these communities across the service spectrum either as a result of lack of understanding, and improper access mediums.

Focusing on the health sector, a synopsis of current health segregation research makes it clear that there are various segregation dimensions to be considered, among them: residential segregation, income segregation, and racial/ethnic segregation. Dolores and colleagues explain residential segregation as being segregation in regard to the composition and spatial distribution of an entire metropolitan area.

Racial or ethnic segregation means that based on race (or alleged race), persons are restricted to either separate institutions/facilities or residences. This practice has historically occurred in Asia, Africa, and America, and works to maintain the many advantages of the race in power. Two former well-known systems of racial segregation include: South Africa's Apartheid system which sanctioned discrimination against non-Whites (including not only Blacks but also Indians and others) as well as the Southern American states after the American Civil War.

These contributory factors impact on: medical service access, patient expectations, and health outcomes. This is illustrated by a number of studies in various parts of the world. For example, in New Zealand, these have been concentrated on the Pacific Island and Asian populations. In New Zealand, the Asian population is 9.5% of the total population making them a significant portion of population. They show across the board a low level of health access with Asian-born Kiwis showing the lowest level of access. It was found that access, mental health, and levels of physical activity are major concerns that need to be addressed in order to provide the correct health service to this sector of the population. The NZASIA study on lack of cervical screening in Asian women also highlighted the impact of segregation and cultural differences on health care access. Another study by Gilbert et al. demonstrated a negative association between reports of discrimination and mental health status, among Black and Latino immigrants.

The New Zealand health system is largely community-focused, and many of the health sectors encourage in-community treatment in order to facilitate reintegration. However, with the influx of migrants and the development of migrant communities, there is now a larger need to understand the space and the community. Residential segregation has been considered as one dimension that contributes to the differentials in access and health outcomes. However, a conceptual framework considering segregation and health outcomes is imperative. A multilevel approach for research designs will allow the study of the impact of individual, neighborhood, and metropolitan area factors on health outcomes.

The following recommendations have been made to curb segregation negativities to service provision access and outcomes: inclusion of mental health measures in NZ Settlement research, collaborations between service providers, researchers and members of migrant communities, and dissemination of research to all key stakeholders.

It becomes evident that segregation has an impact on health outcomes, patient expectations as well as service access. However, the impact may indeed be positive. Some speculate on the potential positive impact of cultural differences. The example of the Pacific Island population is used to emphasize this. If socioeconomic factors were the only drivers of ethnic differences in mortality rates, then the Pacific Island population should have the highest mortality rate – however, they show a rate intermediate between that of Maori and non-Maori non-Pacific people in New Zealand. This could be a result of their cultural protection from the full impact of their socioeconomic position, and acculturation could increase the "culture capital" of the community. This will be useful in policy options for service provision within these communities.

Lorent et al. wrote that "although segregation is generally considered to be detrimental, some studies have shown that ethnic concentration provides advantages such as nurturing social contacts, improved job opportunities and integration of newly arrived immigrants." The Roseto effect, from the name of an Italian community in the United States, indicates that collective social functioning may influence health. Thus, some communities may be protected against surges in disease related to their social cohesion.

The extant literature recognizes the impact of segregation in the health sector, the potential for both positive and negative influences that need to be researched further, the need for a broader conceptual framework, and the inclusion of all stakeholders as part of the research and implementation process. There is therefore a clear need for further research on specific migrant communities to assess, first their inherent access traits and service expectations. Second, these need to be considered on several segregation dimensions in order to assess the positive and negative impacts that these factors may have. Finally, based on these findings, well-informed policy may then be developed to improve medical access levels, and overall health outcomes.

Related Topics

- ► Acculturation
- ► Discrimination
- ► Ethnic enclaves
- ► Melting pot

Suggested Readings

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Self-Concept

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The formation and preservation of self-concept is a fundamental aspect of human development that can present unique challenges for immigrants. The nature of the self and how individuals behave depends to a large extent on the patterns of action and interaction in the society in which they live. Children, adolescents, and adults each face different obstacles in the establishment of the sense of self, particularly when moving from one culture to another. Self-concept has been found to be correlated with mental and physical health, and as a result of the struggles many immigrants face, negative self-concept can sometimes develop, decreasing their quality of life. There are a number of ways to cope with this effect on both an individual and a systemic level. When providing education, social services, or medical and mental health treatment, an understanding of basic trends in self-concept and the ways in which people's views of themselves change throughout the acculturation process can be extremely valuable.

Definitions and Theories of Self-Concept

Self-concept can be defined as a complex, learned, multidimensional system of beliefs, attitudes, and opinions that each person holds about him or herself. This construct is a culmination of cognitions, feelings, and observations about one's self, assessments of the way others perceive and act toward the individual, judgments of other people's behaviors, and evaluations of personal historical narratives and ambitions for the future. Self-worth, self-efficacy, ethnic identity, and metacognition can all be aspects of an individual's self-concept. A variety of traits, characteristics, and likes and dislikes make up the self-concept, including gender roles and sexuality, cultural identity, romantic relationships, family expectations, academic achievement, career goals, and hobbies. Self-concept can evolve over time, particularly when undergoing extreme stress.

Theorists throughout history have had different ways of conceptualizing the self. William James described self-concept as being made up of a material or physical self, a social self, and a spiritual self, and wrote that people have as many social selves as there are individuals to recognize them. George Mead hypothesized that self-concept arises through social interactions as an outgrowth of the individual's concern about others' reactions, and also that there are as many selves as there are social roles. Some of these roles are thought to be of considerable significance for the individual across multiple domains, while others are specific to particular situations and settings. Carl Rogers' theory places the self as the central ingredient in personality and adjustment, and is based on a belief that there is a basic human need for positive regard from both oneself and others. Harry S. Sullivan further postulated that it is the interaction between a child and caregiver, particularly the mother, that is of utmost importance, as children internalize the values and prohibitions that receive approval from significant others. At the core, most theorists see self-concept as a learned, socially influenced way of seeing one's self in terms of values, roles, interests, goals, and relationships that influence behavior and life choices.

Formation and Transformation of Self-Concept

Over the course of one's life, individuals go through a process of consolidating and reintegrating the different components that make up their self and world view. During transitional periods, a person's awareness of the social and historical context of his or her life, aspirations for the future, character traits, struggles, and successes are all important in facilitating the capacity to deal with the developmental tasks specific to that particular stage. Two of the aspects of the self that help people organize, coordinate, examine, and understand their experiences are unity, the degree to which the person's experiences are interrelated and have meaning, and continuity, the degree to which the individual experiences oneself as the same person during these transitions. Related to these factors is the capacity to represent and reflect on thoughts and feelings in both the self and in others, and to show empathic understanding of one's experiences.

At the start of the lifespan, children's perceptions of their abilities affect their values, self-regard, and beliefs about their competence to achieve personal and academic goals. These beliefs are derived from interactions with the environment and significant others, and is shaped by both cultural and biological factors. As individuals transition through adolescence and into adulthood, the self-concept becomes more complex, due to the need to continuously reorganize the self to cope with change and increased demands, responsibilities, and role expectations. In stressful, anxiety-provoking situations, an individual's personality functioning and the stability of his or her psychic organization is put to the test. Once a crisis is resolved, emotional growth can occur; however, if conflicts are not resolved successfully, stagnation or psychopathology can occur. Throughout different developmental stages, the task is to reintegrate the internal world and reshape the self-concept based on interaction with new environments and new experiences.

The Impact of Self-Concept on Health

A number of physical and mental health factors have been associated with self-concept. Adults with positive self-concept tend to see themselves as healthier and more productive, with more control over their fitness, compared to their peers with negative self-concepts. These adults may be more likely to make healthy choices congruent with their views of themselves. For adolescents, positive self-concept has been associated with strong communication skills, academic success, and respect for authority. Adolescents with negative self-concepts have been found to have a higher risk for delinquency, depression, smoking and substance use, physical inactivity, and obesity. In general, people with a strong self-concept are more likely to be active, engage in self-care, and avoid risky behavior, all of which improve health and well-being.

Specific Challenges for Adolescent and Young Adult Immigrants

Much like the process of emerging adulthood, immigration has been described as a time of psychological flux demanding a need to reorganize the self. Historical perspectives held that immigration could be seen as a trauma that leads to “culture shock,” or a state of mourning the loss of a variety of love objects in the abandoned culture coupled with changes in identity that occur in the face of a new culture. A splitting of the self would occur in which immigrants are caught between their old selves and their attempts to adapt to the huge changes experienced in the transition to a new culture. The “sense of coherence” of the self is confidence that internal and external environments are predictable and that one has the inner resources needed to meet environmental demands, which can be threatened by immigration. The stressors following immigration can be particularly difficult for adolescents simultaneously trying to cope with a complex developmental phase. Learning a new language and cultural norms, dealing with new stimuli, confronting reactions of the host population, and coping with the myriad of emotions awaken by this process demand physical and emotional energy and time. Contemporary scholars see adolescence as a chance for immigrant youth to incorporate the values of cultural and family traditions, as well as those of the school, community, and workplace into their self-concept.

The values of collectivism and individualism vary across cultures, and can have a significant impact on the sense of self in young immigrants. In individualistic cultures, a high value is placed on sovereignty, self-sufficiency, personal goals and achievements, and having control over one’s own life. The quest for independence from parents is thought to be a typical adolescent developmental process, and pursuing one’s own dreams is emphasized. In more collectivistic cultures, personal meaning is derived from the coexistence of others, the needs of the group come before the individual, and connection to one’s family is an essential part of self-concept. In these cultures, striving for independence may not be a central focus, and if transitioning to a more individualistic society, the values placed on the self versus others can come into direct conflict. Despite this conflict, collectivism can be an asset and protective factor for ethnic minority families, especially under conditions of racism, immigration, or poverty. An alternative view of collectivism and individualism is that these are not two mutually exclusive constructs, but rather interacting qualities that work together in both individual and relational development. When working with immigrant populations, it is essential to have an understanding of and respect for the values of the culture from which they came, and to avoid imposing one’s own views on what is considered optimal development. At the same time, it is also important to be cognizant of the specific pressures placed on individuals in the host culture, and to be aware of the difficulties immigrants may face in the maintenance of self-concept.

Navigating the Process of Change in the Self-Concept of Emerging Adults

A loss of feelings of belonging and competence can be particularly damaging to young people trying to assert themselves as competent and masterful. Especially in individualistic societies, with adulthood comes an expectation of becoming responsible for attaining goals and relinquishing childish dependence upon parents. Developing a personal authority that reflects a young person's growing responsibility for their life improves the ability to make goals and commitments. Some degree of independence from parents combined with parental support is necessary to accomplish the developmental tasks of this stage. However, the nature of relationships between children and parents can take on different patterns in immigrant families.

Along with individual developmental tasks of adolescents, young immigrants often have responsibilities and obligations including helping the family financially, advising and translating for parents, and taking care of siblings. Greater expectations for assistance, support, and respect for the family can lead to a less consolidated and coherent sense of self compared to nonimmigrant peers, because keeping responsibilities to the family in mind can make it challenging for young adults to incorporate all of the different roles they play into their self-concept. Adolescent immigrants tend to be both more autonomous from their parents, taking on increased individual and family responsibilities, and simultaneously more connected to their parents, due to family obligations and needs. For immigrants, experiencing high levels of chronic stress and daily hassles impacts the sense of self, as it can be confusing to navigate expectations of multiple roles when personal values and desires are highly dependent on the needs of others. In order to maintain a healthy, adaptive self-concept, the tasks of emerging adulthood may need to be negotiated within a context of closeness with the family that has less emphasis on independence.

Catherine R. Cooper's Individuality and Connectedness model has been used to explore ways to bridge the multiple worlds that adolescents inhabit in order to strengthen their self-concept and motivation to succeed. Within this model, it is predicted that with enough support, adolescents can move toward achievement on behalf of both themselves and their families and communities. Self-concept can be built by examining the many worlds the individual inhabits in terms of expectations, experiences, behaviors, relationships, desires, and how each world overlaps or contrasts with the others. Educators can help these students find ways to pursue ideal lives and individual goals for themselves that include a sense of morals related to collectivistic values of family, community, and culture, as opposed to treating these adolescents as simply passive reactors to social, economic, and cultural forces.

Themes of Adjustment in Self-Concept

Individuals who migrate at later stages of development undergo more subtle and complex changes in self-concept compared to children and adolescents. Moving to a new country in adulthood with a sense of self that is closely linked to the culture of origin can lead to a number of different splits and reintegrations of the self. One theme that is often seen is moving from love or hate to ambivalence. Immigrants may hold "all-good" or "all-bad" conceptions of either the former country or the new culture, and idealizations and devaluations must be synthesized for healthy adjustment to occur and for both countries to be seen as multidimensional with positive and negative elements. A second theme is feelings of being "too close" or "too far" from either the old or the new culture, and a process of consolidating experiences can lead to a more optimal distance from each. A third split and reintegration is moving from a focus on the past or future to concentrating on the present. In these cases, there may initially be idealizations of the old country combined with longings to return in the future, and a resolution of this conflict can occur if the individuals can be mindful of the present and see a meaningful future in the new country. Finally, when transitioning to a new country, perceiving the new culture and customs as part of a "mine versus yours or us versus them" split can eventually be integrated into a "we and our" framework. During this process, new immigrants move from identifying totally with one culture and rejecting the other to feeling as if both cultures have become a part of who they are.

Adult immigrants may have a tendency for nostalgia and a need to mourn the loss of the old culture. In some cases, "ethnocentric withdrawal," clinging to an idealized view of one's earlier culture, or "counterphobic assimilation," a complete renouncement of the earlier culture, can occur. Nostalgia can lead to depression and a wish to return to something that was never there in the first place, and can block development and growth. In some circumstances, this can be a healthy, adaptive defense to protect the self from overwhelming anxiety, but in other cases, these defenses become pathological, preventing acculturation. Mourning the mental image of the lost culture may be necessary to move forward. Although this process may be painful in the moment, it is important and essential in the long run to better adapt to the new society.

Social Identity Theory and Strategies for Dealing with Negative Self-Concept

According to Tajfel and Turner's social identity theory, self-concept is largely shaped by group identification, and positive social identities are formed through favorable comparison of the individual's in-group against an out-group. Social identity theory is based on the assumption that there is a basic human need to belong, and people will strive to maintain a positive view of themselves and their own reference group. Being an immigrant can play a very important role in the conception of the self, as discrimination often works to shape and strengthen social identity. Negative self-concept is likely to develop through intergroup comparisons that result in feelings of deprivation and disadvantage, and when destructive stereotypes are internalized.

To ward off damaging effects of a negative self-concept and increase feelings of control, people may try to strengthen their self-concept through a variety of means, including individual mobility, social creativity, and social competition. The first coping mechanism, individual mobility, involves personal attempts to leave or dissociate from one's in-group. If their group is devalued, immigrants may try to distance themselves through acculturation and assimilation. Through upward social mobility, individuals attempt to move from a lower status to higher status group. Through social creativity, an individual may attempt to alter their perceptions instead of actions. There are a number of ways individuals use social creativity, including seeking new elements for intergroup evaluations, redefining existing elements, or selecting a lower-status reference group for comparison. Upward comparison within one's own group can be identity-enhancing, because it makes the group identity seem more positive and attractive. Conversely, the "black sheep effect" refers to the tendency for unlikable in-group members to be more negatively evaluated than unlikable out-group members. Changing the comparison group is another alternative. Instead of comparing to the dominant majority, an individual may make comparisons to other minorities or to other marginalized groups from the past.

The final coping mechanism, social competition, may be the most difficult to utilize, as it requires engagement in social action to promote changes in the status quo. These group actions, usually performed by people who have been living in the host culture for many years, may be used to gain acceptance from the majority culture. In these cases, social competition can be used to reject social inequality and promote collective actions to improve the condition of the group. Social action can influence in-group members to reduce behaviors that reinforce negative stereotypes. Attempting to change deviant behaviors of in-group members who impact the perceptions of the majority group can improve social status within the host culture.

Conclusion

Self-concept is complex, constantly evolving, and vulnerable to the experiences of immigration, acculturation, and assimilation for people of all ages. Although a number of different theories attempt to define and explain self-concept, one thing that remains consistent is the belief that self-concept can impact adjustment, psychological and physical health, quality of life, and important life decisions. The process of immigration can naturally bring about changes and re-integrations of the self and these transformations can be either adaptive or destructive. There are a number of ways in which immigrants can work toward modifying the old self into an integrated conceptualization that both respects and honors the culture of the past and incorporates new world values in a way that enables a successful, healthy transition.

Related Topics

- ► Acculturation
- ► Culture shock

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Suggested Resources

Collectivism vs. Individualism. http://freedomkeys.com/collectivism.htm

Cooper, C. R. Bridging Multiple Worlds Alliance. http://www.bridgingworlds.org/

The George Mead Project. http://www.brocku.ca/MeadProject/

Self-Medication

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Globally, the majority of care in illness involves self-care, including self-medication without resort to a medical professional. Self-medication includes self-treatment with over-the-counter medications, herbal medicines and other "traditional" remedies, and – commonly in less-regulated contexts – prescription medications. In many immigrant source countries, "prescription" drugs such as antibiotics are easily obtainable without a prescription from pharmacies and community shops; informal medicine vendors may also sell imported prescription pharmaceuticals in countries with stricter vendor controls. Thus, immigrants may be accustomed to a wide range of self-medication practices. Self-medication is influenced by cultural knowledge, preferences, and familiarity with medicines and ailments; economics and access to health services, drugs, and sources of medicine knowledge; social relationships with family, friends, medicine vendors, and physicians who influence ideas about medicines and their uses; and other sources of information including advertising and health education.

Cultural practices guide medication use the world over, resulting in self-medication patterns among immigrants that may be different from the native-born population of a given nation and unfamiliar to local health providers. For example, in many parts of the world certain forms of medications are preferred, such as injections, which may be perceived to be stronger or faster-acting than pills and carry the potential infection risks of needle-sharing. Antibiotics may be perceived as appropriate for a broad range of ailments independent of bacterial infection; certain antibiotics may be associated with particular organs or symptoms, for example. Medication choices may be guided also by other cultural perceptions of medication efficacy. For example, humoral (hot-cold) theory is widespread globally, and may result in a preference for medications that are perceived as "hot" for "cold" ailments and vice versa, and a rejection of medications that are viewed as humorally inappropriate. For example, a "hot" medication such as penicillin might be seen as inappropriate for a "hot" illness such as a rash. Concerns about side effects may also be culture-specific and affect medication choices and uses. For example, Mexican immigrants in the USA describe vitamins and iron pills as inducing hunger, a side effect that may be desired (e.g., to make children eat) or avoided (e.g., to prevent weight gain) depending on the circumstances. Cultural and habitual guidelines for medication use also may determine the timing and dosage of medication consumption – for example, people may be accustomed to following "rules of thumb" such as taking medications in the morning, in the afternoon, and at night rather than every X number of hours.

A preference for certain familiar or trusted medications, or certain medication types or forms, may influence immigrants to import medications informally from their home countries for use in self-medication, including "prescription" medications obtained without consulting a physician. For example, in the United States, Mexican immigrants may border-cross into Mexico in order to buy Mexican oral antibiotics and other medications, or injectable medicines including antibiotics and vitamins. Even those whose countries of origin are more distant may import familiar medications from abroad, or they may have friends and family import medications. Such medications may also be sold "under the counter" in local shops owned by immigrants. Researchers in developed countries have expressed concerns about the quality, safety, and unregulated availability of some medications obtained from less-developed nations.

The practice of obtaining medications from abroad is encouraged by familiarity, cultural preferences, and experiences of efficacy associated with drugs from "back home." The practice is influenced also by the fact that immigrants may find it difficult to select, read, or interpret the proper use of unfamiliar over-the-counter medications in their new countries, especially given language barriers experienced by recent or elderly immigrants. Medications purchased abroad also may be less costly, as well as conveniently available without a prescription. Lack of health insurance and other barriers to health services use may encourage greater self-medication among immigrants than the general population, whether with pharmaceuticals purchased locally or abroad. In contrast, some recent immigrants lacking the necessary language skills, familiarity, and income to effectively select, purchase, and read the instructions on locally available over-the-counter medications may lack access to the ability to self-medicate easily for everyday ailments, impeding their use of appropriate self-care. Borrowing or reusing leftover prescription medications may be additional strategies used to compensate for a lack of familiarity with, or access to, locally available medications.

Herbal and other "traditional" remedies may be used in self-medication as well. While generational differences may occur, younger second-generation immigrants may also learn from their elders, resulting in intergenerational continuity in self-medication practices. Forms of traditional medicine employed by immigrants may include oral and topical preparations, self-prepared herbal medicines and commercial herbal products, as well as other treatment practices such as massage, other forms of physical manipulation, and spiritual healing. Home remedies may be used for ailments ranging from colds to severe and chronic conditions, and may be employed in combination with prescribed or over-the-counter pharmaceuticals. Informal practitioners from immigrant communities may be consulted also as sources of medicines and advice; these practitioners range from herbal experts to lay "injectionists" who inject medicines sometimes obtained from abroad. While "natural" home remedies may in some cases be preferred as a less toxic or dangerous alternative to pharmaceuticals, it is important to note that cosmopolitan medicines are extremely popular globally, and are commonly accompanied by expectations of the availability of a "pill for every ill" such that a wide range of drugs may be sought even for minor or self-limiting ailments.

Related Topics

- ► Alternative and complementary medicine
- ► Cross-cultural health
- ► Cross-cultural medicine
- ► Cultural background
- ► Cultural competence
- ► Cultural humility
- ► Drug use
- ► Prescription drug use

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Suggested Resources

For information on a worldwide view of responsible self-care and self-medication. http://www.wsmi.org/pdf/wsmibro3.pdf

For information on reducing adverse self-medication behaviors. http://worldwidescience.org/topicpages/r/reducing+adverse+self-medication.html

Serologic Tests

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Serologic tests refer to detection on antibodies present in serum using an antigen–antibody reaction.

Antibodies are formed in response to an infection (against a given microorganism), against other foreign proteins (mismatched blood transfusion), or to one's own proteins (autoimmune disease). The first use of the term "antibody" was in an article by Paul Ehrlich, "Experimental Studies on Immunity," published in October 1891. Antibodies (known as immunoglobulins) are gamma globulin proteins that are found in blood or other bodily fluids and are used by the immune system to identify and neutralize foreign substances entered into the body known as antigens, such as bacteria and viruses. Antibodies are produced by a kind of white blood cell called a plasma cell.

There are many categories of antibodies but, classically, IgM antibodies are specific for an acute phase of a disease, while IgG antibodies are specific for a chronic form or for exposure in the past to a certain antigen.

An antigen is generally any foreign substance (for example, whole bacterium or parts of it) that enters into the body, induces forming of antibody, and reacts specifically with it.

Serological tests are useful for the diagnosis of infections with bacteria that cannot be cultivated, on culture media (*Treponema pallidum*, *Mycobacterium leprae*) or can be cultivated with difficulty (*Chlamydia trachomatis*) when the site of infection cannot be reached in order to collect samples to perform direct diagnosis. These serologic tests have several advantages including the following: the test results are not influenced by therapy with antibiotics, the tests are easy to be performed (agglutination test, precipitation tests), are relatively cheap, and can be used both as diagnosis tests and confirmatory tests.

Disadvantages of this test include the time lag between onset of infection and the development of antibodies to the infecting microorganism resulting in the possibility for false negative results.

Methods used for serological tests that are commonly used in immigrant populations are: agglutinations tests, precipitation tests, complement fixation tests, hemmaglutinations tests, inhibition of hemaglutination tests, immunoflorescе, ELISA (Enzyme Linked Immunosorbent Assay), RIBA (Recombinant Immunobinding Assay)-Hepatitis C or WESTERN BLOT (HIV infection).

Related Topics

- ► Communicable disease of public health significance
- ► Medical examination (for immigration)

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Sex Ratio

► Mortality and morbidity

Sex Work and Sex Workers

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Sex work consists of engaging in sexual intercourse or performing other sex acts in exchange for money or favors. Sex work can be voluntary or forced through coercion or sex-trafficking. It can be empowering for those who make the active choice to engage in these activities, disempowering for those forced into this type of work against their will. Sex work can be a strategy for survival and in some cases for self-determination.

A sex worker is a person who works in the sex industry, such as prostitution or pornography among others. Some sex workers are paid to engage in sexually explicit behavior which involves varying degrees of physical contact with clients. A sex worker may be any combination of sex (male/female), gender (masculine/feminine/trans), and sexual identity (straight, bisexual, lesbian/gay.)

“Sex,” in contrast with “gender” underlines the social and cultural dimensions of masculine and feminine, and distinguishes between biology for the former, and society for the latter, and similarly between nature and culture.

“Trans” could mean many things: trans(s)exual, transgender, trans-amorous, trans-man, trans-woman, transfag, transdyke, male to female, female to male, genderqueer, intersex, pre-op, post-op, non-op, drag king, drag queen, gender-neutral, two-spirit, poly-gendered, boi, trans-partner, man, woman, or others.

Sex workers can and have been categorized using a number of methods.

The means of procuring clients: market sex workers (at the lowest rung of the earnings ladder); streetwalker (low, medium, high income worker); employed commercial such as massage parlor, bar, nightclub workers (low, medium, high income worker); freelancers and escort (medium, high income worker); phone sex operators (have sexually oriented conversations with clients, and do auditive sexual role play); web cam sex and performers in live sex shows; performers of erotic dances and other acts for an audience (striptease, go-go dancing, burlesque, peep shows).

The mode of employment: those working in the primitive labor market (persons who solicit in the street any time); those in the enterprise labor market (massage parlor and establishments); and those in self-employment (call-girls-boys-trans and social escorts).

Their pick-up mode: selected by clients viewing a group of women, along the streets, at entertainment or health center, through intermediaries such as pimps, procurers, or agents.

Their employment status: primary (with no other employment) or secondary (full time or occasional part time).

The sex of the customers and the sexual behavior that a sex worker engages in may not correspond to his/her sexual orientation.

In most countries, sex workers are stigmatized, discriminated, prosecuted, and harassed. Sex workers are commonly perceived as belonging to a social group which may engage in high-risk behavior for acquiring or transmitting HIV and other STIs. But in many parts of the world the reality may be quite different. It is difficult to determine precisely the incidence of HIV infection among sex workers, or the prevalence of safer sex practices during commercial sex transactions. Some limited studies have been carried out around the world over more than two decades of the HIV pandemic, and the results do not seem to confirm that sex work in itself significantly contributes to the spread of the infection. Like other marginalized populations, sex workers often receive scant attention from both public health officials and researchers. The stigma and the risk of criminal sanctions attached to sex work make reliable data hard to come by, and even more so for male and trans sex workers. According to research, the most common pathogens found in sex workers correspond to those that are highly prevalent in the general population. These were human immunodeficiency virus, *Neisseria gonorrhea*, *Chlamydia trachomatis*, *Treponema pallidum*, *Trichomonas vaginalis*, and Human papillomavirus.

Research has shown that in many developing regions of Africa and Asia, sexual relations with a greater number of partners and population mobility feature as principal factors for spread, transmission, and acquirement of STIs. This is especially relevant for sex workers who are often forced to leave their own country to work abroad. According to international data, most sex workers are illegal immigrants who find themselves living in very poor socio-hygienic conditions, which greatly limit their ability to seek access to information on available health services, prevention practices, and their legal rights. Consequently any access to healthcare services they may have is usually woefully inadequate. Language differences, the culture gap, and isolation from the local population make health-seeking behavior more difficult. To make matters worse, sex workers are not generally provided with targeted up-to-date information about prevention practices such as protected intercourse or safer sex.

Related Topics

- ▶ Addiction and substance abuse
- ▶ Africa
- ▶ AIDS knowledge
- ▶ Asia
- ▶ Barriers to care
- ▶ Behavioral health
- ▶ Bisexual
- ▶ Communicable disease of public health significance
- ▶ Discrimination
- ▶ Emigration
- ▶ Female genital diseases
- ▶ Female sex workers
- ▶ Homosexuality
- ▶ Human immunodeficiency virus
- ▶ Human rights
- ▶ Illegal immigration
- ▶ Immigration in the global context
- ▶ Immigration status
- ▶ Lifestyle
- ▶ Migration
- ▶ Prostitution
- ▶ Sexually transmitted diseases
- ▶ Stigma
- ▶ Substance use
- ▶ Trafficking

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Suggested Resources

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TAMPEP. European Network for HIV/STI Prevention and Health Promotion among Migrant Sex Workers. http://tampep.eu

The Lesbian, Gay, Bisexual & Transgender Community Center. http://www.gaycenter.org

Sexually Transmitted Diseases

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Sexually transmitted diseases (STDs) are one of the most common causes of illness among population of young age. They have major negative consequences on the health of affected individuals, on their reproductive potential, and on the communities which they come from. In this context it is true that each individual's choices are private matters, but one's sexual behavior may have significant implications for public health.

STDs have important social and economic implications. Every year, millions of young people reach the "reproductive age." Many do so in a safe, controlled way, being able to establish a balance between their goals, education, and sexual maturity, as essential, secure, and stable elements of human life. Nevertheless, instability and migration expose especially young people to an increased risk of unprotected sexual practices and STDs, such as HIV infection. In particular, the poor and uneducated people get to be involved in sexual activities without access to proper information and protection methods. Beyond socioeconomics, there are also various cultural and moral reasons for their lack of information. Throughout the world, there is evidence that informed people behave much more cautious than uninformed ones.

Historically, migration has been a major way in which diseases have spread. Infectious diseases usually spread farther and faster as transportation infrastructure is improved. The transmission pattern follows major routes and passes through international airports and seaports.

The more the people move, the faster the STDs are transmitted, just like other infectious diseases can spread. For instance, mobility itself has been considered an independent risk factor for HIV infection. While research results on the prevalence of STDs among migrant groups in different countries are still unclear and contradictory, classic studies show that the spread of HIV often coincides with migration patterns. Usually, HIV infection appears first in urban areas and then diffuses to rural areas along major road networks. A study in Kenya found that men who migrated between urban areas were more than twice as likely as nonmigrants to engage in high-risk sexual behavior – that is, to have more than one sex partner and to have sexual relations without using condoms. It was not clear whether their behavior was more risky because they moved or whether those who moved were prone to more risky sexual behavior than others.

Other factors may also increase risk for STDs in migrants and refugees. STDs spread most quickly in conditions of poverty, powerlessness, and social instability. Such conditions are often found in illegal immigrant communities, and even in legal ones. These people are underinsured at best, most of them having no financial resources for any health care plan at all. Also, immigrants often settle in areas with high prevalence of HIV infection, are exposed to intravenous drug use, and may be in poor health. The disruption of social ties and family life that occurs during migration, especially in situations of poverty and crisis, increases the risk of STDs, as immigrants could find new sex partners. Sometimes people have no choice but to sell sex for protection, money, food, and other goods.

During the last 30 years, population mobility both within and across national boundaries has increased dramatically all over the world. All mobile populations that are sexually active are at increased risk of acquiring STDs. The risk of acquiring an STD may be enhanced by poor understanding of the global epidemiology of these infections and the means available to mitigate risk. Rates of STDs may be elevated among migrant and marginalized populations (e.g., refugees, internally displaced, street youth). These populations may be overrepresented among commercial sex workers in many countries.

STDs are among the most frequent transmitted infections worldwide, the rates of the STDs being particularly high in developing areas. In 1990, the World Health Organization estimated the global burden of curable STDs at more than 250 million cases (syphilis, gonorrhea, chlamydia, and trichomonas). Estimates rose to 340 million new cases of STDs in 1999 and they included 151 million cases in South/Southeast Asia, 38 million cases in Latin America, and 69 million cases in Africa. In many countries, these increasing figures have been fueled by the economic and societal disruption of the HIV pandemic. In sub-Saharan Africa, in particular, there has been an explosive growth in the number of children who have lost one or both parents to AIDS (about 14–20 million in 2000). Many of these children have been driven to trade sex for food in order to survive.

More than 20 different infectious agents can be acquired and/or spread by various types of sexual contact (e.g., vaginal, anal, oral-genital/oral-anal). *Chlamydia trachomatis* is the most prevalent bacterial STD worldwide but prevalence rates for many of these infectious agents still vary widely by geographic region, for example, *lymphogranuloma venereum* is common in Southeast Asia, Africa, Central America, and the Caribbean, accounting for 2–10% of genital ulcers in India and Africa; chancroid is also common in many of the world's poorest regions such as areas of Africa, Asia, and the Caribbean, while rarely reported in the United States. Yet, changes in migration, immigration, and travel patterns during the last 50 years have ensured that almost any STD can be acquired anywhere in the world.

Many of the people who move frequently, including truck drivers and other transportation workers, sex workers, and seasonal agricultural workers and other temporary immigrants have a high risk of STDs. Although not considered temporary immigrants, long-distance truck drivers are of particular concern to disease-control programs because they are often at high risk and can spread STDs over long distances. They travel frequently, often to areas with high levels of STDs and, because they are away from home for long periods of time, they may have many different sex partners.

For example, in a survey among 400 West Bengal long-distance truck drivers, more than 60% reported having visited sex workers, 36% had never heard of AIDS, and only 22% were regular users of condoms. About one-half of truck drivers arriving in Kigali, Rwanda, from Mombassa and Nairobi, Kenya, were HIV-positive, according to a 1994 study. In a study of 200 adolescents who frequented truck stops in Kenya, half the boys and almost one-third of the girls reported having had at least one STD.

Many sex workers move from place to place, whether voluntarily or involuntarily. For example, women from Cambodia, Laos, Myanmar, and Vietnam work in brothels in Thailand. Sex workers from Thailand and the Philippines work in Japan. Thai women become sex workers in Singapore, and Nepalese women work in India, where 35% or more of sex workers are HIV-infected. Sex workers may spread HIV from cities to rural areas when they return home. In Ghana, many rural women who left for Côte d'Ivoire and became sex workers brought HIV infection back home to their villages, which now have a high prevalence of HIV infection.

Often, boom towns and tourist centers that attract temporary immigrants and visitors also attract many sex workers, to whom people away from their spouses or usual partners may turn. Immigrants who have sex with sex workers suffering from an STD can transmit the disease to other sex workers and also to their spouses or other partners at home if they do not use condoms.

HIV/AIDS has spread even to remote countries with conservative norms about sex. For example, in the Pacific Island nation of Kiribati some men who leave the country to work on foreign ships have become infected with HIV and have spread the virus upon returning home.

Some countries have charged international immigrants and foreign visitors with introducing HIV. China has held foreign tourists responsible for bringing the virus inside the country, although many HIV cases in China have involved returning emigrants who had had contact with sex workers elsewhere. In Ethiopia, refugees along with sailors and sex workers have been blamed both for the introduction into and for the transmission of HIV within the country. Mexico's Health Minister recently pointed to Mexicans returning home from the United States as the reason why the incidence of HIV/AIDS was increasing in rural areas of Mexico, especially where there is substantial migration to and then back from the USA. An estimated 25% of HIV/AIDS cases in Mexico occur in individuals who have been temporary immigrant workers in the United States.

A few countries such as India, the Gulf States, South Africa, Cuba, and Iraq have tried to stop the spread of HIV/AIDS by preventing people suspected of being infected with HIV from entering the country. However, border controls are ineffective and only create a false sense of security and detract attention from the need to reduce high-risk sexual behavior within the country. The World Health Organization (WHO) has also taken a stand against mandatory HIV testing in refugee situations, arguing that the tests can be inaccurate and do not prevent the spread of the disease. Mandatory testing may even increase the spread of HIV, if unsterile needles are used for drawing blood for tests, by infecting the people being tested.

The emergence and subsequent expansion of HIV infection and AIDS has had a major impact on preventing and controlling STDs and has also complicated the health care provided to such patients. It is advisable to perform syphilis serological tests and counseling and voluntary testing for HIV in all patients seeking consultation for any STD. In all cases, it is advisable to inform the patient about STDs issues (including HIV infection) and to present possible ways of preventing such infections.

Antibiotic resistance of some of the pathogens which cause STDs is increasing and further complicating the management of these cases. Providing adequate medical care in cases of STDs remains the most important element in controlling their spread, since it prevents complications and sequelae, and reduces transmission in the community.

Prevention has a very important role in STDs management, due to the absence of any possibility for vaccination against some diseases (syphilis, gonorrhea) on the one hand, and to the absence of any curative therapy for viral diseases such as hepatitis B and C or HIV infection, on the other. But yet, we know exactly how to prevent such infections.

The need to ensure a more effective prophylaxis in this area becomes a social obligation. Sexually transmitted diseases, with their gravity and their impact on social life, cannot be placed at the same level with other infectious and contagious diseases, because they are perfectly and completely preventable. All sexually active individuals must be properly informed, appropriately counseled, and encouraged by health authorities and by the media to modify sexual behaviors that are known to favor the transmission of infections.

Prevention methods in STDs vary according to efficiency and moral acceptability: information, education, behavioral changes, and use of condoms. While the use of condoms reduces the transmission of various sexual infections, the true preventive measures aim at modifying sexual behavior through information. But even in this context of radical prophylaxis concrete proposals are different. Some physicians reduce the level of information to a simple data communication, particularly about the transmission of sexual diseases and about condom protection, which means education for “safer sex.” Further, modifying sexual behavior includes a reduction in the number of sexual partners.

Public health authorities must identify the most suitable methods to decrease the number of cases of STDs among immigrants through information and sexual behavior modification, but also to educate young people, in particular about respect for human sexuality.

Contact tracing is the process by which sexual partners or other persons exposed to sexually transmitted infections are identified, located, evaluated, tested, and treated, as well as counseled about prevention. (This process may be known as partner notification in some countries; in the U.S. partner notification is a procedure that is distinct from contact tracing.) All sexual partners, parents of the infected newborns, intravenous drug users who share the same syringe and needle, or individuals who might be involved in cases of sexual abuse are possibly exposed to STD. Informing partners, treating and counseling them are mandatory in all cases of STDs. These measures have a positive impact not only on public health (surveillance and fight against the disease), but also significantly contribute in reducing the risk of patient re-infection.

Health authorities must carry out epidemiological investigations to determine the risk of an STD epidemic and to identify infected people (ill or carriers) and their contacts. Systematically identifying infected individuals is of great importance as the spread of STDs is heavily related to their behavior. In order to interrupt the chain of transmission, it is critical that the infected individuals be recognized, treated, and educated regarding sexual behavior changes.

Epidemiological investigation in venereology starts from the person asking for medical care and subsequently aims at the identification of the infection source. Both partners will be treated and they will discontinue sexual activity until certification of healing through laboratory tests. Sometimes there is a certain resistance from the patients in achieving the epidemiological investigation, due to the specific mode of transmission of these infections.

Immigrants as a group are already subject to discrimination, rejection, and social marginalization, because of their cultural and socioeconomic status. Specific illness beliefs may sometimes alter their own perception toward STDs, and language barriers can discourage them from seeking medical care. These could be the reasons why patients often refuse to provide history data which are useful to epidemiological investigation, leading to misdiagnoses or mistreatments.

The patients mostly assess the impact of the STDs on their personal life rather than on their health or on the other's health. Because of poor education and low exposure to media or to the world outside community, many infected immigrants may not be aware that some of the STDs are actually easily diagnosed and treated. As a consequence, strategies are needed to encourage testing for curable and non-curable STDs. In order to be effective, the strategies must consider the individuals' attitudes and beliefs about the influence of STDs on sexual relationships, as well as the public perception about existing methods of prevention, diagnosis, and treatment.

Relatively little attention has been paid by humanitarian agencies to the treatment of refugees and immigrants suffering from STDs. Among eight refugee camps in the Great Lakes Region of East Africa, only the two oldest camps provided comprehensive treatment for STDs at separate clinics; these served mostly men who were reluctant to bring in their wives or other partners for treatment. If attention is to be paid to STDs and especially HIV/AIDS, it is on a case-by-case basis. Such diseases are identified, for example, during pregnancy or childbirth rather than as part of a screening effort. For this reason little attention is given to treatment of partners and to follow up.

Yet, for public health reasons, some countries have established health care programs that enable any person suspected of suffering from an STD to access care. Such programs offer diagnostic methods, counseling, treatment, and follow-up for free, no matter the age, nationality, employment status, or medical insurance of the patient.

Related Topics

- ► Education
- ► Health perception
- ► Health promotion
- ► Human immunodeficiency virus
- ► Internally displaced persons
- ► Marginalization
- ► Prostitution
- ► Public health
- ► Refugee health and screening
- ► Sex work and sex workers
- ► Syphilis

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Sexually Transmitted Infections

► Sexually transmitted diseases

Shame

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Shame is the painful feeling arising from the awareness of something dishonorable, improper or ridiculous, done by oneself or another. Shame is a complicated feeling that can have many origins. Any person can feel ashamed, but it can have wide ranging and complex implications for the health of immigrant persons. Shame can come from the dominant culture, for example, shaming immigrants based on their language, accents, practices, and customs. This can lead to immigrants being less likely to access needed services in their new homes because they fear, often correctly, that they will experience the shaming feeling directly from the dominant culture. As an example, a study in the *UCLA Law Journal* noted that police receiving phone calls about immigrant women being battered "were not taken seriously or responded to appropriately." This inappropriate police response mirrored a dominant attitude about immigrant women, particularly Latina immigrants, in Los Angeles. Members of immigrant communities are well aware of the attitudes of the culture around them and modify their behaviors to defend themselves from shaming from the dominant culture. In this case, an immigrant woman's response to shaming from the external culture may initially be seen as not self-protective, but understanding the full context of the response from authorities can reframe this response as protecting oneself and community from shaming.

Immigrants also experience shame based on things that may be stigmatized in their cultures of origin, but not necessarily the culture where they live. For example, immigrants may have different explanations for the causes and outcomes of illnesses and may see illness as a physical mark of shame. Ultimately, this belief may lead immigrants to be more reluctant to seek health care, because either they do not want to acknowledge or address an issue that they believe is shameful or they do not want others thinking that they have a shameful condition.

Immigrants can also feel ashamed because of conditions that may be seen as shameful in their cultures of origin and in their new cultures. Though infection with HIV is less stigmatized in many places around the world than it originally was, it still causes many people shame and is treated as shameful in many places. Immigrants that are infected with HIV may be less likely to seek care for their illness, because they are afraid of being shamed both by health authorities and by their own communities. In addition, feeling shamed for a condition like HIV may lead people to be exposed to violence, and immigrants are more vulnerable to violence because of the stigma and shame they may receive from people in their host country. Occupations can also be a source of stigma for immigrant persons – such as undocumented labor or sex work. Immigrants who earn money in these ways, or in other parts of the underground economies, may feel shame about their source of income, if their language or immigration status does not allow them to be employed in other ways.

Ways that immigrants may be shamed are interlocking and overlapping – people may feel them from many different angles. Any experience of shaming may lead persons to internalize that shame, and that internalization may leads not only to the changes in behavior discussed above, but also to larger psychological disturbances. A person that feels deeply ashamed of any of his/her circumstances may experience depression, or feelings of suicide, or other psychological difficulties. In immigrants, this may lead to even more serious problems, because they may not be able to access therapeutic services due to lack of money or other concerns. In addition, there may be a lack of therapeutic professionals that are linguistically or culturally competent with the particular community, or the person affected may be unfamiliar with the country of residence's health care system. Traditional healers and other therapeutic professionals within the immigrant's community may also be inaccessible because of the shame related to the issue that the particular immigrant is facing. Shame is complex, interlocking, and can have significant effects on the health and well-being of all peoples and is of particular interest in immigrants because of their unique circumstances.

Related Topics

- ► Acculturation
- ► Culture shock
- ► Discrimination
- ► Identity
- ► Marginalization
- ► Mental health
- ► Poverty

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Shenkui

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Shenkui is a Chinese culture-bound syndrome attributed to excessive semen loss. Similar to the more widely studied *dhat* found most frequently in India, sufferers of *shenkui* endorse both physical and psychological symptoms which are ascribed to an imbalance in Yin and Yang. Semen is an essential component of Yang, or male energy, and disharmony, or an excess of Yin, can result from semen deficiency and loss. It is believed that excessive semen can be lost through repeated sexual intercourse, masturbation, nocturnal emissions, or through the perceived passing of semen in white or turbid urine. Physical symptoms of *shenkui* include general weakness and malaise, musculoskeletal pain often in the back or kidney region, dizziness, and sexual dysfunction. Males presenting with the disorder often report high levels of anxiety and panic, as well as fear that the loss of Yang through semen loss will result in death.

Shenkui is classified as a culture-bound syndrome in the DSM IV-TR and the ICD-10 Classification of Mental and Behavioral Disorders.

Related Topics

► Cultural background
► Culture-specific diagnoses
► Dhat

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Shiatsu

► Alternative and complementary medicine

Shin-Byung

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Shin-Byung translates into English as "God" or "divine illness." Often referred to as a Korean "folk illness," it is characterized by physical and psychological symptoms that manifest in an individual who has been called to be a *Mudang*, or Korean shaman. Reported most frequently in women, *shin-byung* consists of three distinct phases. The initial phase of *shin-byung* is characterized by physical complaints such as general weakness and malaise, lack of appetite, gastrointestinal upset, musculoskeletal pain, and dizziness. Psychological symptomotology may also be present in the forms of insomnia, depression, or anxiety, and individuals may report increased levels of fear and confusion. The duration of the initial stage varies greatly between cases, from days to decades. Further, individuals in this stage are often unaware they have *shin-byung*, and as such may seek medical treatment for that which they view to be purely somatic difficulties. During the second phase of *shin-byung*, an afflicted individual becomes aware that she or he has received a divine call to become a *Mudang*. This call, as well as the diagnosis of *shin-byung*, is revealed through dreams, periods of dissociation/depersonalization, and/or hallucinatory experiences. Previous somatic symptomotologies come to be understood as the beginnings of possession by ancestral spirits. Individuals in the second stage of *shin-byung* have been characterized in the literature as resembling persons with Western mood, dissociation, and/or psychotic disorders. The final phase of *shin-byung* is marked by full possession of the sufferer and the assumption of the shaman role. This phase is often reached through participation in a shamanic initiation ceremony. Once initiation is complete, the somatic and psychological symptoms initially experienced in phases one and two of *shin-byung* largely dissipate, and the individual emerges a *Mudang*.

Shin-Byung is classified as a culture-bound syndrome in the DSM IV-TR; however, it does not appear in the ICD-10 Classification of Mental and Behavioral Disorders.

Related Topics

- ► Cultural background
- ► Culture-specific diagnoses
- ► Health beliefs

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Situational Ethnic Identity

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Ethnic identity classically has been defined as the component of one's social identity that is derived from membership in a certain ethnic group. This fundamental definition has been expanded in recent years to address the complexities of modern society. Recent literature has moved beyond the view of ethnic identity as an entirely stable entity and toward a definition that encompasses a more dynamic and fluid aspect of the self. These studies support the notion that one's ethnic identity is comprised of both stable and context-specific features which interact on a daily basis.

Certain contextual "cues" have been identified as sources of fluctuation. One is the presence of others from the same ethnic group. A group of Asian immigrant children living in Scotland reported stronger Asian cultural values when the interviewer was Asian than they did when the interviewer was English. In a group of Greek- and Italian-Australian youths, subjects were more strongly identified with their ethnic heritage in the company of family or at immigrant gatherings while they reported feeling more "Australian" when surrounded by their Australian peers. Paradoxically, research also suggests that minority status tends to strengthen one's identification with a particular ethnic group. African-American students on a predominantly White campus, when interviewed by survey, felt that they "represent all African-Americans."

Another setting in which ethnic salience tends to increase is in the presence of cultural symbols, such as language, ethnic media, and cultural traditions. Chinese-American college students reported an increased prominence of their "Chinese" identity when exposed to Chinese language. Paradoxically, in a study of bilingual individuals living in China, participants were actually more likely to endorse Chinese values when a questionnaire was offered in English as compared to the same questionnaire offered in Chinese. In these examples, it appears not to be the language itself that increases ethnic salience but an effect of contrast to the cultural background out of which a person normally operates.

In addition to these situational factors, recent literature has identified more stable elements of identity that contribute to greater ethnic salience. People who hold their ethnic identity as more central to their overall view of themselves are more likely to experience varying situations through the lens of their ethnicity. For example, students with higher ethnic centrality are more likely to see race as an explanation for negative feedback from a supervisor. It is also hypothesized that ethnic salience occurs more frequently in individuals who see their ethnic group as honorable or esteemed.

This fluidity of ethnic identity can move beyond the more abstract ideas of self-concept and play a measurable role in one's behaviors, performance, and psychological well-being. In a study involving Asian-American women, the participants were given a mathematics test after answering a questionnaire focused on aspects of either their gender or their ethnicity. When their ethnic identity was activated, they performed significantly better on the test. The difference in their performance was thought to be due to a self-application of common cultural stereotypes that Asians have superior mathematics skills as compared to other ethnic groups and that women have inferior mathematics skills as compared to men. This effect has been well studied among African-American students, who consistently show worse performance on tests which are presented to them as a way to measure intelligence or specific abilities as opposed to a test which measures such things as hand–eye coordination or "psychological factors involved in solving verbal problems." This may be explained by the fact that, for African-American students, tests which diagnose intelligence make salient a negative cultural stereotype of decreased academic ability.

The expression of ethnic identity can also directly affect one's psychological well-being. A sense of belonging to an esteemed group can have important psychological benefits. In a diary study of Chinese- and Mexican-American high-school students, those with a higher regard for their ethnic group were happier and generally less anxious over a 14-day period. These adolescents were also less likely to be negatively affected by daily stressors, indicating that ethnic regard may serve as a buffer against normative stress. This is consistent with previous studies that indicated that among African-American adolescents, those with positive connections to their ethnic group were protected from the deleterious metal health effects of racial discrimination.

The way in which one navigates multiple cultural identities can also affect mental health. Specifically, the degree to which one views his identities as compatible affects his emotional reaction to different settings. A person who has attained a compatible identity can respond in a contextually specific manner while maintaining a coherent sense of self. Alternatively, others experience internal conflict while navigating different environments, often feeling pressure to regulate their behavior to adapt to the given situation. These individuals, termed "cultural chameleons," tend to have a more compartmentalized self-image, have shown significantly decreased psychological well-being, and show increased sensitivity to rejection in daily social interactions.

Related Topics

- ▶ Acculturation
- ▶ Acculturative stress
- ▶ Ethnic identity

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Slavery

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Slavery is an aged concept that has been used across many different civilizations to justify harsh living conditions and the absence of human rights and freedoms. It is a life of confinement and forced labor ruled by fear and profit, a strategically constructed institution of bondage and servitude which is cheap and expendable. This type of violent control over another person considered to be property is driven by economic gain. Most often, slaves are native indigenous people, minority ethnic groups, and individuals living in poverty or of low socioeconomic status or social class. Slavery dates back to ancient civilization when slavery was thought to be natural and that some people were predestined to be slaves. The forms of slavery include prisoners of war, child abandonment, punishment for crime, repayment of debt, and birth slave children.

The term “slavery” is often equated with historical episodes such as the Arab Slave Trade and the TransAtlantic Slave Trade. Although these occurrences of slavery are dated, the conditions are still pertinent. Slavery is a disturbing truth that continues to be prevalent in many areas of the world. The conditions of slavery can include debt bondage, indentured servitude, and serfdom. Debt bondage, one of the oldest forms of slavery, is a hereditary repayment of debt in exchange for labor, adopted from the medieval peonage system where one is obliged to servitude until debts are paid off. Indentured servitude is the provision of labor for a predetermined time in exchange for goods or services. Serfdom is a condition of bondage where one is lower class and unable to abscond bondage.

Many countries in South Asia, South America, Africa, and even Europe and the USA presently struggle with the ongoing issue of modern day slavery. More than 4,100 bonded workers in India are subject to a historical tradition of discrimination and bondage, which stems from a traditional Hindu hierarchal caste system. South Asia currently has the largest number of slaves working in debt bondage, many of whom are illiterate, impoverished, and subjected to systemic discrimination. The slaves’ acquired debt is impossible to repay; therefore their debts are passed to the next generation, perpetuating a cycle of generational slaves. Even though the nations that make up South Asia have officially banned slavery practices, the growing issue of slavery has yet to be aggressively addressed.

As the leading sugar exporter in the world and with a growing cattle and logging industry, Brazil has an increasing need for workers. These workers are usually impoverished men who are enticed from city slums and villages. Despite promises of honest wages, they are coerced away to remote plantations where they remain indefinitely in debt bondage. An estimated of 100,000 individuals are involved in farming as slave labor. The government has made efforts to fight slavery by implementing the 2003 National Plan for the Eradication of Slavery, which includes severe penalties for slaveholders.

In Africa, slavery mostly affects women and children. In countries such as Togo, Benin, Sudan, and Swaziland, shrine slavery is heavily prevalent. Shrine slavery is the usage of women and girls as sex slaves. With a lack of rights and major dependence on males, African women are highly susceptible to abuse and sexual manipulation. This type of sexual violence gives insight into how the African women suffer disproportionately from the deprivation of human rights. African slave children are often used to work in agriculture, manufacturing, and the sex trade. These child laborers make up the highest percentage in the world, with nearly 80 million children forced to work as slaves.

The United Nations (UN) has been working relentlessly to eliminate slavery in its entirety; the 1956 UN Supplementary Convention on the Abolition of Slavery was established to eradicate slavery, enhance human worth, and express the importance of human rights.

The UN has also created the Working Group on Slavery, whose primary focus is to prevent the selling of children, child prostitution, child labor, and the exploitation of children. Most recently, the UN has instituted what is referred to as the Trafficking Protocol, a set of guidelines established in 2003 to encourage anti-trafficking policies, increase awareness, and encourage proactive involvement. Many of these policies have been adopted by countries worldwide, but despite their efforts, nearly 12.3 million people suffer from forced labor. Slavery is still practiced in many countries in isolated areas away from the view of the public and the mass media.

A significant issue in contemporary slavery is human trafficking, a growing $32 billion industry that endangers the lives of mostly women and children. This modern day form of slavery promotes the illegitimate trade of people for the use of mostly bonded labor and sex labor. It is an international crime responsible for the degradation of millions of human beings. With an estimated 800,000 victims trafficked across international borders every year and 161 countries affected by human trafficking, there is an urgent need for an international plan to eradicate human trafficking. The USA is a target country for trafficked persons, with an estimated 50,000 slaves in the country. Nearly 17,500 foreign nationals are trafficked into the USA every year; the most highly concentrated areas for human trafficking are New York, California, Florida, and Washington DC. Due to this alarming statistic, the USA has implemented the Victims of Trafficking and Violence Act, which provides services and protection for those victims of trafficking.

New immigrants can face circumstances of poverty and other difficult conditions. Immigrant women and children can also be at greater risk for exploitation, harassment, and mistreatment. Immigrants may face a lack of protection, may be fearful of or not know how to report they are being abused, making them targets for ongoing abuse and manipulation. Consequently, the need for stronger UN policies, governmental acts, and laws are essential to protect the livelihood of immigrants and others. As immigrants are affected by the many push-pull causes of migration, it is important for them to understand and recognize the dangers of slavery and trafficking as well as their newly acquired citizenship rights.

Related Topics

- ► Child labor
- ► Labor migration
- ► Marginalization
- ► Prostitution
- ► Sex work and sex workers
- ► Sweatshop
- ► Trafficking
- ► Trafficking Victims Protection Act
- ► United Nations Convention on the Rights of the Child
- ► Universal Declaration of Human Rights
- ► Violence

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Sleeping Blood

► Sangue dormido

Smoking

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Globally, six million people die prematurely due to tobacco use each year; 72% of those live in developing countries. The male smoking rate is about 35% in developed countries and 50% in developing countries, while the comparable US number is 23.1%. For women in developing countries the smoking rate is 9% and 22% in developed countries, while the US women's rate was 18.3%. The global tobacco epidemic affects smoking prevalence in the United States, because the majority of immigrants to the United States come from less-developed Latin American and Asian countries where tobacco use is common for men and increasing in social acceptability for men and women.

This entry discusses smoking prevalence among immigrant populations, secondhand smoke exposure issues affecting these populations, and interventions to prevent or reduce smoking among immigrants. What are the immigrant smoking rates? What can be done to reduce these rates or to keep them low? What implications do these rates hold for US tobacco policy? This discussion will focus primarily on Asian Americans and Hispanics, giving breakdowns within these broad categories when they are available. Unfortunately, published research provides little insight into migrants from other regions.

For first generation immigrants (living in the United States but foreign-born), the male smoking rate is lower than the 35–50% noted above. The rate is 14.4%, and the women's smoking rate is 7.6%, also slightly lower than the 9–22% figure. The reasons for this lower smoking rate are unknown, although it is possible that those who migrate are healthier than those who do not, so are less likely to smoke. In addition, the regulatory environment in the United States, which restricts where people smoke and imposes excise taxes on cigarettes, may help to discourage smoking initiation. Further, in the United States, smoking is increasingly concentrated among poorer populations. By contrast, smoking in developing countries from which people migrate may still be spread across social classes. Thus, the high rates in the country of origin may reflect higher smoking rates among those of higher socioeconomic status, who may be less likely to migrate.

Research on acculturation, traditionally measured by indicators such as length of time in the United States or language spoken at home, has found that immigrants' health behaviors mirror that of the rest of the population as those immigrants acculturate. Smoking follows this trend; the more acculturated immigrants are, the more likely their smoking rates will mirror those of the overall United States population. Being born in the United States to two foreign-born parents has a protective effect for both men and women, with smoking rates of 11% and 8%. But, if either parent is born in the United States, the smoking rates for both genders begin to approach those of the rest of the US-born population. If the mother is foreign-born and the father not, men have a smoking rate of 18.1% and women 15.7%. If the father is foreign-born and the mother not, men have a smoking rate of 16.3% and women 16.1%.

Hispanic Smoking Prevalence and Immigrant Status

The overall rate of smoking prevalence for Hispanics in the United States is 15.8%, including 20.7% of men and 10.7% of women. By comparison, the prevalence rates for non-Hispanic Whites were 22.0% overall, 23.5% for men, and 20.6% for women. Immigrants who identify themselves as "Mexican," as opposed to "Mexican-American," had an overall smoking prevalence of 15.5% compared to 18.3% for Mexican-Americans.

For women, Mexican-Americans who spoke English were more than twice as likely to smoke than those who identified as Mexican, and being born in the United States also doubled the rate of smoking prevalence. Acculturation, though, has only consistently shown an effect on women's smoking among Hispanic populations; acculturation increases Hispanic women's smoking rates. For example, Hispanic women in California who spoke mainly English had a smoking prevalence of 14.7%, while those who spoke mainly another language had a rate of 6.1%. In Houston, for women of Mexican heritage, the smoking prevalence for those born in the United States was 15.2% compared to 7.2% for those born in Mexico.

Mexican-American youth in Southern California who reported a US orientation, while they perceived their parents had a Hispanic one, were at increased risk for smoking. By contrast, youth with a Hispanic orientation were less likely to smoke.

Asian American/Pacific Islander Smoking Prevalence and Immigrant Status

In 2008, Asian Americans had an overall smoking rate of 9.9%, 15.7% among men and 4.7% among women. But, while the overall smoking prevalence for Asian Americans is low compared to other populations, this is based on highly aggregated data that does not differentiate among different ethnicities or by level of acculturation. For Asian immigrants, more acculturated men smoke at lower rates than less acculturated men, whereas the reverse is true for women.

Disaggregated data on immigrants from Asian countries reveal some important differences based on country of origin. In California, men's smoking rates were uniformly higher than those of women, and the highest male rates were seen among Korean (36.7%), Vietnamese (32.4%), and Filipino (24.5%) populations. For women, the highest rates were among Japanese (13.2%), Korean (9.0%), and Filipina (7.7%) populations. Immigrants from India had a smoking rate of 4.6% compared to a rate of 21.4% of those from Japan. Tobacco control advocates will need this kind of disaggregated data in order to plan culturally specific interventions on tobacco cessation and tobacco use prevention.

Prevalence surveys conducted in English, however, may be missing data from Asian populations who are not English-proficient, thus missing high prevalence rates in non-English–proficient populations, which represent over 60% of Asian Americans. Regional surveys conducted in Chinese, Korean, Cambodian, and Vietnamese have found an overall smoking prevalence of 29%, with men at 42% and women at 14%.

Although the effects of acculturation on smoking status are well documented, attention has been paid to other factors as well. For example, Asian Americans who reported "unfair treatment" had 2.62 times the odds of being a smoker as did those who did not. Those who reported racial/ethnic discrimination were 3.06 times as likely to be smokers as those who did not. Smoking may be a way to cope with stress for some immigrants.

Youth have often been studied separately. Asian American adolescents start smoking later than non-Asian American youth, have a lower smoking prevalence than non-Asians, and are more likely to smoke if they are more acculturated. In California in the 1990s, Asian American youth had a 30-day smoking rate of 6.9% compared to the 14.2% rate of non-Asian American youth. Youth of Chinese heritage reported the lowest rate, 2.8%, while Filipino youth were highest at 8.6%. Acculturated adolescents may be twice as likely to smoke as their non-acculturated peers. For example, those whose native language was English were significantly more likely to smoke than those for whom it was not, 7.9% compared to 4.5%. Acculturation was sometimes based on self-report and sometimes on specific behaviors, such as language spoken, language read, and diet.

Secondhand Smoke Exposure

In 2004, 38.3% of Asian Americans reported being exposed to secondhand smoke at home, although there were differences by subpopulation. The levels were highest in Vietnamese homes (44.9%), followed by Cambodians (43.8%), Koreans (42.0%), and Chinese (29.7%). Among the variables that predicted higher rates of smoking in the home were living in the United States less than 5 years, less acculturation, and being foreign-born. The overall US data for this time period indicate that 27.3% of households allowed smoking in the home.

Boston residents of Vietnamese and Chinese heritage indicated that they were interested in smoke-free environments and understood some of the health risks of secondhand smoke but were reluctant to confront smokers directly. They were thus supportive of strict laws and indicated that media messages urging mutual respect would be helpful in creating smoke-free environments.

US residents who are foreign-born are more likely to support smoke-free policies in bars, restaurants, indoor worksites, malls, sporting events, and hospitals than are those who were born in the United States to foreign-born parents. 75.7% of the former supported smoke-free policies in 4 of the 6 venues, while 65.7% of the latter did. Third generation residents, those who were born in United States to US-born parents, were less likely than the first two groups to support smoke-free policies; they supported smoke-free policies in 4 of the 6 venues 59.1% of the time. The latter group's support levels begin to mirror the attitudes of other

US-born individuals. Thus, policy preferences, like smoking prevalence, begin to resemble those of non-immigrants over time.

Interventions to Reduce Tobacco Prevalence

Interventions to encourage smoking cessation can be effectively targeted to reach immigrant populations. For example, a targeted social marketing program that was conducted over a 2-year period in New York in conjunction with citywide policy changes, including tax increases and smoke-free air laws, resulted in a drop in smoking prevalence among Chinese-Americans from 17.7% to 13.6% and among men specifically from 30.3% to 22.9%. But more high-quality research needs to be done on cessation and prevention programs among immigrant populations.

The tendency of immigrants as they acculturate to mirror the smoking prevalence of other US residents has important implications for prevention programs. In addition to programs targeted at immigrants, it is also important to continue work to bring down the overall US smoking rate. That is, if immigrants are conforming to a larger societal norm, then it is important to change that norm. A California study focused on Chinese and Korean immigrants who smoked found that Chinese immigrants quit smoking at seven times the rate that smokers in China quit and Korean immigrants quit at three times the rate of Korean smokers. The multi-lingual California tobacco control program mattered – over 80% of the sample recalled seeing an anti-smoking message in the previous month – and the social norms of California created an environment that encouraged quitting. In addition, for those living in ethnic enclaves that lack a social norm against tobacco use, some effort needs to be made to build these norms. Certainly, one way to influence the social norms of ethnic enclaves is through smoke-free policies and culturally appropriate, community-based prevention and cessation efforts.

In addition, monitoring industry targeting of immigrant populations and working with other countries on their tobacco-control efforts are important pathways toward mitigating tobacco use in immigrant communities. The tobacco industry has developed strategies for targeting Asian and Hispanic immigrants through marketing campaigns and geographically focused promotions. In addition, industry campaigns have been designed to target immigrants based on assimilation status.

Conclusion

Smoking-prevention efforts in immigrant communities thus have some unique challenges and opportunities. One, because immigrants come from countries that likely have more tax policy environments than many states in the United States, tobacco-control advocates should be concerned about policy development in these countries. Two, advocates should work with communities to interrupt the trend in which women begin to smoke more as they become acculturated. More community-based participatory approaches are needed to design interventions and understand the impact of those interventions. Three, advocates should be concerned about the degree to which aggregated data may obscure important elements of the tobacco epidemic among immigrant populations. This entry has illustrated the nuances that exist when populations are disaggregated. In addition, little is known about immigrant populations from regions other than Latin America and Asia/Pacific Islands. For all of these populations, we may need to look beyond measures of acculturation to understand smoking uptake and cessation. And finally, advocates need to monitor tobacco industry targeting efforts both inside the United States and in countries from which people are emigrating.

Related Topics

- ► Acculturation
- ► Addiction and substance abuse
- ► Ethnic enclaves
- ► Immigration status
- ► Substance use
- ► Tobacco
- ► Tobacco control
- ► Tobacco use

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Social Capital

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Social capital as an interdisciplinary concept in social and behavioral sciences came to widespread prominence during the late 1990s and is currently among the most widely researched topics. This article briefly discusses the concept and associated theory, and its relevance to immigrant health.

Most commonly stated, it is the “glue” that binds individuals and communities together for efficient social life. Robert Putnam, a political scientist, used the concept to explain the difference in performance of regional governments between northern and southern Italy. Putnam later published “Bowling Alone: America’s declining social capital” in 1995, claiming that social capital in the country has been in decline for the last few decades and that this explained the reduced political participation of its citizens among several other indicators of civic engagement. Although Putnam’s work brought the concept into popular imagination, John Field, in his 2002 book “Social Capital,” explains that Pierre Bourdieu, a French sociologist studying the hierarchical French upper class society, and James Coleman, an American sociologist studying the differences between educational outcomes of Chicago schools, defined and used the concept prior to Putnam’s work. In the last decade or so, social capital has been used to explain a number of social phenomena such as individual employment, social mobility, immigration and assimilation, educational outcomes, family structure, criminality, organizational effectiveness, urban revitalization projects, neighborhood stability, lower loan default rates, and general health, among others.

In spite of the accumulating empirical literature over the last three decades from a wide variety of fields of study, and several theoretical expositions, relations between constituent elements such as trust, norms, and social networks are still disputed as are the measurement instruments and techniques. Considerable efforts advanced the techniques of measuring social capital at an individual level and at group/community level with organizations such as the World Bank adapting this concept for comparisons across countries.

Varying definitions and measures add to its conceptual richness as well as its practical unwieldiness. Most definitions of social capital include three elements: trust, trustworthiness, and networks. The networks people belong to are hypothesized to yield several benefits to them ranging from increased material or emotional support due to higher levels of trust and trustworthiness within that network. According to Bourdieu, social capital is the "aggregate of actual and potential resources which are linked to the possession of a durable network of more or less institutionalized relationships of mutual acquaintance and recognition." He clearly separates the network from the actual resources realized through the network, which he terms "social capital." Coleman, on the other hand, defines social capital by ". . .its function. It is not a single entity, but a variety of different entities having two characteristics in common: They all consist of some aspect of social structure, and they facilitate certain actions of individuals who are within the structure." The strongest criticism of this definition points to the all-encompassing nature of the concept, opening the door to social capital being all things at the same time. Putnam's definition of social capital as "features of social organization such as networks, norms, and social trust that facilitate coordination and cooperation for mutual benefit" is similar to Coleman's, but clearly identifies networks, norms, and trust as three major components of social capital. Following this definition, memberships in groups and networks formed a major part of subsequent measures of social capital. Bourdieu's conceptualization is at an individual level while Putnam's is at a community level. In contrast, Coleman argued that "social capital is embedded in the social relationships between individuals but is available to rational actors as a means of achieving their goals." Notwithstanding these more fundamental differences in definition and measurement, the concept appealed to researchers in a variety of fields and was promoted as a potential bridge between several fields within social sciences.

Three types – bonding, bridging, and linking social capital – are generally identified in the literature. Bonding social capital refers to the close-knit ties, familial or otherwise, among members of a group. Bridging social capital refers to the lose ties between individuals at different levels of the power hierarchy of the group. Linking social capital also refers to loose ties but between individuals from different political and/or social groups. Linking social capital is often invoked to represent access to external resources. Although social capital was generally seen as a beneficial asset to individuals and communities, scholars also acknowledge it as an exclusionary mechanism for groups to restrict their membership and thus the associated benefits.

Social capital was identified as a contributing factor to better outcomes on a number of measures, including health, for members of immigrant groups. Tight-knit relationships within immigrant groups are shown to contribute to several positive outcomes in education, employment, health, and access to other resources. Several studies, starting with Roseta (in the state of Pennsylvania, USA) in the 1950s, show that first generations of immigrants have better health outcomes than descendants of immigrants. These better outcomes were attributed to the strong social cohesion and associated norms within the immigrant groups, which were absent in comparison groups. Descendants are less likely to maintain such close ties and follow the norms of older generations from another land. Although the concept needs to be developed on several counts, social capital is useful as a metaphor in explaining several phenomena such as health status, particularly among immigrant populations.

Related Topics

- ► Assimilation
- ► First generation immigrants
- ► Social networking

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Social Integration

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Introduction

It is in our human nature to initiate, maintain, and develop relationships with other humans. Any kind of relationship connecting at least two persons is based on common interests, common beliefs, and common actions. In other words, it connects peers. It is important to note the term “common.” The globalization process that initiated increased immigration, along with annual increases over the past three decades, expanded this term to mean a common geographic place, the same country.

In the context of globalization, adaptation to a new world is a must for the immigrants that want to be part of it. The adaptation process is strongly dependent on factors such as the immigrant’s culture, host language proficiency, and time spent in the host country. All immigrants’ social interactions with the new populations they are trying to integrate into can be called “social integration.” The wider concept of adaptation includes cultural integration, structural integration, economical integration, and social integration.

In contrast to social integration, social marginalization excludes individuals from the host society, and isolates them. Examples of marginalized groups are homeless people, long-term unemployed, delinquents, difficult teenagers, immigrants, disabled persons, and substance abusers. Vulnerable populations can also include individuals with serious medical conditions, obese individuals, the elderly, prisoners, etc. What they have in common are difficulties at some time in the life span with adapting to and accessing the broader social setting.

Research and Social Integration

Social integration as a field of research reveals approaches to smoothly integrate the newly arrived into local society. Similar cultures, similar languages, and similar habits facilitate the social integration process. Critical challenges occur where there are differences in key factors, for example, ethnicity. A proven means to facilitate social integration is ethnic intermarriage. Weaker ties between ethnic groups are casual contacts or friendships, while intermarriage is based on similarities in language and habits, but not necessarily culture-based habits. Sharing the same family model and life view not only support ethnic intermarriage, but also marriage between peoples of the same ethnicity. Another key factor is language. A minimal level of proficiency in the host country language is required unless the broader host population knows the language of the immigrant group. Since verbal communication is the fastest and simplest way to share thoughts, language is the strongest tie between individuals either from the same ethnic group or from different groups. While ethnic intermarriage can be found either vertically (e.g., between immigrants and the local population) or horizontally (e.g., between minority groups), the vertical path allows immigrant minorities more rapid access to local society and local values, and facilitates faster intercultural exchanges and cohesion.

All types of contact, ethnic intermarriage, casual contact, or friendship have been demonstrated to be based on factors such as race or cultural background. For instance, race is the most important factor in cross-group interactions in the United States, while in Europe cultural differences are more important than race.

Integration involves a larger host group and at least one smaller group, always a minority and almost always a group with special needs which classify the members as vulnerable against the host group. Social meaning includes all social interactions between the vulnerable population group and the host. Taking it together with integration, the concept of social integration is defined as all social actions with the aim to allow small groups of vulnerable populations to access and use social resources such as communication and common values.

Models of Social Integration

Social integration models are based on multicultural societies, such as the United States, the Netherlands, Germany, Canada, Italy, among others. All have a history of immigration, but there are differences in the models used in each country. The models in Canada and the United States recognize the rights of minorities but do not necessarily promote management of relations between different ethnic groups or races. An integration model supposes an acceptance of any culture with all its specific elements. Moreover, this model supports and empowers different ethnic communities. The most important ethnic minorities are confirmed by the State and the opinions from their advisory bodies have to be taken into account by the State. The State allows media (e.g., radio, TV, print) to promote minority cultures and allows religious schools to be established. This model is used by the Netherlands and was based on the historical foundation of the Dutch State. The State structure has different cultural, religious, and political groups. This model promotes coexistence as tolerance of difference, civil dialog, collaboration as participatory development planning, and cohesion as the result of shared meaning and values.

Other models of integration were implemented in France, based on assimilation of the migrated population into the majority, and in Germany, based on integration of immigrants into the local job market where immigrants took low paid and "dirty" jobs that the mainstream German population would not have accepted. The German model may be found in Denmark, Italy, Austria, and Greece, and while immigrants gained access to the labor market they were excluded from civic and political participation, resulting in insecure legal status. During the 1990s there was an anti-immigration sentiment in Germany, with exclusionary and xenophobic attacks on ethnic minorities. However, the anti-immigration sentiment in Germany has changed, and recently an integration model has been implemented. It offers education and job training for young immigrants to develop careers or even more, start families.

Past experiences with new immigrants facing language and cultural barriers when arriving in the host country, resulting in high unemployment rates, low income, and poverty, caused some host countries to change their immigration policy. For instance, a minimal level of host language proficiency is today required for those who seek permanent residency in Canada and the Netherlands.

Facilitating Factors for Social Integration

Studies reveal that the younger the immigrant, the easier the social integration process. Immigrant children 15 years of age and older face many integration issues, while those younger than 15 years of age learn the host language faster and more easily integrate into the host educational system. Some studies show that the younger immigrant populations gain faster access to social resources, and vertical ethnic intermarriages are more often found. However, those who migrate over 15 years of age tend to marry within their ethnic community and have fewer peers from the mainstream host population.

Therefore, elements that facilitate social integration include open dialog with other groups, horizontally with other minorities or vertically with the majority population, period of time spent in the host country, host language proficiency, age at migration, and ethnic intermarriage. Social integration indicators vary from model to model. A common indicator of integration is socioeconomical status of the immigrant group. This is a major indicator of equality and cohesion with proportional participation in the labor market, education, health, and housing. Another indicator is public attitudes and perceptions regarding the immigrant group, although this indicator would depend on the context and method of measurement. Other indicators may be the ethnic intermarriage rate, accommodation of religious needs of the immigrant group in public life, and participation in social tasks and discourse.

Related Topics

- ► Acculturation
- ► Assimilation
- ► Discrimination
- ► Education
- ► Employment
- ► Ethnic minority group
- ► First generation immigrants
- ► Language acculturation
- ► Social networking

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Social Learning Theory

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Learning is a phenomenon that is interconnected with our daily living. Social learning theory illustrates the impact of modeling and observation on behavior and attitudes. It is considered observational learning, in which behaviors are first observed then imitated; also known as modeling. There are three kinds of observational learning: live, verbal, and symbolic. Live learning is when a behavior is actually demonstrated, verbal learning is when an explanation of a behavior is given, and symbolic learning is when behaviors are derived from books, films, and/or the mass media. All are thought to be important in the outcome of behaviors.

This theory incorporates both behaviorism and cognitive learning in its premise, two prominent forms of psychological thought. Behaviorism, the objective science of studying observational behavior, interprets how the environment influences human behavior. Cognitive learning is the field of studying internal thought processes that help encode, store, and retrieve information. Therefore, it interprets how psychological processes influence human behavior. Social learning theory essentially uses both environmental and psychological factors to explain modeling of human behavior.

Albert Bandura, a renowned mid-twentieth century psychologist, expanded on work done by earlier researchers, while trying to explain learned aggression in adolescents. He believed that behaviors were not inherited; they were simply learned by observing others. According to Bandura, there are four steps to the learning and modeling process: (1) *Attention*, precisely paying close attention to the behavior as it is occurring. (2) *Retention*, able to recall what one has derived from the behavior. In other words, the individual is coding, rehearsing, and essentially preserving information. (3) *Reproduction*, performance of the modeled behavior. (4) *Motivation*, the reason behind imitating the behavior. Continued imitation of behaviors is due to some rationale to mimic the behavior. Motivations can be either external or internal, or positive or negative, therefore affecting how a learned behavior is demonstrated and the likelihood of reoccurrence.

Replicated behaviors can either be positively motivated, used to strengthen the behavior, or negatively motivated, used to weaken the behavior. These can include direct reinforcement/punishment, vicarious reinforcement/punishment, and self-regulation (reinforcement/punishment). Direct reinforcement/punishment would be when a replicated behavior is either praised or criticized by someone else. Vicarious reinforcement/punishment is when the behavior is observed and recalled as being reinforced or punished, allowing the behavior to be seen as either acceptable and encouraged, or unacceptable and shunned. Self-regulation is when satisfaction or displeasure is experienced for meeting or failing one's own standards for fulfilling the behavior. Bandura faulted behaviorism for its overly simplistic view on human behavior being primarily influenced by the environment. He believed in "reciprocal determinism" meaning that human behavior, the person, and the environment heavily influence each other. These three variables illustrate the interconnectedness of the two disciplines of behaviorism and cognitive learning and reflect the multifaceted factors incorporated in the system of learning.

Of the many behaviors that can be learned through modeling, aggression is one of the most researched. Bandura's famous and most talked about studies illustrate how modeling is highly effective in learning aggression. The "Bobo doll experiment" was created by Bandura and his colleagues to demonstrate how exposure to aggressive models would be replicated in the same manner by child observers. Results showed that children who witnessed aggressive acts committed against the Bobo doll replicated the acts in much the same manner and exerted much more aggression than other children who had not witnessed aggression against the Bobo doll. Bandura's study, the most influential study of social learning theory, was an empirical investigation of the many different factors that play a significant role in learning.

As it applies to immigrants, social learning can occur and produce a state of compliance and adaptation. Social learning can permit immigrants to learn new customs and lifestyles of their new home. It can provide them with the opportunity to contribute to their new communities; adopt modern day skills, customs, and expectations; and improve their current skills and education. Social learning plays a significant part in assimilation. It is evident that not all social learning is positive; negative aspects of social learning can expose immigrants to crime and other deviant behaviors.

Related Topics

- ► Acculturation
- ► Assimilation
- ► Community
- ► Compliance
- ► Youth antisocial behavior

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Social Network

► Social networking

Social Networking

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Social networking is the practice of building and mobilizing social relationships. It connotes an active process whereby individuals identify, seek, forge, and maintain connections with others. Today, social networking is often associated with online services like Facebook and MySpace, which facilitate the cultivation of relationships and the building of online, sometimes virtual, communities of shared interest. The focus here, however, is more generally on the ways that people assemble and maintain networks of social relationships with kin, friends, coworkers, and others through varied means of communication. While this may include computer-mediated forms, social networking is clearly also done through face-to-face, telephone, and written means.

According to social network theory, people and their actions are embedded in a web of relational ties that both enable and constrain. The structure of this web can be a factor of the overall structural and environmental conditions in which social relationships are embedded. As important, the structure of a person's network – for example, how interconnected network members are – can be a factor of the active efforts, strategies, interests, and attributes of the social networking individual. As with social network structure, the attributes of a person's network – like the proportion of contacts who are smokers – also enable and constrain behavior. Such network dynamics help explain, for example, the spread of health conditions like HIV/AIDS and obesity.

Social networking is important for understanding various dimensions of immigrants' experiences. Drawing on social network theory, immigration researchers have examined the role social networks play before, during, and after migration. The networks that emerge from the migratory process consist of sets of interpersonal ties that connect prospective migrants and former migrants in a migratory chain. This chain involves the mobilization of key relationships, information, and material resources. Immigration policies, such as those in the United States and Canada, where immigrant visas are allocated on the basis of family ties, reinforce and formalize the operation of chain migration networks. These ties are thought to increase the likelihood of emigration by lowering the costs, raising the benefits, and mitigating the risks of international movement. Besides reunifying family members, chain migration creates portals between migrant destinations and hometowns. Through social networking, prospective migrants in hometowns secure assistance from fellow townsmen and women already settled abroad and who have – often by virtue of their own network connections – access to employment leads, housing information, legal advice, and other resources. Such valued resources available through relationships are known as social capital. Upon arrival, ties to earlier migrants continue to play an important role in immigrant adjustment and well-being. Co-ethnic organizations and ethnic enclaves in the host society provide a base from which to further accumulate and mobilize social capital in times of need.

Immigrants' ability to enhance their social capital after migration can depend on the mode and degree of their incorporation into the host society. In turn, this can depend on, among other things, language proficiency and immigration status. An immigrant's lack of proficiency in the official host country language could limit her/his ability to build interethnic relationships or navigate formal institutional channels. Undocumented immigration status can have a similar effect, as immigrants fearing discovery or exploitation may limit interactions to those they trust. Such constraints have been shown to have important health consequences. Language discordance between healthcare provider and patient hinders comprehension of a patient's complaints or a doctor's treatment. Undocumented immigrants are less likely to be insured, less likely to seek preventative medical services, and more likely to delay seeking treatment. Drawing on informal community- and trust-based networks can help to overcome such barriers to immigrant health. Bilingual relatives can serve as interpreters, a fellow church member can recommend a trusted doctor, and a friend may know a friend who works for a health insurance company and can help in navigating bureaucratic hurdles.

As the preceding examples suggest, both strong ties (close relatives) and weak ties (acquaintances or friends of a friend) provide valued resources with significant health outcomes. However, the literature on immigrant health has emphasized the role of strong social support networks in overcoming barriers to healthcare and relieving the effects of stress. But it is clear that weak ties are a crucial source of social capital. In fact, the strength of weak ties, as proposed by Mark Granovetter in his influential study, lies in their ability to provide access to new information. While true that strong ties in densely knit networks can mobilize help more quickly and intensely, they can also result in the network circulation of redundant information. Additionally, people with dense and homogeneous networks may find themselves subject to the normative expectations and practices dominant in their network. This can impact health if, for example, poor health habits – from smoking to sexual risk taking – characterize a person's network. Weak ties, on the other hand, can add diversity (of ideas, attitudes, backgrounds, goods, services) to a person's network. Not only does such diversity provide access to novel health information and healthcare options, but also presents alternative models of health behavior for comparison and adoption. Thus, social networking serves as a way for individuals to broaden the quantity, quality, and diversity of contacts available for ready assistance. Social networking highlights the ways that social connectedness is important for immigrants' healthy adjustment to life in a new land.

Related Topics

- ► Family
- ► Healthy immigrant
- ► Language
- ► Social capital
- ► Social integration

Suggested Readings

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Social Security Disability Insurance

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Social Security Disability Insurance (SSDI) is a payroll tax-funded, federal insurance program in the USA. SSDI is managed by the Social Security Administration, and it is designed to provide income to people who are unable to work due to a disability. SSDI offers a wide range of benefits to family members when a primary wage earner in the family becomes disabled or dies. To finance SSDI, Social Security taxes are paid by workers, employers, and self-employed persons. SSDI benefits are payable to widowers, widows, and disabled children or adults. Since SSDI is a social insurance program, benefits are only granted after a lengthy determination process, whereby the applicant must prove that he or she is disabled.

Qualifications

To qualify for benefits, a person must have a mental or physical condition that prohibits him or her from being involved in any "substantial gainful activity (SGA)." SGA refers to any significant activity, physical or mental, which is performed for remuneration or profit over a reasonable period of time. To qualify, an individual's monthly earned income must be less than $1,000. Additionally, the condition is expected to last at least 12 months or result in death. Also, a person must be under the age of 65. Finally, a person must have worked 5 out of the last 10 years as of the determined date of onset of disability. In general, benefits continue until beneficiaries are able to work again on a regular basis. There are also a number of special rules, called "work incentives," that provide continued benefits and health care coverage to help the person make the transition back to work.

Benefits

The monthly amount of disability benefit is based on the Social Security earnings record of the insured worker. Eligibility for monthly SSDI benefits begins 5 months after Social Security determines the onset of disability. Payments are started 1 month in arrears (behind payment date). For instance, the disability benefit for January's payment will be paid in early February. Benefits may continue while the individual remains disabled and meets work or other eligibility requirements. Benefits can discontinue for specific activities, reasons, or events. SSDI beneficiaries are periodically reviewed by Social Security officers to determine whether there is any medical improvement in an individual's condition and to assess continuing eligibility. These reviews are either a medical Continuing Disability Review (CDR) or a work Continuing Disability Review (CDR).

When beneficiaries start receiving disability benefits, certain members of their family also may qualify for benefits. Benefits may be paid to children, spouse, and divorced spouse. Each family member may be eligible for a monthly benefit of up to 50% of disability rate. However, there is a limit to the amount that Social Security can pay the family members. If the sum of the benefits payable on their account is greater than the family limit, the benefits to the family members will be reduced proportionately.

Related Topics

► Disability

Suggested Readings

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Social Service Needs

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Introduction

Since the Immigration and Nationality Act of 1965, the number of first-generation immigrants living in the United States has quadrupled to more than 38 million in 2007. Emerging trends in immigration have included steady growth, varied and frequent changes in ethnic composition, and declining socioeconomic levels. It is little wonder that upon arrival immigrants are faced frequently with urgent social service needs. This is true especially of refugees and those less likely to have a support network in place, either in the United States or in their country of origin. Affordable housing, jobs, and access to health services consistently are reported as chief among immigrants' needs.

Federal Policy on Social Services for Immigrants

Social workers and others concerned are tasked with designing programs that comply with federal policy and support immigrants in their social and economic integration. The Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996, reformed dramatically the nation's welfare system, but served also to restrict severely immigrants' eligibility for social services. In addition to income, eligibility for major federal benefits was linked to immigration status and whether the applicant arrived before August 22, 1996, the date the law was enacted. The Act's passage was met immediately by bipartisan calls for restoration of social services to legal immigrants. Consequently, in 1998, the Agriculture Research, Extension, and Education Reform Act restored eligibility to legal noncitizen children, elders, and disabled individuals who entered the United States before PRWORA's enactment on August 22, 1996. Then in 2002, the Farm Bill broadly restored eligibility for legal noncitizens who fell into one of three categories: disabled, regardless of date of entry; residing in the United States at least 5 years; or a child age 18 and under, regardless of date of entry.

The food stamp restorations to legal immigrants has had great significance in terms of policy, as the provisions were expected to become the most expensive portion of the $6.4 billion in nutrition assistance authorized by the Farm Bill. Equally notable, for the first time since welfare reform, the Farm Bill extended a federal benefit to legal noncitizen children who had lived in the United States for fewer than 5 years. The 5-year waiting period still applies to most legal immigrant adults for the Food Stamp Program (FSP) – and to most legal noncitizen adults and children for welfare and Medicaid.

How best to meet the social service needs of US immigrants is a complex issue, with public opinion varying greatly. The debate has been renewed with proposed reform in areas of both immigration and healthcare. The topic is made even more complex by other concerns such as the state of the economy, frequent budget cuts, and a growing number of US citizens lacking healthcare coverage.

Areas for Further Research

Social workers have called for additional research into the "chilling effect" phenomenon, in which previous eligibility restrictions have been correlated with barriers to current program participation, even long after the restrictions have been lifted. Additional topics that have been suggested for continued research include institutional challenges to reversing eligibility restrictions; the effects of restrictions on different populations; the degree to which the restoration brought new immigrant households to the FSP, versus extending more benefits to households already receiving benefits but with some legal immigrant members; the potential impacts of sponsor deeming and liability policies that might lead to reduced participation among newly eligible noncitizens; and the need for strategic investments in outreach and other efforts to improve access and boost participation among targeted populations.

Related Topics

- ► Access to care
- ► Community programs
- ► Emigration
- ► Food insecurity
- ► Health barriers
- ► Health care
- ► Health care utilization
- ► Health disparities
- ► Housing
- ► Immigration status

Suggested Readings

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Suggested Resources

For information on the U.S. Citizenship and Immigration Services. http://www.uscis.gov

Social Stress

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International migration constitutes a significant life event, during which immigrants often face drastic differences in social norms, cultural beliefs, and language proficiency in the host society. Many use the term "acculturative stress" (i.e., the psychological, somatic, and social difficulties that may accompany acculturation processes) to describe stress experienced by immigrants as they adapt to the host society; however, some researchers have argued that (a) acculturation is not necessarily a stressful experience and (b) immigrants' experience of stress may or may not be related to the acculturation process.

Recent research has highlighted that stress is a socially constructed experience and is dependent on individuals' interpretation of their experiences. The interpretative nature explains the inconsistent findings in which some found an elation period for new immigrants and others found that emotional distress is highest during initial resettlement (particularly the first few to 18 months). Whereas some immigrants may find the challenges in the host society refreshing and exciting, others may view it as undesirable obstacles. Alternatively, an immigrant may consider some challenges stimulating and others agonizing. Differences at life stages may also influence individuals' interpretation. For example, young parents may feel proud and satisfied that their children are well assimilated, indistinguishable from native others in the host society; in contrast, elderly immigrants may experience a significant sense of loss and guilt recognizing that their native culture will be permanently lost to their future generations.

By situating stress in social contexts, researchers highlight individuals' experiences of stress as (a) consequences of their social circumstances and (b) a determinant for specific outcomes (e.g., psychological distress). Immigrants experience specific stress factors that are unique to their backgrounds and life experiences. Migration circumstances (e.g., asylum seekers versus economic-motivated settlers), socioeconomic status (e.g., professionals versus migrant farm workers), legal status (e.g., legal versus illegal immigrants), expected duration of stay (e.g., temporary versus permanent residence), ethnic group (e.g., ethnic majority versus ethnic minority), language proficiency, and host culture receptivity influence immigrants' adaptation process. For example, most of the immigrants who arrived to the United States after 1970 were from countries in Latin America and Asia. They often experience more entrenched prejudice and discrimination and fewer opportunities for economic advancement in comparison to those in earlier waves of

European immigration. Length of time in the host society is also an important factor. Generally speaking there is initial euphoria when first arriving the host society; however, immigrants soon experience increased disenchantment and demoralization during the acculturation process, which often is accompanied by stress. The experience of stress may taper off as immigrants develop strategies to meet the challenges of the host society. Although there appears to be a U-shape trajectory of elation to depression to recovery, recent studies have suggested that duration of stay is a moderator, rather than a predictor, of immigrants' experience of stress, which can fluctuate over time due to immigration demands and their ability to meet those demands. Another factor is the location of settlement, which may have implications for the availability of social support and other resources (e.g., financial resources). Moving to a different country often entails a loss of one's support network, resulting in difficulties in meeting challenges in everyday life. On the other hand, if individuals are able to reunite with family members or to live in ethnic enclaves in the host society, they may adapt better and experience less stress due to the increased social support. Some researchers also have noted that pre-migration stress (e.g., exposure to violence) may also increase individuals' susceptibility to post-migration stress.

Immigrants' experience of stress may be reflected in their experience of depression and cardiovascular diseases, both of which are known to be sensitive to prolonged exposure to stress. Stress also is found to negatively influence the immune system and to be correlated to various medical conditions, including chronic pain, asthma, arthritis, hypertension, gastrointestinal disorders, and preterm labor, among others. Due, in part, to the self-selection of healthy people to immigrant, immigrants generally have better health status than average native-born residents in the United States. Some researchers also have argued that foreign-born immigrants may experience less stress and better health because their cultural values (e.g., strong family network and aversion to risky behaviors) and practices (e.g., healthy diet and physical activity) provide a buffering effect to their immigration demands and challenges; however, the cultural buffering effect tends to subside over time and across generations. For example, researchers have found that the stronger a Japanese immigrant adheres to the original Japanese culture, both during childhood and retention during adulthood, the lower the risks of coronary heart disease. First generation Hispanic women are less likely to have adolescent pregnancy or low birth weight children than the second generation. From these perspectives, it is important to recognize that first generation immigrants do not necessarily experience the highest level or amount of stress; rather, different generations of immigrants experience different stressors at fluctuating levels and at different stages of life as they meet their distinctive immigration demands in their adaption and acculturation processes.

Finally, it is important to note that the host society as a whole also experiences stress in its socio-structural systems as it attempts to accommodate and assimilate new immigrants. The influx of immigrants, along with their cultural values and social norms, can create significant pressure for the host society. These "stressful" events in the host society are subject to interpretation as well. Some host societies may view the demographic changes as an exciting inflow of resources to rejuvenate, strengthen, and/or diversify its international competitiveness. Others, however, may consider these changes as threats to contaminate their original cultural components and design policies to moderate or even prohibit the fusion and infusion of "foreign" cultures.

Related Topics

- ► Acculturative stress
- ► Social networking
- ► Stress

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Social Support

► Social networking

Socialized Medicine

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Socialized medicine (sometimes equated with universal health care) refers to a system of publicly funded health care, whose primary objective is to provide accessible, affordable, and quality health care services to all eligible members of the population. Benefits of socialized medicine include increased life expectancy, improved general health, and decreased infant and maternal mortality, to name a few. Socialized medicine is financed in a variety of ways, including taxation and contributions from workers and the government. Many countries have some form of socialized medicine, including industrialized nations (i.e., United Kingdom, Canada, and Australia) and developing countries (i.e., Ghana, Cuba). The United States is the only industrialized nation which does not have a universal health care system. However, in recent years some areas of the United States have moved toward implementation of state-wide, near-universal health care systems that mandate health insurance for all residents. Such systems may allow exceptions to be made for individuals meeting certain poverty-level criteria.

In recent times, there has been increasing controversy regarding whether immigrants (documented and undocumented) are entitled to any benefits of socialized medicine. Proponents for immigrant rights argue that from an ethical standpoint health care is a fundamental human right (supported by international human rights treaties), and therefore immigrants are entitled to benefits, regardless of whether they are legal or permanent residents. Such proponents view socialized medicine as a means of mitigating the racial and class inequalities in a given population. Opponents of immigrant rights argue that socialized medicine should be a privilege reserved for citizens and that any coverage of noncitizens will increase economic costs and diminish the quality of health care received (i.e., longer waiting lists, overworked physicians).

In some countries, there are regulations in place that allow immigrants access to socialized medicine under specific circumstances. For example, in the United Kingdom, refugees (displaced persons granted asylum in a foreign country as a result of war, violence, or fear of persecution taking place in their native country of residence), asylum seekers (persons who have formally applied for refugee status in a foreign country), and other overseas visitors who have had “lawful residence” in the country for at least 12 months prior to their need for health care are allowed to utilize the National Health Service, the United Kingdom’s socialized medicine system. However, this still does not account for the health care needs of undocumented (illegal) immigrants and failed asylum seekers.

In countries such as the United States, that do not have a formalized system of universal health care, legal immigrants are restricted (or prohibited entirely) from receiving benefits from social insurance programs such as Medicaid and Medicare; illegal immigrants are not eligible for Medicaid or Medicare services. Such restrictions may inevitably result in an increased dependence on emergency room visits as a source of primary care or deter immigrants from attempting to access any health care services, for fear of deportation or financial repercussions. Immigrant children and immigrant elders are perhaps the most affected by such decisions, given that they already represent particularly vulnerable subgroups across the world.

As a group, immigrants often arrive in their host countries with a health advantage over the general population. However, they undergo various environmental and lifestyle changes that place them at higher risk for disease. The process of adapting to a new culture (acculturation) can be very stressful, particularly for those who left their country under adverse circumstances such as refugees, asylum seekers, and illegal immigrants. Furthermore, many immigrants live below the poverty level, and those who are noncitizens have higher poverty rates than naturalized citizens. This means, that in addition to the stressors of acculturation, immigrants may be forced to deal with less than desirable living conditions, malnutrition, and extreme financial hardships. Such factors may severely compromise their health and undermine any preexisting health advantage that they might have had. Chronic diseases such as obesity, diabetes, hypertension, and cancer are on the rise among immigrants. In addition, untreated infectious and parasitic diseases among immigrants remain a problem.

Currently, socialized medicine has had varying degrees of success in addressing the health care needs of immigrants. For those able to receive care, socialized medicine has been largely beneficial. However, the system is not without limitations. Language barriers and unavailability of interpreters impede necessary communication between immigrants and health care workers. This can be frustrating for immigrants who may perceive such barriers as culturally insensitive, while health care workers are frustrated by their inability to get information necessary for proper diagnosis and treatment. In addition, by the time immigrants come forward to receive care, their ailments are in advanced stages and treatment options may be limited. Also, conditions in an immigrant's native country (or sheer distance) often make it difficult for health care workers to access traceable history of disease or treatment; immigrants may not even be able to provide self-report information on such history. Finally, because of the ambiguity regarding entitlement to socialized medicine benefits, providers are unsure who is eligible, what care they can provide, and what penalties exist for providing care to ineligible individuals.

From a population health perspective, it would seem that granting immigrants access to socialized medicine would not only improve the overall health of communities, but also be more cost effective in the long run (i.e., preventive care can reduce long-term costs for untreated conditions).

Related Topics

- ▶ Acculturation
- ▶ Health barriers
- ▶ Health care
- ▶ Health disparities
- ▶ Health policy
- ▶ Language barriers
- ▶ Public health
- ▶ Refugee

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Socioeconomic Status

- ▶ Poverty

Somatic Symptoms

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Somatic symptoms are body-related symptoms that are experienced by an individual. Sometimes individuals experiencing such symptoms may undergo numerous medical tests that yield negative results prior to receiving a psychological diagnosis. In psychiatry and psychology, the terms “somatic,” “somaticize,” and “somatizing” are often used when patients presenting physical complaints lack apparent biological or medical underpinnings and the symptoms are deemed to be brought on by mental distress. Unlike malingering, patients who somaticize are not thought to feign their symptoms. Studies suggest that patients who somaticize have often experienced physical pain, discomfort, or trauma prior to the onset of symptoms.

Immigrants and refugees sometimes display symptoms of somatization during the initial stages of acculturation. If a physician suspects that an immigrant or refugee is somatic, he or she cannot consider a psychological cause of disease until physical conditions have been ruled out. This process may involve multiple visits and costly tests. Somatic symptoms vary between cultures. Worldwide, somatic complaints manifest most commonly in the form of gastrointestinal pain, abnormal skin sensations, numbness, chest pain, headaches, palpitations, and shortness of breath. The most common somatic symptoms in the USA include gynecological, gastrointestinal, and cardiovascular complaints. Somatization is a common result of psychological trauma. Studies suggest that exposure to war is a significant predictor of somatic complaints. The presence of psychological trauma, including exposure to war, should alert clinicians to the possibility of the presence of posttraumatic stress disorder (PTSD).

Individuals in many different cultures unintentionally convert personal or social distress into somatic ailments. Such conversion symptoms are allegedly reported more frequently in non-Western societies. Displaying a degree of somatic symptoms may be customary in some cultures and is not necessarily indicative of a mental disorder. In some cultures, the display of somatic symptoms tends to be less stigmatizing than other psychological symptoms, and therefore, more socially acceptable.

Related Topics

- ▶ Mental health
- ▶ Mental illness
- ▶ Posttraumatic stress disorder
- ▶ Trauma exposure

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South Asians

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South Asians are culturally diverse people who trace their origin in the Indus Valley of the Indian subcontinent. The civilization has existed here since 2500 B.C. From 1858 to 1947, the majority of this region was colonized by the British. The end of British rule culminated in partition of India into two nations, India and Pakistan (East and West), in 1947, and the ensuing conflict over Kashmir. In 1948, Sri Lanka (formerly Ceylon) became an independent state. In 1971, East Pakistan separated from West Pakistan and became Bangladesh. Today, South Asia encompasses the countries of India, Pakistan, Bangladesh, Sri Lanka, Nepal, and Bhutan. The latter two were previously monarchies and became democratic states in 2008 and 2007 respectively. According to the United Nations’ data presented in the World Population Prospects (2008 Revision), South Asia occupies 3.8% of the world’s land and 24% of the world’s population. Not surprisingly, several subcultures exist in South Asia with diverse languages and religions. The major religions of South Asia are Hinduism, Islam, Sikhism, Buddhism followed by Jainism and Christianity.

South Asian Immigrants

Most South Asian immigrants have migrated directly from aforementioned countries. However, a minority belong to the South Asian diaspora. The word diaspora comes from Greek and refers to “a scattering of seeds.” South Asian diaspora refers to people whose ancestors were from the subcontinent of India but migrated to other colonized communities established by British and French in the nineteenth century. Some of these countries are Guyana, Trinidad and Tobago, East and South Africa, Fiji, and Mauritius. More recently, they have also been identified from countries like the United Kingdom, the United States, Australia, and New Zealand. South Asian diaspora invokes a concept of community with multiple locations and movements or “twice migrants.”

In the last few decades, the number of South Asian immigrants has increased dramatically in various nations throughout the world. This could be explained by the “push–pull” phenomenon. Pushing forces are those negative circumstances which exist in the countries of origin (e.g., political instability and ethnic or religious conflicts) leading to emigration. Pulling forces are the attractive features (e.g., safety and economic opportunity) in the countries adopted by migrants. Some scholars link the increased emigration of South Asians to the post-colonial aftermath with a breakdown of local culture and the political system, suspension of economic progression, and the rise of structural hierarchies and social stratification (e.g., gender and caste). This is possibly compounded by increasing economic divide between countries.

North American Settlement

South Asians comprise one of the fastest growing immigrant groups in North America. However, their immigration trends have changed over time.

In the USA, immigration from South Asia has occurred in three waves. The *first wave* lasted from 1907 to 1924 and comprised almost exclusively a few thousand men from Punjab who arrived as farm laborers or migrant workers and settled in California. Most of them married Hispanic women due to the US immigration law which discouraged returning to South Asia for marital purposes. After World War II, the immigration policies started to relax. The Luce-Celler Bill of 1946 established a small quota for immigration from regions of India and Pakistan and permitted their naturalization. In 1952, the McCarran-Walter Act removed all race restrictions on immigration, supplanting the 1790 Naturalization Law which only accepted “free, White persons” as citizens.

The *second wave* of South Asian immigration began with the Immigration and Nationality Reform Act of 1965 and continued until the mid-1970s. In 1965, the annual quota of immigrants was raised to 20,000 per country and allowed family reunification. This policy shift, amidst the civil rights movements, came as a response to criticism from the United Nations and the need for skilled professionals. The policy favored high-skilled workers such as medical doctors, engineers, and scientists. This led to a large proportion of South Asian immigrants securing white collar jobs in the USA and their labeling as “model minority” (for other Asian groups).

The *third* wave of South Asian immigration began in 1976 when stricter regulations started to emerge for skilled workers. The recent immigrants are generally less educated and often arrive to join their predecessors. They are often in low paid jobs or self-employed running grocery stores, gas stations, restaurants, or taxies. With lesser economic stability, many family members may live together under poor conditions which contradict the previous “model minority” status. According to the 2000 census, 1,678,765 Americans identified themselves as Asian Indian regardless of the country of birth. The largest proportions are found in California and New York.

In Canada, South Asian immigrants have arrived in two dominant waves. The *first wave* of South Asian immigrants came from Punjab in the early 1900s as industrial workers. During this era, family members of non-European migrants were not permitted. It is estimated that in 1908, there were 5,000 South Asians in Canada. In 1909, Canadian government limited immigration to only people who came by continuous travel from their country of birth. This regulation effectively halted South Asian immigration, and between 1909 and 1943, only 878 South Asians were permitted to enter Canada. During this period, unlike the US policy, South Asian men were permitted to return to their native countries. Thus, many visited their homeland to marry or bring their wives and any children less than 18 years of age. After the World War II, immigration restrictions were gradually removed. By the 1950s, immigration rules eased with an annual immigration quota for various countries. In 1967, immigration policy moved toward a point-system based on qualifications and, hence, eliminated preferential support to Caucasian immigrants.

The *second wave* of skilled South Asian immigrants and their families began in the 1970s and continues to date. Currently, Canada selects economic immigrants on the basis of attributes such as education, needed professions, language skills, and age – all of which are grouped under the rubric of human capital – along with pre-migration health screening. In 2006, South Asian immigrants became the top visible minority group in Canada. The number of South Asian immigrants in Canada rose by 37% between 1996 and 2002. According to 2006 Canadian census, 1,316,770 people are self-identified South Asians regardless of the country of birth. The largest numbers reside in Toronto, Vancouver, and Montreal.

Settlement Challenges

Migration is not without challenges for South Asians arriving in countries like Canada and the USA where most of the population is of European or Caucasian descent. Immigrant South Asians may experience multiple oppressions not only from their own community (i.e., gender and class-based norms) but the dominant society as well. Several studies report that immigrants encounter settlement challenges due to systemic, informational, cultural, and linguistic barriers. Compared to European immigrants, the intensity of these settlement barriers is often higher for South Asian immigrants due to their visible minority status leading to experiences of being different, also called "minoritization." Studies with South Asians report experiences of overt or subtle discrimination or racism. In the USA, South Asian immigrants are also likely to be influenced by negative stereotypes of African Americans. Recent South Asian immigrants also encounter the expectation to be a "model minority" like their predecessors though they may lack the socioeconomic advantage enjoyed by their predecessors. Post 9/11 discrimination is another stressor for South Asian immigrants.

Transnationalism

In the modern world of technology, migration is not a unidirectional experience. With the availability of affordable, rapid transportation and communication technologies, immigrants are able to travel frequently between their countries of origin and settlement, and retain close contacts with families and friends left behind. Scholars have documented the value given to maintaining attachment and close ties among South Asian first- and second-generation immigrants. This mitigates their ability to maintain their original cultural norms and health beliefs while assimilating and acculturating with dominant norms of the settlement society. As described by Portes and DeWind transnationalism represents "the obverse of the canonical notion of assimilation, sustained as the image of a gradual but irreversible process of acculturation and integration of migrants to the host society. Instead, transnationalism evokes the alternative image of a ceaseless back-and-forth movement, enabling migrants to sustain a presence in two societies and cultures." This adds urgency to the need to understand the social, historical, economic, and political context for immigrants in pre- and post-migration countries.

Cultural Norms, Values, and Beliefs

Cultures norms, values, and beliefs are formed by social organization and activities of families and communities. To understand the transformation of norms, values, and beliefs, it is important to examine the family structure and community orientation from a cross-cultural perspective.

In South Asia, a traditional family structure has extended kinship and a shared household where several married brothers live under the same roof with parents and unmarried sisters. Senior members of the family, such as parents or grandparents, control the social activities of younger family members. Thus, elders hold the authority to make decisions about employment, education, matrimonial selection, and age of marriage for younger family members. A traditional marriage is arranged by parents often at young age, because economic independence of a man prior to marriage is not viewed as necessary in the context of a shared household.

The meaning of marriage is to build relationships between families, instead of two individuals, and this in turn signifies family honor and obligations. Men are given higher status in the family due to their expected role in economic contributions, limiting women's power in decision-making. In contrast, the Western family structure is nuclear and a typical household has only one married couple while unmarried adult children often live separately. This encourages children's independence in Western families but necessitates financial viability before marriage, leading to marriages at a later age.

The organization of family units contributes to orienting the respective community. One such example is the collectivist and individualist orientation of cultures. South Asian culture is collectivist in nature where self is interdependent; personal goals and communal goals are closely aligned; social behavior is guided by obligations, duties, and communal goals; and emphasis is placed on maintenance of relationship even when disadvantageous. The Western culture is individualistic where self is independent; personal goals have priority over group goals; social behavior is guided by attitudes, personal needs, rights, and contracts; and relationship maintenance is critically analyzed for advantages and disadvantages. Thus, autonomy and uniqueness are valued in the West while sharing of resources and conformity are desirable in the South Asian culture. In this light, desire for group harmony encourages self-sacrifice, obedience, elders' respect, and filial piety among South Asians. Strong patriarchy in South Asian culture can lead to exploitation of collectivist values and norms. For example, women are held responsible for maintaining the family unit which leads to their higher self-sacrifice than men. Women are also expected to be obedient in their roles as daughters, mothers, and wives, also referred to as "three obediences." This often leads to their subordination in a family and community.

Cultures are not static and also have individual variations. Yet, cultural transformation is rapid for individuals who migrate to a region with different cultural patterns. This also raises the possibility of intergenerational tensions. For example, migration of South Asians to Western culture may mean loss of extended kinships and shared households which can lead to decreasing bonding. At the same time, their next generation aspires for independence contrary to the values of parents and grandparents leading to stress at the both ends.

Health and Determinants of Health

Although large-scale studies with adequate number of South Asian immigrants are limited, three health issues frequently emerge in the published literature. These include their low use of preventive services (e.g., cervical and breast cancer screening), high risk of cardiovascular diseases, and domestic violence. Please see relevant sections for these issues.

There is dearth of knowledge about the health determinants specific to South Asian immigrants. Some small scale community studies generate important insights but the findings are not necessarily generalizeable. In this light, it is important to explore various conceptual frameworks to set direction for future research, programs and policies.

One such framework is presented by Bierman et al. to understand the pathways through which multiple factors determine the health of immigrants, in particular at the intersection of gender and ethnicity. First, the geo-political environment constitutes the overarching context, creating forces that determine who migrates, where they migrate from, and their resulting migration settlement. Thus, the health and wellness of South Asian immigrants is the product of macro-level or national factors, such as the economy, labor market conditions, and immigration policies. Second, the meso- or community-level factors determine health such as neighborhood characteristic, social networks and discrimination. Finally, the micro-level factors related to individuals and families (income, education, and family structures in countries of origin and in the adopted nation) contribute in immigrant health. Socially constructed gender roles and its shifts in the countries of origin and settlement mediate at the macro, meso, and micro levels, resulting in different health outcomes for men and women.

Future research is needed to improve understanding on the population-specific determinants of health to tailor health, social and economic policies aimed at optimizing health and well-being of immigrants, including South Asians.

Related Topics

- ► Acculturation
- ► Collectivism
- ► Discrimination
- ► Ethnicity
- ► Health policy
- ► Healthy immigrant
- ► Tamils

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Southeast Asia

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Background

For the purpose of this entry, Southeast Asia consists of members of the Association of Southeast Asian Nations (ASEAN). These nations include Brunei, Myanmar (formerly known as Burma), Cambodia, Indonesia, Laos, Malaysia, Philippines, Singapore, Thailand, and Vietnam. East Timor is generally recognized to be in Southeast Asia but is not a member of ASEAN. For historical and cultural reasons Papua New Guinea is considered to be part of Oceania.

Few other regions on earth have experienced and been defined by the impact of continuous conflict, famine, and external forces of control as Southeast Asia. In order to approach the questions of health policy and the individual care of Southeast Asian immigrants, it is critical to recognize the devastating impact of war and genocide in the twentieth century. Geographically the region is divided into two distinct areas. Mainland Southeast Asia stretches from Myanmar southeast to Vietnam. The countries to the south are grouped under maritime Southeast Asia, including Singapore, Brunei, the Philippines, and Indonesia; the latter of which is spread across 17,508 islands. The entire region is geologically very active with frequent earthquakes and volcanic eruptions. The Boxing Day Tsunami of 2004 originated in Indonesia, and much of the destruction was within the Southeast Asian region. The tsunami was caused by one of the largest earthquakes ever recorded and killed 230,000 people across 14 countries.

The region contains many extremes: The population of Brunei is estimated to be 400,000 with a GDP per capita of US$36,700 whereas the population of Indonesia was reported at 240,271,522 with a GDP per capita of US$4,000, still surpassing the region's lowest GDP per capita – Myanmar, at US$1,200.

Another extreme is religion. Today Indonesia is home to the world's largest population of Muslims whereas Thailand is almost 95% Buddhist. In the region overall, Islam and Buddhism are dominant, but there are large populations of Christians as well as enclaves of Hinduism and remote areas that practice animism.

Outside Influences

Before the 1500s, the first known nation-states in the region were sophisticated Buddhist and Hindu empires with strong Indian influences. They existed for at least a thousand years prior to the thirteenth century, and many left extraordinary religious structures such as the Hindu Angkor Wat in Cambodia and the Buddhist temple Borobudur in Indonesia.

During the thirteenth century, two major events occurred in different areas of Southeast Asia. In mainland Southeast Asia, Kublai Khan's Mongol forces swept into Myanmar and overthrew the reigning Bagan kingdom. The Mongols were followed by the Tai-Shan people from Yunnan, China, who would fan out to Myanmar, Thailand, and Laos. In maritime Southeast Asia, Muslim traders arrived, and Islam began to take hold. One of these traders was thought to be a Chinese merchant named Zeng He, who arrived in the fifteenth century with Muslim Chinese crews. The ties he established across Southeast Asia during his voyages paved the way for one of the first waves of Chinese migration to Southeast Asia and the formation of Chinese communities across the region.

Early European Influence

In the 1500s Europeans began to arrive. Eventually the Portuguese claimed Timor, and the Spanish ruled the Philippines. The Dutch established the Dutch East Indies (modern day Indonesia), the French established control in mainland Southeast Asia and called it Indochina (including modern day Cambodia, Laos, and Vietnam), and the British Straits Settlements included modern day Singapore, and Malacca, and Penang in Malaysia. The British also expanded into Myanmar from their colonial outposts in India. Along with European trade and outposts came missionaries and Christianity. The European presence in the nineteenth century led to a second wave of Chinese migration to the area, as developing and exploiting local resources resulted in an insatiable demand for labor. This wave is sometimes referred to as the great "Chinese Diaspora." The migration led to a strengthening of ties between China and Chinese communities that had been established hundreds of years previously by traders in the fourteenth to seventeenth centuries.

World War II

The 1940s brought World War II and the Japanese occupation of much of Southeast Asia. Japan invaded Cambodia, Laos, and Vietnam but left the French colonial authorities in place until 1945. In a last ditch effort to gain support of the Asian population as their new empire crumbled, the Japanese jailed the French authorities. This led to disruptions in production and contributed to a famine in Indochina that killed one million people in 1945. The Japanese did not occupy Thailand, as it aligned with Japan and declared war on the USA and the UK. However Thailand generally did not act on the war declaration, and more than 50,000 armed Thais supported the Allied war effort. Myanmar was an active battle ground while the British fought to keep the Japanese out of India.

Many Indonesians initially greeted the Japanese occupation of Indonesia as freedom from Dutch oppression. Although Indonesian nationalists cooperated with the Japanese, thousands of Indonesians were conscripted for slave-labor military projects such as the Burma–Siam Railway and died as a result of poor treatment and starvation. Japanese troops committed sex slavery on a broad scale. The United Nations estimated that during this period four million Indonesians died as a result of forced labor and famine.

In Singapore the British forces suffered a crushing defeat resulting in Japanese purges of ethnic Chinese in Singapore, systematic massacres in which 25,000–50,000 people died. After the war ended in 1945, the effects of the Japanese occupation and failure of the British defense of Singapore sparked a political awakening that led to the eventual independence of Singapore through peaceful means.

Revolution and Anti-Colonial Struggles

After the Japanese surrender and the end of World War II, the Philippines gained independence peacefully in 1946 and Myanmar in 1948. Indonesian independence fighters gained independence in 1949 after 4 years of conflict with the Dutch. In the territories that would form the nation of Malaysia in 1957, the British fought and suppressed a communist insurgency from 1948 to 1960. This was the forerunner of an ideological conflict that would spread throughout Southeast Asia over the next 30 years as the USA and the West developed a policy of "containment" against communist expansion in the region. Nowhere was the conflict more devastating than in the former French colonies, Vietnam and Cambodia, where it had consequences on immigrant health that continue today.

First Indochina War

The war began after World War II when the French returned to resume colonial control of Vietnam. The Viet Minh, a communist movement, fought the French with support from the People's Republic of China and later from the Soviet Union. After defeating the French in 1953, negotiations resulted in Vietnam being split in half with the North going to communist Viet Minh control and the South to an American-backed regime. Negotiated plans for an election were never followed through, and this led to renewed conflict.

Second Indochina War: Vietnam, Cambodia, and Laos

The 1954 division led to the Second Indochina War (referred to in the USA as the Vietnam War) from 1960 to 1975. It began with indirect American support in the 1960s and escalated to years of continuous bombing campaigns and massive commitments of troops and resources from the USA and its allies. Due to massive public opposition and lack of political will, USA signed the Paris peace accords and withdrew in 1973. Two years later South Vietnam fell to the forces of the Communist north. By the end of the war more than 3.1 million Vietnamese had been killed and 2.6 million injured. The end of the war marked the end of 116 years of foreign control of Vietnam and 30 years of continuous warfare by the leaders of the Communist party in Vietnam.

Cambodia gained independence from France in 1953 and remained a constitutional monarchy until open conflict with the communist (Maoist) Khmer Rouge began in 1970. Fighting continued until the Khmer Rouge gained control of the country in 1975, the same year the North Vietnamese gained control of South Vietnam and unified their country. Within days of capturing the capital, Phnom Penh, the Khmer Rouge led by Pol Pot began a campaign of genocide that killed 20% of the population or approximately two million people from 1975 to 1979. Cambodia was invaded by Vietnam in 1978, and despite a limited Chinese invasion of Vietnam in 1979 to support their Cambodian allies, the capital Phnom Penh fell to the Vietnamese. Stability did not come to Cambodia until an agreement in 1991 that was policed by 20,000 U.N. Peacekeepers.

The Laotian Civil War (1953–1975) occurred between the Pathet Lao communists and the French colonialists and later the Royal Laotian Army. Despite American, Thai, and South Vietnamese intervention, efforts by the North Vietnamese supporting Pathet Lao communists were ultimately successful, and the Pathet Lao overthrew the Royal Laotian government in 1975.

Legacy of War: Unexploded Bombs, Land Mines, and Refugees

Laos has the unfortunate distinction of being the most heavily bombed country, excepting the atomic bombs dropped on Japan. In their attempts to interdict North Vietnamese supply convoys to the guerillas in the south, the US Air Force is thought to have dropped one bomb load every 8 minutes, from 1964 to 1973. More bombs are reported to have been dropped on Laos in these 9 years than the combined ordinance used in World War II. It is thought that in some areas almost one third of the bombs did not explode, a legacy which still causes death and maiming today.

Thirty-five years later, residual effects from the Indochina war in Cambodia include land mines and unexploded military ordinance that the warring forces (US, Vietnamese, Royal Cambodian, Thai, Khmer Rouge, and other military forces) left. Cambodia is one of the most heavily mined areas in the world, and it is estimated that two to four million mines remain. Cambodia has one amputee for every 290 people; UNICEF estimates that children sustained half of land mine casualties in Cambodia, many of whom will not have access to modern prosthetics. These victims also have unmet mental health needs and commonly express symptoms of posttraumatic stress disorder (PTSD) and chronic depression.

Between 1975 and 1995, more than three million people are thought to have fled Vietnam, Laos, and Cambodia, many as "boat people" who ended up across the globe. Some estimates suggest that as many as 250,000 boat people died on their journey. The ones who survived did so in extremely harsh conditions, often languishing in refugee camps for years with the constant threat of return to the country they had fled.

Emigration to Other Countries

Because of American military and political involvement in Indochina, almost 1.4 million refugees from Southeast Asia were relocated to the USA; 1.1 million of them are thought to be Vietnamese, the majority living in California and Texas. A significant percentage of Vietnamese refugees are the progeny of Vietnamese women and the more than three million male American personnel stationed in Vietnam during the war. These children often experienced ridicule and abuse in Vietnam.

From 1975 to 1993 more than 500,000 Cambodians fled into Thailand, and another 100,000 entered Vietnam. At least 300,000 of those Cambodians permanently fled the region, with more than 179,000 migrating to the USA, 50,000 to France, and 45,000 to Australia.

The American resettlement of more than a million refugees from the Indochina war was influenced by the experience of Miami, Florida, in coping with the Cuban refugee crisis. In the 1960s, Miami received hundreds of thousands of refugees, and its social service system was overwhelmed. Therefore, the government dispersed Southeast Asians widely throughout the USA. It was a failed social experiment, as the refugees were isolated by differences in language, food, lack of community, and religious or spiritual support. Refugees migrated within the USA toward locations where family and community leaders had settled, primarily in areas where there was infrastructure established by Asian-American populations.

Myanmar

The conflict in Myanmar has generally been an internal one. Myanmar maintains trade and relations with its neighboring states and China but is otherwise isolated from the international community. The conflicts began when a 1962 coup d'état led to military rule. Since that time, inefficient central control of production and other economic policies have changed Myanmar from "the ricebowl of Asia" to one of the world's most impoverished nations. Over half the Burmese population consists of diverse ethnic groups. There has been a long history of government offensives against a variety of ethnic insurgent groups resulting in hundreds of thousands of refugees and internally displaced persons. Burmese refugees in Thailand include the Karen, Karenni, Shan, Tavoyan, and Mon ethnic groups. The U.N. estimates that at least 150,000 Burmese refugees have gone to Thailand, 125,000 to Bangladesh, and 20,000 to Malaysia.

Human Trafficking

Approximately 200,000–225,000 women and children are trafficked annually in Southeast Asia alone. The majority of these women are trafficked to countries within southeast and eastern Asia, but at least 30,000 are transported to the USA each year as unwilling prostitutes and domestic labor. Additional tens of thousands end up in Australia and Europe. Human trafficking is a form of exploitation that involves controlling and transporting people through the use of force, deception, or coercion. It is reported to be the third most profitable criminal activity in the world after drug and gun smuggling and resulted in estimated worldwide profits of US$31 billion in 2008.

The classic pattern of trafficking occurs when a woman is lured by a placement agency to leave her rural village to come work in a city as a maid or receptionist at a hotel or spa. Traffickers then isolate the woman and often rape her and threaten to maim or hurt her or her family if she does not work as a prostitute for them. There are numerous variations on this theme: Traffickers target children with promises of a school program and turn them into beggars or flower sellers; men are promised well-paying construction jobs and find themselves as indentured slaves in mines or other work in unsafe conditions for little pay. The traffickers are reportedly organized crime syndicates, parents, relatives, friends, intimate partners, and neighbors. Trafficked women are at high risk of sexually transmitted diseases and often have their access to health care and testing restricted by their employer; they may be banned from using condoms if clients pay extra or insist.

Young girls who are virgins are highly sought after by traffickers, as they are free from HIV or STDs. They are also thought to convey increased vigor to their male clients. Healthcare workers who see victims of trafficking may not realize their patient's history or may mistakenly screen them for domestic violence. Trafficked immigrants are usually under severe threats not to discuss their status with healthcare workers or have been told that healthcare workers will notify the police and throw them in jail if they find out that they are illegal immigrants. Most countries in Southeast Asia are primarily source countries for victims. Thailand is a significant source country for women sent to Japan, Taiwan, Europe, North America, South Africa, and Australia. Thailand is also a significant destination for women from Myanmar, Laos, Cambodia, and southern China who are brought there for the domestic sex industry.

Narcotic Trafficking

The "Golden Triangle" of opium production across northern Thailand, northern and eastern Myanmar, and western Laos has been the center of poppy cultivation (the source of opium and heroin) since the nineteenth century. In the 1990s, Thailand drastically reduced poppy cultivation and narcotics traffic to the point where it is no longer a significant producer. In 2000 Myanmar produced 60% of the world's heroin and Laos was the third leading producer. This contributes to regional instability but also significant health problems including drug addiction and HIV. Overland heroin trafficking takes drugs into China and across Myanmar to India where the drugs can be distributed internationally. Along the more common routes, heroin trafficking has been demonstrated to cause epidemic outbreaks of HIV; the HIV prevalence along these routes ranges from a low of 30% to as high as 80% among injection drug users.

Culture and Communication

The following section primarily applies to first generation immigrants being treated by Western healthcare workers and is meant to be a general guideline. Cultural practices vary widely across Southeast Asia. More importantly, expectations and knowledge vary widely within cultural groups and among patients and families.

In many Southeast Asian cultures, importance is placed on the family over the individual. Elder family members are given significant weight in decision-making, and families are expected to care for elders. The oldest male is often given the role of speaking for the family, and this can be difficult for Western healthcare workers who may not understand why a female or younger patient is deferring or refusing to make a decision if the spokesperson is not present or disagrees. Because there is a cultural norm to show deference and avoid conflict with authority figures, Southeast Asian families may appear to be passive or ignorant when they do not respond to cognitive reasoning by doctors and nurses. Younger members of the family or women may also avoid eye contact.

Many Southeast Asian cultures do not see a clear hierarchy of knowledge with science playing a primary role. Instead there is often an attempt to seek a balance between modalities of spiritualism, alternative medications, and Western therapies. This can lead to mixing and matching of therapies that may be bewildering to Western caregivers who are focused solely on interpreting illness from a pathophysiologic standpoint. Some Southeast Asian traditions have very strong practices about restoring the balance of "humors" and will identify many foods and therapies as either cold or hot. Healthcare workers who do not understand or ignore these belief schemas may find themselves alienating the person or family they are trying to help. Because complicated cognitive explanations may not be effective across language barriers, other techniques may be necessary. Two successful approaches that have been employed are engaging spiritual or community leaders as advocates and integrating Western treatments with alternative practices such as spiritual and complementary medicine. It is often much more acceptable if a Western treatment is seen as bringing harmony and balance, rather than replacing existing practices. Practitioners may also find that while many Southeast Asian cultures deeply respect the role of the doctor, it does not mean they will blindly follow along. The building of rapport through listening and establishing mutual respect can be time consuming and challenging; however, it will be very rewarding in terms of establishing a basis for trust and adherence to therapeutic recommendations.

As a broad generalization, many people from Southeast Asia will come to a practitioner focused on symptoms rather than a particular disease. Patients in Western cultures tend to expect a doctor to translate their symptoms into a diagnosis; significant anxiety may occur if the doctor is unable to give a diagnosis, even if the symptoms are relieved. Many Asian cultures place an emphasis on alleviating the symptoms first. Southeast Asian patients may not be impressed by a practitioner who provides a clever diagnosis but does not offer a prescription or therapy to alleviate their chief complaint. It is crucial in these encounters to listen carefully to the patient or family as to why they are presenting; if the presenting symptom is not addressed, it may be impossible to engage the patient or family later in therapy.

Paradoxically, some (but not all) Southeast Asian patients come from cultures where they expect the doctor to make a pronouncement of a definitive diagnosis and prescribe a treatment plan in a paternalistic (rather than collaborative) manner, often based on a few vague symptoms. This relates to traditional expectations that healthcare providers have "supernatural" powers to make various predictions. Also, similar expectations can lead to consternation among patients and families when well-meaning practitioners attempt to engage the patient and family in decision-making in an ethically sensitive manner. This is not to imply that clinicians should be paternalistic. However, the manner of the communication needs to be sensitive to their expectations. When there is doubt, cultural expectations and norms should be inquired about and understood, rather than insisting on an individualistic approach.

Mental Illness

Nowhere are these cultural and communication issues more of a concern than in mental health evaluations. With the tremendous history of violence, bombings, starvation, torture, rape, and forced migration, many immigrants are at risk for mental illness or distress, particularly posttraumatic stress disorder (PTSD), and clinical depression. Immigrants to Western countries in particular may describe isolation, harassment (verbal, sexual, or physical), stigma, and loss of status. It is very difficult for Southeast Asians to discuss mental illness, and practitioners should be alert for psychosomatic presentations of PTSD and depression when vague symptoms are reported that do not respond to any treatment. Investigations of functions like sleep, appetite, and motor activity may be more useful than inquiry about mood and guilt. Prior direct or indirect exposure to trauma is normal in Southeast Asian immigrants. While many people are resilient and able to cope with their traumatic past, others suffer chronic sleep disturbance and survival guilt. For some, PTSD symptoms may surface after many years of apparent good mental health, either because of role transitions (e.g., a father who no longer needs to provide for his family after he retires) or during times of new social stressors. Functional status such as changes from social roles (e.g., caring for grandchild by grandmother, job performance of husband) should also be inquired about to help elucidate the severity of depression and PTSD.

While most clinicians strive for a good rapport with patients, a strong alliance and validation is crucial before introducing the idea of psychiatric care or referral. This may take several visits and even then should be introduced slowly and sometimes indirectly, to "save face" and to avoid shame on the part of the patient, since psychiatric disorders are associated with "weakness." Except in the most extreme circumstances, family members or friends should be rarely used as interpreters when completing mental health evaluations. While this is an awkward and potentially inappropriate practice in almost any culture, for Southeast Asian patients, it could be truly intolerable for elders to place this burden on their children or to share this distress. Use of inappropriate interpreters will often result in incomplete information and minimization or denial of symptoms. In the USA, phone-based medical translation services and interpreter services have been instituted and even mandated in many settings. Sufficient time should be allocated in each visit to account for the time needed for translation.

End-of-Life Care

In the USA, many patients of Southeast Asian ancestry will respond well to palliative care when it is characterized as comforting, peaceful, and engages the entire family. This is particularly true of patients coming from Buddhist traditions. However, hospice workers need to recognize that families of these patients may attempt to undertake care even when it is draining and exhausting, as they may see asking for assistance as a failure of their obligation to their elders or family. By the same token, Western medical teams can be confused when Asian palliative care patients are brought to the emergency room even though nothing medically urgent has occurred; this can be due to misunderstandings about the role of the hospital or the family feeling overwhelmed. A serious issue of ethical conflict described by caregivers of Asian patients is that they may be requested by the family not to inform a patient that they are dying. This can be out of an instinctive fear not to upset their loved one, but also may come from a sense that it will expedite death. This apparent clash between Western and Eastern values can often be resolved by directly asking the patient or responsible person about their preferences for information sharing, prior to the disclosure of the information to any particular party.

Osteoporosis

Southeast Asian women may be at higher risk for osteoporosis after menopause. At least one study has shown that bone density reference values may be lower for elderly women born in Southeast Asia. Among premenopausal women, there appears to be higher bone mineral density in association with earlier age of menarche, years of education, lower height, and coastal birth (due to seafood consumption).

Culture-Specific Syndromes

These are unique patterns of symptoms that occur in many cultures around the world. They include symptom clusters or behaviors that occur within cultures without clear relationships to Western pathophysiologic understanding of human disease. There are many within Southeast Asian cultures and they are discussed in the medical literature. Some of the more famous examples are given below:

- *Amok*: a dissociative episode characterized by a period of brooding followed by an outburst of violent, aggressive, destructive, or homicidal behavior.
- *Koro*: an episode of sudden and intense anxiety that the penis (or in the rare female cases, the vulva and nipples) will recede into the body and possibly cause death, known as “rok-joo” in Thailand.
- *Latah*: hypersensitivity to sudden fright, often with echopraxia, echolalia, command obedience, and dissociative or trancelike behavior. The Malaysian syndrome is more frequent in middle-aged women. Known as “bah-tschi,” “bah-tsi,” and “baah-ji” in Thailand and “mali-mali” or “silok” in the Philippines.
- *Koucharang*: (Cambodia) or “thinking too much illness” is associated with past trauma and symptoms of headaches, behavioral changes, and other somatic complaints.
- *Khyol*: “wind illness,” may also refer to dizziness and fever, but commonly describes a disturbance of balance that can be due to a variety of illnesses.

Infectious Diseases

The prevalence of HIV in Southeast Asia ranges from 0.2% in Laos to 1.4% in Thailand. In 2007 the epidemics in Thailand, Myanmar, and Cambodia were declining while in Vietnam and Indonesia HIV rates were increasing. Routes of transmission are both injection drug use and sex, often but not exclusively through prostitution. Other infections seen in refugees and Southeast Asian immigrants include: amebiasis, angiostrongyliasis, anthrax, capillariasis, chikungunya, cholera, cryptococcosis, cyrptosporidiosis, cysticercosis, dengue, Japenese encephalitis, filariasis, gnathostomiasis, helminthiasis, hepatitis B (15% of the population in some studies), leishmaniasis, leprosy, leptospirosis, malaria, medliodosis, mycetoma, strongylodiasis, trenatodes, tropical sprue, typhus, and yaws.

Health Promotion and Healthcare Maintenance

Research has consistently demonstrated that Southeast Asian immigrant populations are less likely to use routine cancer screening services. In addition, the risk of hepatitis A and B is higher for Asians and routine screening and vaccination is recommended, especially in those with comorbidities. *Helicobacter pylori* is highly prevalent and should be part of the work-up for gastro-esophageal disease. Finally, a system of care should be in place to screen for and provide follow-up treatment for depression and PTSD. A number of PTSD support groups, especially tailored to particular Southeast Asian groups (e.g., Vietnamese from a particular region, Hmong, etc.), may be helpful though more systematic research is needed. Given the community orientation of many Southeast Asian groups, healthcare practitioners should routinely ask about preferences for religion or spirituality, minority group affiliations, language spoken (with particular attention to dialects, which is informative about a person's geographic and ethnic origin), use of herbal medications, traditional healing practices, and view of Western medicine and psychotherapy for those receiving mental health services.

Related Topics

- ▶ Alternative and complementary medicine
- ▶ Amok
- ▶ Anti-Asian violence
- ▶ Asian Americans
- ▶ Barriers to care
- ▶ Cambodia
- ▶ Colonialism
- ▶ Culture-specific diagnoses
- ▶ Depression
- ▶ Displaced populations
- ▶ Explanatory model of illness
- ▶ First generation immigrants
- ▶ Mental health
- ▶ Posttraumatic stress disorder
- ▶ Refugee
- ▶ Somatic symptoms
- ▶ Trafficking
- ▶ Trauma exposure
- ▶ War-affected children

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Spain

- ▶ Hispanics
- ▶ Latinos

Spanglish

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Spanglish is the use of both Spanish and English in a manner linguistically defined as code-switching. Code-switching occurs when speakers of two languages use the languages interchangeably. Spanglish is spoken by an estimated 35 million people in the USA, although Spanish is spoken by about 250 million people worldwide, while English is spoken by roughly 350 million.

Spanglish is commonly referred to as the language of Chicanos, that is, Americans of Mexican descent. However, Spanglish, and different varieties of it, are also spoken among other groups of Latinos in the USA, including Puerto Ricans. In fact, code-switching occurs in many instances where people are bilingual in other languages besides Spanish and English, such as Maltese and English, French and German, Spanish and Catalan, and English and French. Typically where there are linguistic borders (i.e., USA and Mexico), or when a country has more than one official language (i.e., Malta), instances of code-switching are found.

The 1990 US census indicated that the Spanish language was lost in the US Southwest after one or at most two generations. A comparison of subsequent censuses revealed that Spanish is maintained only in those regions where recent immigration from Spanish-speaking countries is intense. Distance from the Mexican border is a key parameter for Spanish language retention, intimately linked to opportunities for using Spanish on a daily basis at home and in the workplace.

Examples of Spanglish include sentences or expressions such as "I'm going back to work *pasado mañana*" (I'm going back to work the day after tomorrow); "*La blusa me costó* forty dollars" (The blouse cost me forty dollars); "I bought a new computer today. *Me lo compró mi hermana*" (I bought a new computer today. My sister bought it for me). Although there is no strict or universally agreed upon definition of both Spanglish and code-switching, in general, code-switching in Spanglish follows two rules, one being that the switching from one language to the other consists of unchanged Spanish or English words, and the pronunciation of the words is not altered but remains as pronounced by native speakers of each language. One exception to this, however, is when what is referred to as linguistic borrowing occurs and particular words have both a Spanish and English part. For example, the word *carro* for car and *puchando* for push, as in "*no puchen el carro*" (don't push the car). If Spanish and English are mixed in such a way that does not follow code-switching rules, it is not commonly comprehensible. In other words, Spanglish is not just a matter of using two languages simultaneously to communicate, but rather it follows a set of grammatical and pronunciation rules. According to most linguists, Spanglish follows the three primary code-switching rules: (1) code-switching can take place only between full word boundaries (free morpheme constraint), (2) monolingual constructs within the sentence will follow the grammatical rules of the monolingual fragment, and (3) permissible switch points are those that do not violate the order of adjacent constituents on both sides of the switch point of either of the languages (also called equivalence constraint).

As with many other forms of communication that are not the predominant and strictly enforced communication styles of the predominate culture in any society, Spanglish does not exist without its critics. Some language purists, scholars, and writers are very critical of Spanglish, defining it as using both poor Spanish and poor English language skills. Some see Spanglish as a degradation and deterioration of the Spanish language and fear that its legitimization will eventually eradicate the Spanish language. However, for many people who speak it, Spanglish is culturally significant because it reflects an identity for groups of individuals of Latino origins living in the USA. People tend to speak Spanglish to those whom they feel emotionally or culturally connected. In fact, it has become deeply rooted in Chicano culture. Spanglish is now used by contemporary writers, radio personalities, musicians, and even politicians on the campaign trail to connect to their audiences. It is commonly used in media and advertising. Some hypothesize Spanglish will continue to become more widely used and eventually fully accepted in the American English vernacular, similar to Yiddish (a combination of Hebrew, German, Russian, Polish, and other Slavic languages which, when it was first used, was referred to as "gibberish" for women and children).

Since Spanglish can be used to convey familiarity and solidarity between speakers, Spanglish used in health care settings could be quite important. Health care providers who are fluent in both English and Spanish can use Spanglish with their Spanglish-speaking patients to break down cultural, racial, and socioeconomic barriers that may exist between patients and medical professionals. Spanglish can create a cultural affinity and show empathy, understanding, and acceptance in an area of human exchange that could otherwise be wrought with miscommunications and misunderstandings, and a social hierarchy that may preclude a patient from seeking medical help in the first place, from being as forthcoming as necessary for a medical professional to properly treat a health issue, or from following valuable medical advice. Speaking Spanglish, or accepting it as a legitimate language among patients, can open up communication in such a way that it may lead to better health outcomes for patients.

Related Topics

▶ Language
▶ Language acculturation

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SSDI

▶ Social Security Disability Insurance

STDs

▶ Sexually transmitted diseases

Sterilization

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Permanent sterilization is the most common method of contraception worldwide; an estimated 180,000,000 tubal ligations are performed each year worldwide on reproductive aged women. In the USA, more than 600,000 tubal ligations are performed yearly. Researchers interviewing women about reasons they voluntarily chose to have a tubal ligation found over 98% cited “completed family,” while 31% said they “could not cope with or afford more children.” Nearly two-thirds reported they viewed a tubal ligation as the safest, most reliable, or most acceptable contraceptive method.

Interestingly, permanent sterilizations chosen by males versus females show converse demographic and socioeconomic profiles. Data from the 2002 National Survey of Family Growth found women who had tubal ligations tended to be less educated (lacking a high school diploma or equivalent), poorer, Hispanic/Latino or Black/African, while men who opted for vasectomies tended to be well-educated, married, relatively affluent, and White. While it is well known that vasectomy is simpler, cheaper, safer, and equally effective as female sterilization, it remains one of the least utilized methods of contraception. Of married women aged 15–49 years, fewer than 5% in developed countries and 3% worldwide rely on their partner’s vasectomy as their method of contraception. An exception to the above is in the sub-Saharan African countries, where for the past decade vasectomy prevalence rarely has exceeded 0.1%; researchers have suggested that vasectomy is unacceptable to most African men. The most common reasons men reported for choosing to undergo a vasectomy were: not wanting more children, viewing a vasectomy as the most secure family planning method, wanting to take responsibility for pregnancy prevention, their or their partner’s dislike for alternative birth control methods, and – among married or cohabitating couples – vasectomy was chosen over tubal ligation because it is safer, simpler, and had a shorter recovery time.

It is well established that in developed countries voluntary permanent sterilization is available to men and women. In the USA, while most men who underwent voluntary vasectomy held private health insurance, being poor does not exclude one from being able to choose permanent sterilization. The federal government and the states jointly finance Medicaid, a health care fund for the needy. Generally, sterilization is covered as a family planning service and receives a 90% match, with 36 states and Washington DC always covering tubal ligations and vasectomies under the family planning benefit.

The USA is known internationally for protecting individual rights and freedoms. While statistics for countries that participate in forced sterilization are not reliable and mostly anecdotal, well documented by the media has been the Chinese government's implementation of its 1979 "one-child family policy." The Chinese government denies claims of authorizing forced sterilizations; however, in 1996 the US Congress enacted a law to grant asylum to victims of forced sterilization, forced abortions, and other compulsory population control.

Charles Darwin's "theory of evolution" may be blamed for the institution of worldwide eugenic programs. In 1865, Sir Francis Galton, a British physician and a relative of Darwin, extrapolated from Darwin's theory that mental illness was hereditary and mentally ill persons were a hazard to society. Galton introduced the term "eugenics" to the European and American public, defining the practice as "reducing the numbers of unfit persons in society."

There was never a federal sterilization statute, but in 1927 the Supreme Court case *Buck v. Bell* legitimized the forced sterilization of mentally retarded persons. Over the next few decades, compulsory sterilization of the mentally ill and retarded was instituted, and some states extended coverage to persons who were deaf, blind, or considered to be physically deformed. With public awareness of Adolph Hitler's genocide policy, sentiments toward eugenics grew less favorable post-World War II. Also, in 1942 the Supreme Court decision in *Skinner v. Oklahoma* weakened the legality of forced sterilization, resulting in fewer being carried out. Despite the *Skinner* case, the routine sterilization of persons in institutions for the mentally ill and mentally retarded continued through the mid-1970s. Today, involuntary sterilization of mentally incompetent persons does occur, but not without following state mandated statutory guidelines and obtaining court ordered consent. The process varies from state to state; however, the goal remains to protect the interest of the patient and the physician.

Related Topics

- ► Eugenics
- ► Family
- ► Family planning
- ► Pregnancy
- ► Reproductive characteristics
- ► Reproductive health

Suggested Readings

Chandra, A., Martinez, G. M., Mossher, W. D., et al. (2005). Fertility, family planning and reproductive health of US women: Data from the 2002 national survey of family growth. National Center for Health Statistics. *Vital and Health Statistics, 23*(25, 26).

Letterie, G., & Fox, W. (1990). Legal aspects of involuntary sterilization. *Fertility and Sterility, 53*(3), 391–398, 398.

Pile, J. M., & Barone, M. A. (2009). Demographics of vasectomy – USA and international. *The Urologic Clinics of North America, 36*(3), 295–305.

Shavell, I. V., et al. (2009). Trends in sterilization since the introduction of Essure hysteroscopic sterilization. *Journal of Minimally Invasive Gynecology, 16*(1), 22–27. (Date of electronic publication: 2008 Nov 08).

Sills, E., Strider, W., Hyde, H., Anker, D., Rees, G., & Davis, O. (1998). Gynecology, forced sterilization, and asylum in the USA. *Lancet, 351*(9117), 1729–1730.

Suggested Resources

For information on the National Survey of Family Growth (NSFG). http://www.cdc.gov/nchs/nsfg.htm.

Stigma

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The concept of stigma is a member of a family of related notions signifying social devaluation, including prejudice, discrimination, racism, sexism, and the like. The modern understanding of "stigma" is often dated to sociologist Erving Goffman's 1963 *Stigma: Notes on Management of a Spoiled Identity*. Goffman based his use of the term on the practice, in ancient Greece, of relying on a tattoo or brand to mark a person as socially subordinate or an outcast (e.g., criminal, traitor, slave). He used the term "stigma" to refer to a personal attribute that may discredit or "spoil" an identity because people respond with negative expectations and discrimination. Already present in Goffman's initial formulation are themes relevant to immigrant health. Goffman elaborated three types of stigma attributes: the body, which includes health conditions such as obesity or disfiguring skin conditions; deviant traits, which include health conditions such as mental illness or addiction (but also legal status, such as being undocumented); or what he labeled "the tribe," referring to racial/ethnic identities that are devalued as "different" in a given context.

Since Goffman's introduction of the term, it has been developed in several directions by psychologists, sociologists, and advocacy groups. Psychologists have tended to rely on experimental methods to examine cognitive and emotional processes associated with viewing someone as possessing a stigma, such as the types and characteristics most likely to evoke this response, and, to a lesser extent, the processes involved in being viewed in this way, such as the factors that might influence loss of (or preservation of) self-regard. Sociologists have largely relied on large attitude surveys, measuring the nature and extent of the stigma assigned to an attribute that "spoils" an identity, how these attitudes vary across groups and over time, and how these attitudes influence various social processes, such as care-seeking, housing, and dating. A partial exception to this pattern is an effort to combine experimental and survey methods by the General Social Survey. Different versions of a vignette were created. For example, one described a person as having psychotic symptoms. Another instead described the person as having personal problems. By randomly assigning respondents to one condition or another, researchers were able to see how people responded to the characteristic described, and to explore whether these differences might be related to characteristics of the respondent. Advocacy groups, particularly those associated with health conditions, such as HIV/AIDS or psychiatric illness, have drawn on empirical work, particularly to document the harmful impact of stigma on its targets, but have primarily treated it as a wrongful, discriminatory attitude, based on ignorance or unreflective emotional responses.

Developments in this area of greatest relevance to immigrant health are efforts to embed well-understood aspects of stigma in broader social context, and integrate multiple levels of influence. In one influential contemporary model, Link and Phelan analyze stigma in terms of the convergence of four processes: the labeling of human variations, cultural beliefs tying certain of those labeled to negative attributes, a social separation of "us" and "them" that sets apart those labeled, and the associated experience of status loss, discrimination, and restriction of life chances by those labeled. This model also stresses the importance of a context of social, economic, and political power. While attitudes and actions of those who hold power can effectively stigmatize those who have little power, those who are relatively powerless cannot do the same for those with more power, however much they might hold negative attitudes toward identity characteristics of the powerful. The Framework Integrating Normative Influences on Stigma (FINIS), developed by Pescosolido and colleagues, draws together multiple different types of data relevant to three levels of influence: the micro, including both characteristics of the target of stigma and influences on the stigmatizer; the macro, including both cultural messages (e.g., linking mental illness and violence) and larger societal structures (e.g., those producing or countering disparities in wealth and power such as universal health care); and the meso, including social networks influences on the nature and extent of "exposure" to individuals with target attributes.

New policy directions may come from better use of empirical data by advocacy groups. (For example, anti-stigma efforts to identify mental illness as a brain disease may have backfired in some respects, by making people more pessimistic about treatment.) Also important may be efforts to make sense of the clustering of stigmatized traits. A sex worker may also be addicted to drugs or have a criminal record. Little is known about how stigma responses are affected. A related need is better understanding of how, when (and whether) to distinguish stigma effects from effects associated with the other conceptualizations of devaluation (e.g., prejudice, discrimination).

Related Topics

- ► Acculturation
- ► Discrimination

Suggested Readings

Hinshaw, S. P. (2007). *The mark of shame: Stigma of mental illness and an agenda for change.* New York: Oxford University Press.

Link, B. G., & Phelan, J. (2001). Conceptualizing stigma. *Annual Review of Sociology, 27*, 363–385.

Pescosolido, B. A., Martin, J. K., Lang, A., & Olafsdottir, S. (2008). Rethinking theoretical approaches to stigma: A framework integrating normative influences on stigma (FINIS). *Social Science & Medicine, 67*, 431–440.

STIs

► Sexually transmitted diseases

Stockholm Syndrome

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In late August of 1973, four employees of a bank in Stockholm, Sweden were taken hostage by an escaped convict and his prison cellmate. The six were together in the bank for over 131 h (over 5 full days and nights). The hostages not only became attached to the bank robbers, but even defended their actions after the standoff ended. The term "Stockholm Syndrome" was coined subsequently, to describe the attachment and positive regard developed by the hostages toward their captors.

Several more recent American cases have been reported to have similarities to the Stockholm Syndrome, including the Patty Hearst, Elizabeth Smart, and Shawn Hornbeck cases. In each case, the victim was taken hostage or kidnapped, yet reportedly developed psychological bonds with the captor. These may be self-protective during the acute crisis or may persist even after release.

Research expectedly shows that hostage victims experience a powerful helplessness. The hostages may start to feel sympathetic toward their captor, and also try to convince themselves that they will not be harmed physically by the captor. The captor may be seen as giving life purely by not taking away life.

Another theory about the development of Stockholm Syndrome is "identification with the aggressor." Identification with the aggressor is also used in understanding childhood abuse and posits that a child victim may grow up to become an adult aggressor. In addition to kidnapping and childhood abuse, other scenarios in which Stockholm Syndrome has been implicated include dating violence, domestic violence, and prison gangs.

Graham and colleagues have suggested several precursors to the development of Stockholm Syndrome, including: a direct threat to survival, an inability to escape, and the victim's perception of both kindness and terror.

Formal study of Stockholm Syndrome is difficult for several reasons, including not only the obvious difficulties in obtaining research samples, but also the difficulties inherent in the lack of formal classification in a psychiatric handbook (the DSM-IV or any international classification system) and need for validation of symptom criteria. Studies about prognosis and appropriate treatment are thus absent.

While there has similarly been a lack of significant formal study, there are special situations in which immigrants may be at risk for developing Stockholm Syndrome. Both child and adult victims of human trafficking may experience traumatic bonding, experiencing terror toward their captors, but also gratitude for supposed favors and indeed their own lives. Those forced into prostitution may form a desperate relationship which could convince others that they are "choosing" to stay. Apparent attempts for escape may even be missed.

Similarly, the self-perception of those in a camp toward their captors may approximate that described originally in Stockholm Syndrome. Narratives about Holocaust victims indicate that they often peaceably went to their own deaths. The situational characteristics enumerated above certainly would apply to concentration camp victims. Too, persons who have lived in a war-torn country may have been placed in situations ripe for the development of the syndrome. Though much is not known about the individual psychological factors which lead one victim to develop Stockholm Syndrome but not another, it is something which health professionals may consider and be sensitive to when they are treating refugees and trafficking victims.

Related Topics

- ► Domestic violence
- ► Holocaust
- ► Prostitution
- ► Survivor syndrome
- ► Trafficking

Suggested Readings

Cerny, C. A., Friedman, S. H., & Knoll, J. K. (2010). Stockholm syndrome. *Correctional Mental Health Journal, 12*, 17–18.

Favaro, A., Degortes, D., Colombo, G., & Santonastaso, P. (2000). The effects of trauma among kidnap victims in Sardinia, Italy. *Psychological Medicine, 30*, 975–980.

Graham, D. L., Rawlings, E. I., Ihms, K., Latimer, D., Foliano, J., Thompson, A., Suttman, K., Farrington, M., & Hacker, R. (1995). A scale for identifying "Stockholm syndrome" reactions in young dating women: Factor structure, reliability, and validity. *Violence and Victims, 10*(1), 3–22.

Namnyak, M., Tufton, N., Szekely, R., Toal, M., Worboys, S., & Sampson, E. L. (2008). Stockholm syndrome: Psychiatric diagnosis or urban myth? *Acta Psychiatrica Scandinavica, 117*, 4–11.

Stress

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Over 100 million immigrants and 13 million refugees have moved across borders in the past several decades. While this experience can foster personal growth as well as offer new opportunities, many deem the experience as extremely stressful. A number of factors can influence the ease or difficulty of this transition including reason for the move (e.g., war/torture vs. potential educational opportunities), financial stability, discrimination, empathy, social support, emotions, and family dynamics. For many immigrants, reducing external stress is not an option. Rather, effective coping styles must be developed. In addition, increasing resources such as culturally sensitive workshops within the community may help to reduce stress for recent immigrants.

Common Stressors

Stressful experiences are often associated with the immigration process itself, but can certainly extend far before (e.g., planning stages pre-immigration) and beyond (e.g., employment search post-immigration) this time period; the current entry will focus primarily on post-immigration factors (e.g., job and acculturation stressors). Often, voluntary migration, optimistic expectations, and high levels of available social support are shown to be associated with positive outcomes for immigrants. However, even if the perception of the immigration is positive, there are a whole host of uncontrollable stressors that come along with the move. For example, language barriers, acculturation stress, insecure job and/or legal status, actual and perceived discrimination, and financial restraint are obstacles that are faced by immigrants.

First, job stressors are often reported as one of the largest concerns by new immigrants. One can imagine that moving to a new country and trying to find a job in a brand new, unfamiliar environment would be extremely difficult. Additional barriers such as language differences within the workplace can increase stress as well. Immigrant workers often face discrimination from employers due to race, ethnicity, and immigration status. This discrimination is linked to work-related injuries and illnesses. For example, immigrant workers have been reported to perform heavier, more dangerous job duties without proper safety training or equipment. In addition, they often receive lower wages and poorer health benefits compared to nonimmigrant workers.

A second, rather common stressor that immigrants face is the process of acculturation, which can be generally defined as adjusting to culture change. This process can be stressful, especially when the new culture is very different from one's original culture. Some experiences that may induce acculturative stress include forming friendships with peers in the new culture, forming or altering family traditions, finding a church, and even grocery shopping for ethnic foods. Sometimes, immigrants can feel a sense of "push-pull" meaning that they can feel as though adjusting to or embracing the new culture means abandoning or pushing away from their native culture; this can lead to an increased sense of stress. In addition, the levels of acculturation can differ between members of a family, causing tension and potential conflicts within the household. Overall, post-immigration factors such as finding and maintaining a new job as well as adapting to a new culture can be extremely stressful for recent immigrants.

Effects of Stress on Mental and Physical Health

There are many ways in which immigration-related stress such as finding a new job or familiarizing with a new culture can affect one's health: (1) physiological changes within the body, (2) worsened judgment causing less effective coping strategies to be used, and (3) an over- or underutilization of the healthcare system. First, stress can increase the likelihood of developing mental or physical illness. For example, immigrant adults relative to nonimmigrant adults living in the USA tend to display higher levels of depression, anxiety, substance use, cardiovascular conditions, and other health problems.

Second, stress can take the form of worsening one's judgment and lead a person to choose maladaptive or ineffective coping strategies. For many immigrants, reducing stress is not an option (e.g., a person cannot change the discrimination that they face in the workplace); instead, effective coping strategies need to be developed. Coping can be defined as the conscious effort to control one's response to stress and adapt. For example, one way of coping may be to distract oneself from the situation and take a walk. In general, there are four types of coping – including active coping, avoidant coping, cognitive-emotional coping, and instrumental support coping. Research shows that avoidance-based coping (e.g., denial, substance use) leads to increased perceptions of stress and lower health functioning. On the other hand, active coping and a support network tends to mitigate the effects of stress on health.

The third way stress that stress can affect immigrant health is by causing a change or increase in symptoms of an existing illness, resulting in overuse or underuse of the healthcare system. Overall, stress worsens previous medical conditions and this results in an increased use of the healthcare system. However, among immigrants, there tends to be an underutilization of the healthcare system. For example, immigrants (compared to native-born individuals) report lower rates of visiting a primary care physician, are less satisfied with the care they receive, and report lower rates of health promotion discussions (e.g., exercise or smoking cessation) during doctor visits. There may be a wide variety of reasons for the underutilization of health care including: differential beliefs of illness (particularly mental illness), use of natural remedies for illness, limited access to health care, and language barriers. Overall, stress can affect immigrants in a variety of ways. Unfortunately, external stress reduction is not always feasible; therefore, the development of effective coping strategies may improve functioning. Additionally, increasing community resources for immigrants may prove to be influential in decreasing their levels of stress.

Increasing Resources to Cope Effectively with Stress

Although reducing external stressors to improve health may not be an easy option for many immigrants, there are potential ways to increase resources for immigrants dealing with uncontrollable stressors. Both internal and external resources are necessary for coping with stressors effectively. For example, a sense of internal control over one's situation can reduce feelings of stress. On the other hand, developing culturally sensitive workshops in the workplace and providing equal training opportunities would help to reduce discrimination and stress externally. Recently, community health education and improving social functioning have been highlighted as potential ways to improve the health of immigrants. First, some suggest that education about symptoms of common illnesses and disorders that many immigrants face could be helpful; clinics may even deliver workshops taught in other languages to decrease the number of barriers for those who do not speak the native language. For example, recent estimates suggest that there has been a large increase in the number of Latinos immigrating into the Southeastern portion of the USA. Thus, local hospitals in these areas could offer public educational workshops on symptoms and treatment options for depression in both English and Spanish.

Second, others highlight the role of a strong social support network in helping to ease the transition and influence better mental and physical health. Many times, due to immigration, social bonds and relationships are challenged, and may disintegrate. Strong social support has consistently been related to better mental health and this relationship is especially apparent in the face of stress. Social support can come in a wide variety of forms from a variety of sources. For example, the number of social contacts as well as satisfaction with number of contacts, emotional support (e.g., provided a "shoulder to lean on"), informational support (e.g., helped find a phone number for a doctor), religious support (e.g., prayed), or tangible aid (e.g., provided with money to pay for a bus ride to work). The role of social support in immigrant health may operate through a variety of pathways. For example, social support may serve as a gateway to learning about resources (e.g., health services, education, nutrition). Stronger support networks may also facilitate a sense of belonging and nurturance, such that the newly immigrated individuals do not have to feel as though they are transitioning alone; support may also facilitate integration into the community through religious ceremonies. Finally, support may act as a buffer, suggesting that support safeguards against behaviors that may promote negative health consequences. For example, those with stronger support networks may be less likely to engage in avoidance-based coping such as substance abuse to handle stressors.

Summary

In conclusion, immigrants face many unique stressors that extend both before and beyond the immigration process itself such as job difficulties and acculturation stress. Increased stressors can lead to poor physical and mental health; while reducing immigration stressors is not always possible, coping effectively may help to reduce the effects of stress. Effectively helping to alleviate the effects of stress and provide aid to immigrants, begins with supplying culturally appropriate, and accessible resources. Moreover, providing immigrants with community-based health workshops in many languages can provide them with the necessary information to gain access to health services or understand common health problems faced by immigrants. Moreover, these workshops may also provide a location for recent immigrants to meet and potentially form social bonds.

Related Topics

- ► Acculturative stress
- ► Discrimination
- ► Emotions
- ► Empathy
- ► Employment
- ► Health care
- ► Job stress
- ► Language acculturation
- ► Loneliness
- ► Occupational integration

Suggested Readings

de Castro, A. B., Gee, G. C., & Takeuchi, D. T. (2008). Job-related stress and chronic health conditions among Filipino immigrants. *Journal of Immigrant and Minority Health, 10*(6), 551–558.

Fazel, M., Wheeler, J., & Danesh, J. (2005). Prevalence of serious mental disorder in 7000 refugees resettled in western countries: A systematic review. *Lancet, 365*, 1309–1314.

Farley, T., Galves, A., Dickinson, L. M., & Perez, M. (2005). Stress, coping, and health: A comparison of Mexican immigrants, Mexican-Americans, and non-Hispanic whites. *Journal of Immigrant and Minority Health, 7*(3), 213–220.

Finch, B. K., & Vega, W. A. (2003). Acculturation stress, social support, and self-rated health among Latinos in California. *Journal of Immigrant Health, 5*(3), 109–117.

Gross, R., Brammli-Greenberg, S., & Remennick, L. (2001). Self-rated health status and health care utilization among immigrant and non-immigrant Israeli Jewish women. *Women & Heatlh, 34*(3), 53–69.

Yakushko, O., Watson, M., & Thompson, S. (2008). Stress and coping in the lives of recent immigrants and refugees: Considerations for counseling. *International Journal for the Advancement of Counseling, 30*, 167–178.

Suggested Resources

For Immigrants in Canada. http://www.hc-sc.gc.ca/hl-vs/jfy-spv/immigrants-eng.php

Health information in many languages. http://nnlm.gov/outreach/consumer/multi.html

Stroke

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Stroke is the third leading cause of death in the world. It is preceded only by heart disease and cancer as the top killers of men and women and accounts for about one in every 18 deaths. Approximately, two to three in every 1,000 persons will have a new or recurrent stroke every year. According to the American Heart Association's latest statistical release, a stroke occurs every 40 sec in the USA, while someone dies every 4 min from this disease. Stroke leads as a cause of severe disability and consumes significant medical and financial resources of the health care system in the short and, especially, the long term. The total cost for stroke in the USA for 2010 is a projected estimate of $73.7 billion.

A stroke occurs when a blood vessel that supplies part of the brain or spinal cord is disrupted either by a clot or by rupture. This interruption of blood flow and oxygen to the targeted brain tissue, if prolonged and not reversed quickly, can lead to permanent injury within minutes to hours. Strokes are typically categorized into two types: ischemic and hemorrhagic. Ischemic strokes occur when an artery carrying blood from the heart to the brain becomes occluded usually by a clot. Hemorrhagic strokes occur when small arteries in the brain rupture and cause bleeding in the brain. This is known as intracerebral hemorrhage. A serious subset of hemorrhagic stroke, called subarachnoid hemorrhage, occurs when an outpouching of a weakened artery wall, known as an aneurysm, ruptures and results in bleeding around the brain. In the USA, 87% of strokes are ischemic, 10% are due to intracerebral hemorrhage, and 3% are from subarachnoid hemorrhage. Although the vast majority of all strokes are ischemic, 30% of all stroke death is due to hemorrhage.

Stroke incidence and risk factors also differ between racial and ethnic groups. Blacks and Hispanics (including Mexican and Latin Americans) have almost twice the first-ever stroke risk compared to non-Hispanic Whites and Asians. African, Latin, and Native Americans as well as Asians have higher incidences of intracerebral hemorrhage as compared to Whites. Non-Hispanic Whites have a higher incidence of narrowing of major arteries, atherosclerosis, in the neck compared to Blacks, Hispanics, and Asians who carry a higher risk of artery narrowing in the head. Major risk factors that contribute to the recurrence risk of stroke include elderly age, previous stroke or transient stroke warning, race, poorly controlled blood pressure and cholesterol, heart rhythm disturbances, blood sugar problems, smoking, female gender, pregnancy, physical inactivity, and clinical depression.

People who are suffering a stroke can present with a variety of symptoms depending on the area of brain injury and the type of stroke. Sudden onset of slurred speech, one-sided face or limb weakness and numbness, disturbances in comprehension and language expression, and abnormalities of vision are common presenting signs of ischemic and hemorrhagic strokes. Hemorrhagic strokes tend to elicit headaches more so than their ischemic counterparts. The sudden onset of the "worst headache of my life" in a drowsy person is highly alarming for an aneurysm rupture and subarachnoid hemorrhage. Any of these symptoms should prompt emergent evaluation at the nearest medical facility by activating the emergency medical response system. Infrequently, stroke symptoms can last for a short period of time (in the order of several minutes to a few hours) with full recovery to normal function. This is known as a transient ischemic attack or TIA. People who experience a TIA should also seek immediate medical attention as the risk of having a stroke in the next 3 months is about 10–15%, with half occurring in the following 48 h.

In 1996, the US Food and Drug Administration approved the use of a medicine called recombinant tissue plasminogen activator (r-tPA) for treatment of acute ischemic stroke. This medicine is administered within 3 hours of the onset of symptoms through a vein as an injection and works to accelerate the breakdown of the clot that is causing the obstruction. Those who are not eligible for r-tPA are usually treated with medicines that can modulate blood clotting such as aspirin, clopidogrel, warfarin, and others. Other, more aggressive therapies are also available at larger academic medical centers for treatment of moderate to severe ischemic strokes including mechanical disruption and local breakdown of the clot from within the blood vessel, opening of narrowed blood vessels in the neck or head with or without the placement of a stent to keep it open. Intracerebral hemorrhage is treated by optimal blood pressure control and investigations to determine the cause of bleeding. Subarachnoid hemorrhages are treated quickly and aggressively in a critical care setting by isolation of the ruptured brain aneurysm by placement of small platinum coils from within the artery or by neurosurgical clipping from the outside of the vessel.

Stroke is a deadly and expensive disease. People of all backgrounds are at some risk of having any stroke in a lifetime. Focuses on primary prevention, risk reduction, and life style modification are more important now than ever to prevent strokes in our constantly changing and aging society.

Related Topics

- ► Blood pressure
- ► Cardiovascular risk factors
- ► Diabetes mellitus
- ► Obesity

Suggested Readings

Adams, H. P., & Wijdicks, M. D. (2007). Guidelines for the early management of adults with ischemic stroke. *Stroke, 38*, 1655–1711.

Caplan, L. R. (2009). *Caplan's stroke: A clinical approach* (4th ed.). Philadelphia: Saunders, Elsevier.

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Easton, J. D., & Sacco, R. L. (2009). Definition and evaluation of transient ischemic attack. *Stroke, 40*, 2276–2293.

Lloyd-Jones, D., et al. (2010). Heart disease and stroke statistics-2010 update: A report from the American Heart Association. *Circulation, 121*(7), e46–e215.

Suarez, J. I. (2004). *Critical care neurology and neurosurgery.* Totowa: Humana.

Suggested Resources

American Heart Association. www.heart.org
American Stroke Association. www.americanstrokeassociation.org
National Stroke Association. www.stroke.org

Student Visa

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Foreign citizens wishing to study in the United States must obtain the appropriate visa that will permit them to do so. The F visa is a classification that allows foreign citizens to study in the United States, primarily at the university level. Children can receive F visas to attend private elementary or secondary schools, or public high school.

Schools or school systems that wish to accept F visa students must go through a certification process with the United States Citizenship and Immigration Services (CIS). Public elementary schools, home schools, and adult education programs are not eligible to enroll F students. The school or school system is then registered in the Student and Exchange Visitor Information System (SEVIS). An official is designated as the designated student officer and authorized to submit student visa applications to the government.

The potential student first applies for admission to a school. If accepted, the designated student officer certifies that the student is admissible and issues a SEVIS form I-20. The student then presents that document to an American Consulate or Embassy for the issuance of a visa. Unlike virtually every other visa category, no application need be made to the CIS. In effect, the CIS outsources its authority to the authorized schools.

Student visas are nonimmigrant intent visas. In other words, in order to qualify for a student visa, the individual must convince an American consular officer that he or she intends to return to the home country at the end of the study program. Individuals who have pending immigrant visa petitions generally will not be issued a student visa. Students who have violated the terms of a different visa status or who have been in the United States illegally are also unlikely to obtain a student visa.

Unlike most other categories of visa, an individual entering on a student visa will not have a firm expiration date placed on his or her stay. Instead, students are admitted "D/S" that stands for "duration of status." In other words, as long as the student is pursuing a full course of study, the student will be allowed to remain in the United States. However, public high school students are limited to 12 months in F visa status. School vacation times are considered to be time in status for students. Students can change educational levels, such as transferring from a junior college to a 4-year university, or going from a baccalaureate program to a doctorate program. Transfers between programs or schools require that appropriate forms be filed by each school with CIS.

In the past, the federal government was fairly forgiving if a student dropped out of school for a limited amount of time and applied for readmission. However, schools are now required to report to CIS and to the Immigration and Customs Enforcement (ICE) any student who fails to attend the school or maintain a full course of study. ICE officers have been known to visit student apartments to arrest individuals who are no longer attending classes. Schools can in some circumstances authorize a student to take less than a full course of study.

Students who become ill during the school year and must reduce or temporarily suspend their studies must receive authorization from the Designated Student Officer (DSO) first. A student may miss a maximum of 12 months of school and still be authorized to remain in the United States in F-1 status.

F-1 students can work on-campus pursuant to the terms of a fellowship scholarship or other financial aid. In addition, at the end of their program of study, most students are eligible for 1 year of practical training. During this year, the student receives an employment authorization document with which the student can seek a job. Such employment is supposed to be related to the field of study, but no restrictions appear on the document itself. Students on practical training who travel overseas and return to the United States are often questioned by Customs and Border Protection (CBP) officers at the airports about their employment. Those not working at a job related to their field of study risk being returned to their home country.

Those who violate the terms of their student status are inadmissible to the United States until they have remained outside the United States for a 5-year period.

Related Topics

► Education

Suggested Resources

United States Department of State website. http://travel.state.gov/visa/temp/types/types_1270.html

Substance Use

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Substance use is a term used to describe the use of mind altering or psychoactive substances in a way that does not cause physical or psychological dependence or addiction. Substance use in immigrants is complicated by differing laws, customs, mores, and traditions between the culture of origin and the nation where immigrants reside, and this can cause legal and personal difficulties when immigrants use substances that may not be accepted in their new homes. Individuals' usage of these chemicals may have diverse and complicated impacts, which may be additionally complicated by the immigrants' socioeconomic and legal status in the new nation, as well as the immigrant's ability to acculturate outside of the home. The following is a short discussion of some substances used in immigrant communities, and their implications for health in the context of immigration.

Alcohol

Alcohol use varies widely around the world, and attitudes about appropriate use of alcohol vary significantly. Much of the complication between what is substance use and substance abuse is culturally bound, such that use that is considered average, typical, or normal, in one place may be considered deviant in another. Immigrants from cultures where, for example, drinking during the day is seen as healthy activity may be surprised if they immigrate somewhere where drinking alcohol at all is frowned upon or illegal (Saudi Arabia), or where drinking during the day is often seen as socially negative (USA). Similarly, immigrants may be confronted with different habits about drinking – as in the USA, where daytime drinking is often frowned upon, but binge drinking is a common habit of young people, whereas in other cultures (France), moderate drinking is taught and encouraged by family members, and binge drinking is rare. Additionally, research suggests that immigrants moving from cultures that abstain from alcohol to cultures where alcohol use is more common tend to drink more, and may be more vulnerable to alcohol abuse.

Tobacco

Tobacco is one of the most commonly used substances (behind alcohol) worldwide, and mores and cultural norms about tobacco use vary widely. In industrialized nations, where public health campaigns about the impact of tobacco use and public restrictions against tobacco use are common, smoking has been steadily declining. In developing nations, this social situation is often different, with tobacco being more acceptable in public places. Immigrants moving between cultures may have to negotiate disapproval of smoking or pressure to quit smoking where they have not previously experienced it.

Cannabis/Marijuana/Hashish

Drugs derived from cannabis are used worldwide in a variety of ways. In the late nineteenth/early twentieth century, many modern governments began outlawing cannabis products. Since then, several of those countries have decriminalized or otherwise altered their legal code to accommodate personal use of cannabis products. Trafficking of cannabis products often follows patterns of immigration, and often immigrants are implicated, frequently incorrectly, in use or trafficking of cannabis.

Khat/Qat

Khat is a plant with mild psychoactive properties chewed or brewed as a tea by many persons throughout East Africa and the Arabian Peninsula. At one point, the plant was only a concern in the immediate area in which it was cultivated. However, widespread immigration of people from the countries where qat is traditionally grown to other parts of the world has led to different legal status in different countries throughout the world. This is most notable in Britain, where it was ruled illegal, and a large public campaign against khat chewing and use was begun.

Ayahuasca/Peyote/Psilocybin/Peyote/Other Psychoactive Plants and Plant Preparations

These plants and plant preparations are used, in different forms, in many places around the world for their hallucinogenic properties. Often, they are used as a part of coming of age rituals, or for spiritual or religious communion. Typically, they are used by indigenous persons for specific rituals, and are not used recreationally. Many of these plants and fungi have been described by foreigners and exported for recreational or other uses. The compound ibogaine, for example, is touted as a natural substance to allow for withdrawal from opiate drugs, and other plant compounds (ayahuasca) have drawn immigrants and tourists to the cultures where they are used to experience their effects.

Related Topics

- ► Acculturation
- ► Addiction and substance abuse
- ► Drug abuse
- ► Injection drug use

Suggested Readings

Johnson, T. P., VanGeest, J. B., & Cho, Y. I. (2002). Migration and substance use: Evidence from the US national health interview survey. *Substance Use & Misuse, 37*(8–10), 941–972.

Suggested Resources

Erowid: Documenting the complex relationship between humans and psychoactives. (n.d.). Retrieved from http://www.erowid.org

Jha, A. (2004). Chew on this. *The Guardian.* http://www.guardian.co.uk/education/2004/feb/05/research.highereducation#history-link-box

Rehn, N. (2004). *WHO: Global status report on alcohol.* Retrieved from http://www.who.int/substance_abuse/publications/global_status_report_2004_overview.pdf

Sudan

► Africa

Suicide

- ▶ Depression
- ▶ Trauma

Supplemental Medical Insurance

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Medicare or "Health Insurance for the Aged and Disabled" became law under the Title XVIII of the Social Security Act of 1965 and was created to increase access to care and reduce the financial burden of care for the elderly, particularly for minorities and the poor. All persons over age 65 who worked at least 10 years in Medicare-covered employment (and their spouses) are eligible to receive Medicare benefits as are certain other disabled groups such as kidney dialysis and disabled workers.

Originally, Medicare was comprised of two parts: Part A (Health Insurance) and Part B (Supplemental Medical Insurance, SMI). Part A covers hospitalizations, home health care, skilled nursing facilities, nursing home, and hospice care and is provided without premiums to most beneficiaries. Part B (Supplemental Medical Insurance) pays for physician, outpatient, home health, and other services. Enrollees must pay a monthly premium for these benefits. Most beneficiaries are enrolled in part A and B. In 1997, Medicare was expanded by the Balanced Budget (Pub. L. 105-33) and created Part C. This was established as the Medicare-Choice program offering options for participating in private health insurance plans. A further expansion in 2003 with the Medicare Prescription Drug, Improvement and Modernization Act established Part D, the fourth part of Medicare. Part D was designed to assist with the cost of prescriptions drugs not covered by Part A or B at a reduced cost to enrollees. The program provides subsidized access to prescription drug insurance on a voluntary basis upon payment of a premium, with premium and cost share provisions for low income enrollees. Currently, Medicare covers 95% of the elderly population in the USA and many persons who are on Social Security because of disability.

In 2008, 45 million were enrolled in one or both of parts A and B and Part D provided coverage for 31 million people.

Supplemental Medical Insurance

Historically, SMI was referred to as Part B. SMI now however, includes both Part B and D as two separate accounts in the SMI fund.

Part B

Part B provides benefits for medically necessary services and preventive services. Original Medicare enrollees generally have to pay for the doctor's visit. If a Part B deductible applies, then enrollees pay all costs until the deductible and then 20% of amount and Medicare pays the balance.

Medically necessary examples include: ambulance services, defibrillation, doctor services, emergency room and urgent care services, eyeglasses, primary care, foot treatment, home health services, nutrition therapy, occupational and physical therapy, surgical dressings, x-rays, radiation, medical supplies, and selected prescriptions. Covered services are commonly delivered in doctors' offices, community health clinics, outpatient, ambulatory surgical centers, or provided in the home.

Preventive service examples include: bone mass density, cardiovascular screenings, colorectal screening, diabetes screening, vaccines, mammograms, glaucoma tests, prostate cancer, screening, Pap tests, and smoking cessation. Preventive services are usually provided in conjunction with medical authorization and in accordance with accepted medical standards of practice. Services may expand as the merits of particular tests, treatments, and procedures are evidenced.

Part D

Since 2006, Part D coverage has offered subsidized prescription drug coverage for everyone with Medicare on a voluntary basis upon payment of a premium and with cost-sharing subsidies for low income individuals. To enroll for Part D, beneficiaries must enroll in either a stand-alone (PDP) prescription drug plan that adds coverage to an original Medicare plan or an integrated Medicare Advantage Plan (like an HMO or PPO) that offers Medicare prescription drug coverage. Both of these are called Medicare drug plans. Plans vary in cost and drugs covered but all plans must provide at least a standard level of coverage set by Medicare. Most prescription plans charge a monthly premium fee in addition to the Part B payment. Many plans also have an annual deductible or an amount that the individual must pay before the plan pays. Co-payments, a common feature, are a share of the cost of the prescription by the enrollee and the plan pays their share. Further, most Medicare plans have a coverage gap when, after a certain amount has been spent by the beneficiary and the plan, the beneficiary pays out of pocket up to a limit. Part D coverage includes most FDA approved prescriptions and biological. Plans, however, set up formularies to determine what they will cover.

Medicare is largely unavailable to immigrants. While a limited number of legal aliens might meet the criteria, benefits of medical care, preventive care, and prescriptions coverage are generally inaccessible to immigrants. Significant gains have been made with aligning the needs of elderly and disabled under SMI as evidenced with the expanded Part D. Yet, many elderly continue to expend out of pocket for care or do not seek care. Immigrant elderly not covered by Medicare will be paying out of pocket for most or all of necessary care, or go without essential services.

Related Topics

- ► Access to care
- ► Medicaid
- ► Medicare

Suggested Readings

Longest, B. B. (2010). *Health policymaking in the United States.* Washington, DC: Health Administration Press.

Suggested Resources

Medicare and You. (2009). www.medicare.gov
Medicare. http//:www.cms.gov

Support Services

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Introduction

Support services to immigrants to the United States (US) come in a variety of forms, from broad-scale state and federal programs to private organizations, nonprofits, and grassroots efforts. Those involved with the support services programs agree that the need is at an all-time high for services that support immigrants as they integrate into US society. The benefits of such programs are enjoyed by immigrants and the larger society as a whole – from a richer and more diverse culture to a stronger and more talented workforce that is better equipped to participate meaningfully in the globalized job market.

Immigrants make up a large portion of all US workers, especially those with lower skills and earnings. In 2005, for example, immigrants comprised 15% of the US workforce; while greater than two out of every ten immigrants were earning below twice the minimum wage, and 45% of all immigrant workers had less than a high school education. In 2000, greater than 46% of immigrant workers had a limited English proficiency, nearly three-quarters of whom spoke Spanish. While there is great variation in immigrants' educational attainment and ability to speak English, they are overrepresented among the lowest skilled workers. In particular, limited English-speaking immigrants have fewer options in the workplace; research shows limited English skills are the single factor most closely associated with low wages and poverty in immigrant families.

With the passage of Executive Order 13166 (EO 13166) – Improving Access to Services for Persons with Limited English Proficiency – each federal agency is tasked with taking steps to provide access to its federally conducted activities. EO 13166 was designed to provide persons who have limited English proficiency (LEP) with greater access to federal programs and activities. As agencies have adopted strategies to comply with the federal mandate, the need persists at all levels for support services to immigrants.

Frequently significant achievements are realized at the local level, where relationships can be formed on an individual basis and outreach programs can be tailored to meet the unique needs of the local immigrant population. These programs are funded frequently by the private donations of individuals and the community. Local programs focus especially on working to promote and improve the self-reliance and dignity of diverse populations.

Need persists across institutions for support services to immigrants. Especially critical to successful immigration are housing, health and human services, education, and the workplace. From the local to federal levels, successful support services provide information and connect immigrants to much needed resources. Past meeting the immediate needs of immigrants – such as housing and food – support services connect individuals to each other and the local community.

Related Topics

- ▶ Access to care
- ▶ Acculturation
- ▶ Acculturative stress
- ▶ Assimilation
- ▶ Health education
- ▶ Health literacy
- ▶ Limited English proficiency
- ▶ Social service needs

Suggested Readings

Anderson, G. (2004). Helping immigrants find a home. *America, 191*(18), 17–21. Retrieved from Academic Search Premier.

Groseclose, R. (2010). Pursuit of the American dream. *Journal of College Admission*, (206), 2. Retrieved from Academic Search Premier.

Hernandez, D., Takanishi, R., & Marotz, K. (2009). Life circumstances and public policies for young children in immigrant families. *Early Childhood Research Quarterly, 24*(4), 487–501. doi:10.1016/j.ecresq.2009.09.003.

Preston, C. (2010). Advocacy groups work to strengthen their influence on immigration laws. *Chronicle of Philanthropy, 22*(11), 16. Retrieved from Academic Search Premier.

Suggested Resources

For information on library support services. http://www.uscis.gov/files/nativedocuments/G-1112.pdf

For information on worldwide refugee resettlement. http://www.refugeeresettlement.net/organizational_profiles?page=1

For information on U.S. citizenship and immigration services. http://www.uscis.gov

Survey Development

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There are several factors to consider in the development of a survey instrument. Once the goals and objectives of the study have been defined, the researcher will need to determine the best means for collecting the survey data (mail, telephone, or in-person).

There are also several elements of survey design to consider. First, the survey designer must decide on whether to use open-ended, closed-ended questions, or a mixture of the two types of questions. Open-ended questions require the respondents to answer in their own words, whereas closed-ended questions call for the respondent to choose a response from those provided in the survey. There are advantages and disadvantages to both types of questions. Open-ended questions can provide the researcher with a vast amount of information from the respondent, but these types of questions require more work for the respondent to answer and for the researcher to interpret and analyze. Closed-ended questions are easier to quantify, but good closed-ended questions can be challenging to develop.

The survey designer should be aware of bias in the way the survey questions are worded. Two common problems include asking leading questions or double-barreled questions. A leading question suggests a possible answer or makes one response seem more acceptable than another (e.g., “Most Americans prefer to purchase products manufactured in the United States. Do you prefer to purchase products manufactured in the United States?”). A double-barreled question is one in which two separate ideas are presented in one question. In this situation, the respondent may agree with one part of the question and disagree with the other, but he/she is unable to convey that through the response choices (e.g., “What factors contributed to your decision to marry and have children?”). Questions should be simply stated and specific; general questions may result in respondents interpreting the meaning of the question in different ways, resulting in unreliable data.

The survey should be pretested with a small number of people that are similar to the target group of respondents. The pretest responses will show problems with the survey instrument such as low response rate for sensitive questions or confusion about the way a question is worded. Questions should be simple and straightforward and make sense to the target population. The survey developer should also ask the individuals who participated in the survey pretest if the questions were clear and easily understood, if the response options made sense and if any options were missing, and if the amount of time the survey took to complete was acceptable.

The introduction to the survey should name the entity conducting the study, describe the purpose of the study, and how the survey respondents were chosen. It should state that the respondent's time is valuable, ensure confidentiality (names of respondents are not associated with results) or anonymity (identities of respondents are not known), and give an estimate of the amount of time it will take to complete the survey.

If the goal is to use the same survey with different immigrant groups, it is important to work closely with the design team, translators, and review panel during the process of survey development. This will help to ensure the development of culturally appropriate survey instruments. One way to ensure correct translation into different languages is to use a technique called "back translation." The English version of the survey is translated into the language of the target population and then translated back into English by a different translator. The two English versions are then compared to identify inconsistencies. It is very important to pretest the survey instrument to ensure that the translation is appropriate for the survey target group.

In order to ensure proper procedures of survey completion, supervisors should spend time observing the field staff interviewing respondents during in-person interviews or listen to interviewers administer the survey over the telephone. In addition, supervisors can validate surveys by re-interviewing a random sample of each interviewer's completed surveys or by reassigning a percentage of surveys to another interviewer for validation. The respondent, however, must be willing to complete the survey twice.

In summary, a survey can be an effective means to systematically collect data which can then be used for planning health or social services and evaluating programs. The data can also help program planners understand whether certain beliefs and practices are widely held, and by whom. However, the survey instrument must be carefully developed in order to collect accurate and reliable information.

Related Topics

- ► Ethnography
- ► Methodological issues in immigrant health research
- ► Mixed methods
- ► Scale validation
- ► Secondary data analysis

Suggested Readings

Gor, B., Shelton, A., Esparza, A., et al. (2008). Development of a health risk factors questionnaire for Chinese and Vietnamese residents of the Houston, Texas area. *Journal of Immigrant and Minority Health, 10*, 373–377.

Rea, L., & Parker, R. (1997). *Designing and conducting survey research.* San Francisco: Jossey-Bass.

Singleton, R., Jr., Straits, B., & Straits, M. M. (1988). *Approaches to social research.* New York: Oxford University Press.

Suggested Resources

American Association of Community Colleges. (2009). Survey development guidelines. Retrieved April 25, 2010, from http://plus50.aacc.nche.edu/docs/pubs/TOC/4_SurveyDevelopment.pdf

RAND, Center for Research on Immigration Policy. (1994). Surveying immigrant communities: Policy imperatives and technical challenges. Retrieved April 25, 2010, from http://www.rand.org/pubs/monograph_reports/2007/MR247.pdf

Survivor Syndrome

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Survivor Syndrome is a group of symptoms that may be experienced by survivors of a catastrophe. Although Vietnam and other wars, cancer, HIV/AIDS, natural disasters, abortion, suicide, corporate lay-offs, and the September 11, 2001, terrorist attacks have all been associated with survivor syndrome, it is most frequently discussed within the context of the Holocaust. There is a huge body of literature on Holocaust survivors, their children, and survivor syndrome. The symptoms of survivor syndrome generally fall into the anxious-depressive spectrum. It is theorized that these symptoms result from the survivor's traumatization and perception, conscious or unconscious, that he or she has done something wrong by not succumbing to tragic events as others did.

Dr. William G. Niederland, a psychiatrist and psychoanalyst, first described survivor syndrome in his 1961 book *The Problems of the Survivor-Part I.* Niederland was himself an immigrant who left his home country of East Prussia and came to New York City in order to escape fascism. During the course of his impressive career, Niederland worked with hundreds of Holocaust survivors and concluded that their traumatization had been of such a severe magnitude that it produced a clinical entity distinct from other forms of psychopathology. Some of these observations took place when Dr. Niederland served as a consultant to German courts ruling on indemnification claims from Holocaust survivors. Dr. Niederland was a prolific writer and authored several important papers and books on the topic of survivor syndrome over the course of four decades.

In his 1968 paper, "Clinical Observations on the Survivor Syndrome," Dr. Niederland listed the following major manifestations of survivor syndrome:

- Anxiety
- Disturbances of cognition and memory
- Chronic depressive states
- Tendency to isolation, withdrawal, and brooding seclusion
- Psychotic and psychosis-like action
- Alterations of personal identity
- Psychosomatic conditions (preoccupation with medical complaints that are believed to be attributable entirely or in part to psychological factors)
- Appearance as a "living corpse"

Many of these symptoms overlap with the symptoms of posttraumatic stress disorder (PTSD) as delineated in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision.* Niederland published "The survivor syndrome: Further observations and dimensions" in 1981. In this article, he stated that survivor syndrome is chronic, many times as severe and can have a frequent and notable influence on the offspring of survivors.

Yael Danieli created a typology of post-war adaptation in which she classified post-Holocaust survivor families into four categories: victim families, fighter families, those who made it, and numb families. Victim families are dominated by depression, worry, mistrust, and preoccupation with continued survival. Fighter families have an intense drive to achieve. They believe in self-sufficiency. Numb families are marked by shock and resignation. Numb parents protect each other to the exclusion of their children. "Those who made it" are similar to the "fighters" in that they have great ambition to make a big name for themselves. "Those who made it", however, use their success to gain commemoration of the Jewish experience during the Holocaust. As you may imagine, these family adaptive types had a strong impact on assimilation into a new country and on offspring.

Some individuals have theorized about a "Second Generation Survivor Syndrome" found in children of Holocaust survivors. Researchers talk about intergenerational transmission of trauma. Psychologist and second generation member Eva Fogelman suggests that instead of a syndrome, there is a "Second Generation Complex" that affects identity, esteem, interpersonal relationships, and worldview. For example, Holocaust survivors may be overprotective of their children and over-involved in their lives. It can be difficult for the children to navigate Erickson's separation-individuation stage of development. This is the stage when adolescents are striving to form their own unique identities. In order to deal with the unique issues faced by Holocaust survivors and their offspring, Dr. Fogelman has helped to form trauma support groups.

The Pulitzer Prize winning novel *The Amazing Adventures of Kavalier and Clay* by Michael Chabon provides an excellent example of survivor syndrome. Josef Kavalier, a Jew, escapes from Prague during the build-up to World War II, leaving his entire family behind. With the help of his cousin Sammy Clay, Josef reinvents himself as comic book artist Joe Kavalier. He has yet another identity as bar mitzvah magician, The Amazing Cavalieri. This is all for the sake of earning money to buy his family's freedom in

America. Joe works almost ceaselessly and forbids himself the pleasures of his success while his family is still being persecuted. When Joe falls in love with the enigmatic Rosa Saks and is able to arrange for his brother Thomas' voyage to New York, he at last allows himself to dream of a bright future. His hope is destroyed when Thomas' ship is sunk by a German U-boat. Joe cuts all ties with those he loves in America and goes into self-imposed exile by joining the US Navy. Determined to kill Germans, Joe nearly dies while posted in Antarctica. The road back to Sammy and Rosa is a difficult one and Joe's deceased family haunts him every step of the way. The character of Joe Kavalier illustrates the majority of Niederland's eight survivor syndrome manifestations listed above.

As indicated earlier, much of the literature on survivor syndrome focuses on Holocaust survivors and their children, but there are many other contexts that have the potential to produce this syndrome and affect immigrants. For example, the 2004 Indonesian Tsunami killed over 270,000 people in 11 African and Asian countries. There have been studies examining rates of PTSD in subsets of tsunami survivors, but it is likely too soon to tell if survivor syndrome will also emerge. As a result of the tsunami, there were changes in both migration and immigration patterns. Countries such as Canada and Australia made changes in visa and immigration policies to help people affected by the devastation. In light of that tragedy, the 2010 earthquakes in Haiti and Chile and the 2011 earthquakes in Japan, mental health professionals the world over need to be prepared to treat traumatized immigrants.

In summary, survivor syndrome can result from traumatic life events. In most cases discussed in the literature, corporate lay-offs being an exception, the trauma is of a horrific extreme with extensive loss of human life and unbelievable human suffering. Symptoms of survivor syndrome do have some overlap with posttraumatic stress disorder (PTSD), such as anxiety and withdrawal. Survivor syndrome differs from PTSD in that there is cross-generational transmission of the trauma with significant impacts on children and even grand-children. For that reason, adjustment to life in a new country can be very challenging for immigrant survivors and their families. That is most apparent and most studied in Holocaust survivor immigrants.

Related Topics

- ► Anxiety
- ► Bereavement
- ► Disasters
- ► Holocaust
- ► Trauma exposure

Suggested Readings

Chabon, M. (2000). *The amazing adventures of Kavalier and Clay.* New York: Random House.

Danieli, Y. (1988). The heterogeneity of postwar adaptation in families of Holocaust survivors. In R. L. Braham (Ed.), *The psychological perspectives of the holocaust and of its aftermath* (pp. 109–128). New York: Columbia University Press.

Niederland, W. (1968). Clinical observations on the "survivor syndrome". *The International Journal of Psychoanalysis, 49*(2–3), 313–315.

Sweatshop

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From an occupational health and safety perspective, a "healthy job" is one that protects against workplace hazards, provides living wages and benefits, respects human dignity on the job, limits excessive stress and workload, offers job security, and supports healthy lifestyles, family life, and communities. While some companies offer many of these elements, others fail to meet the most basic health needs of their workers and, worse, expose them to hazardous and even deadly conditions in what are often referred to as "sweatshops."

The United States Government Accountability Office officially defines a sweatshop as any workplace that is not in compliance with more than one labor law (federal or state) governing minimum wage and overtime, child labor, industrial homework, occupational safety and health, workers' compensation, or industry registration. The term originally referred to garment factories, but has come to generally describe workplaces with abysmal conditions. These conditions include exposure to hazardous materials, repetitive job tasks, and extreme temperatures, often accompanied by long hours, low wages, child labor, forced labor, lack of freedom of association and the right to collective bargaining, and abusive management. Industries that commonly utilize sweatshops are apparel, shoe, electronics, toy, and other textile manufacturing plants/factories. One of the most significant historical incidents that exposed the dangers of such worksites, and subsequently led to increased regulation, was the Triangle Shirtwaist Factory fire of 1911 in New York in which 146 workers (mainly immigrant women) died as a result of being trapped inside or jumping to escape. Over 80 years later, history repeated itself in the Kader Industrial Toy Company, Thailand. More than 200 workers were killed and 469 injured in a fire where doors were locked and workers leaped to their deaths to avoid burning alive. Arnold and Bowie in 2003 noted that US companies including Hasbro, Toys “R” Us, J.C. Penny, and Fischer Price had been contracting with this factory to produce toys. Chan in 2001 discusses a gruesome account of the tragedy given by a witness of the disaster. He described how the piles of bodies of victims who had been trying to open the doors from the inside tumbled out after outsiders were finally able to open the exits.

Although sweatshops still exist in the USA, the majority are in developing countries in Asia and Latin America. Beginning in the 1970s, global capitalism saw a growth in multinational corporations, manufacturing in poorer countries, contingent work, and displacement of workers from their home countries or regions seeking employment. In order to maximize profit, multinational corporations outsourced production to countries where there are fewer or ineffective labor, wage, and health and safety protections for workers. Poor people within these countries flocked to the cities to find work. Developing nations, encouraged by international organizations such as the World Bank and the International Monetary Fund, established “Free Trade Zones” (also known as Export Processing Zones) to promote foreign investment using tax incentives and lax regulations. Employers set up factories in these zones that frequently exhibit inferior “sweatshop” conditions. For example, they employ large numbers of migrant workers (hundreds to thousands), and provide housing, although often under substandard health conditions. The multinational corporation normally divests itself of any legal responsibility by subcontracting to local outfits. Workers often have little legal recourse to challenge questionable labor practices.

Sweatshops impact immigrant health both directly and indirectly in various ways. Common workplace hazards that directly impact health include harsh physical conditions (e.g., toxic chemical exposures, repetitive motions, airborne pollutants, malfunctioning machinery, fire hazards). Workers experience high injury and illness rates due to dangerous working conditions. For example, Chan in 2001 describes how in the Shenzhen region alone in China, 90% of some 12,000 hospital-certified industrial injuries in 1998 involved maiming. A striking example of such conditions as presented by Arnold et al. is a Nike factory located in Vietnam which exposed 10,000 workers to toluene (a toxic chemical used as a solvent) at amounts 6–177 times that allowed by Vietnamese law.

In addition to the more traditional workplace hazards, the sweatshop economy creates indirect health impacts. Workers’ health declines as a result of substandard wages, lack of access to healthcare, forced migration, environmental degradation, stress, and lack of dignity and respect. Stressful circumstances, like poor wages or lack of decision making control over work, can expose workers to multiple psychosocial risks, including anxiety, insecurity, and worry. These psychosocial risks or stressors can increase risks of infections, diabetes, high blood pressure, heart attacks, strokes, and depression. Obligatory overtime, which is rarely paid in such sweatshops, threatens worker health by increasing exposure to worksite hazards, increasing stress by making fulfillment of family obligations difficult, and often causing sleep deprivation. If workers are required to work while sick, they are more likely to spread contagion to other workers. Insufficient rest can cause chronic fatigue, decreased vitality, depression, inattentiveness, and even serious mental illness. In addition these workers often have no outlet to complain or seek help. Workers have limited rights to associate or to collective bargaining. These facilities commonly draw workers from rural areas to more urban centers, which often removes family and legal support, and limits access to education.

Sweatshops also have significant impacts on global public health. They often do not pay for the public services they use for production and distribution and do not contribute the country’s tax revenue. The prevalence of sweatshops can be detrimental to overall societal public health resources if they are not contributing to infrastructure such as health care access via taxes as are local businesses. Local economies disrupted by the arrival of multinational corporations, which often fail to provide a livable wage, have experienced increased displacement levels due to workers seeking a means of survival elsewhere.

In order to promote accountability among sweatshop employers, international standards such as the Worldwide Responsible Apparel Production (WRAP), the Fair Labor Association Standard (FLA), and SA8000 have been established. In addition to the International Labour Organization, which established a set of conventions and recommendations on safety and health that provides a template for minimum safety standards, a number of global and local organizations exist that have led the struggle against sweatshops.

Related Topics

- ► Border health
- ► Labor migration
- ► Labor unions
- ► Occupational health
- ► Trafficking
- ► Universal Declaration of Human Rights

Suggested Readings

Arnold, D., & Bowie, N. (2003). Sweatshops and respect for persons. *Business Ethics Quarterly, 13*, 220–242.

Boncich, E., & Appelbaum, R. (2000). *Behind the label.* Berkeley: University of California Press.

Chan, A. (2001). *China workers under assault: The exploitation of labor in a globalizing economy.* New York: M.E. Sharpe. Inc.

Suggested Resources

International Labor Organization. www.ilo.org

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Sweden

► Immigration in the global context

Switzerland

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History

The land now known as *Switzerland*, called *Helvetia* in ancient times, was a league of cantons, or boroughs, in the Holy Roman Empire. In 1291, as a defensive alliance among three cantons, the Swiss Confederation was founded around the core of three German forest districts: Schwyz, Uri, and Unterwalden. Although in 1499 the Swiss victory against the Swabian League of Emperor Maximilian I amounted to de facto independence within the Holy Roman Empire, it was not until 1648, under the Treaty of Westphalia, that European countries recognized Switzerland's independence from the Holy Roman Empire. A constitution of 1848, modified in 1874, replaced the confederation with a centralized federal government.

Geography

Switzerland extends across the north and south side of the Alps; the country's 41,285 km^2 covers a diverse landscape and climate. The population is about 7.8 million, with an average population density of 190 people/km^2. With its mountains, the southern half of the country is populated more sparsely than the northern half. Switzerland lies between latitudes 45°N and 48°N, and longitudes 5°E and 11°E. It contains three basic topographical areas: the Swiss Alps on the south, which comprise about 60% of the total land area; the Central Plateau or middleland; and the Jura mountains on the north. Many glaciers are found within the Swiss Alps, totaling an area of 1,063 km^2. From these glaciers originate several major rivers that flow to all of Europe; these include: the Rhine, Inn, Ticino, and Rhone. Switzerland has more than 1,500 lakes and contains 6% of Europe's fresh water.

Although the Swiss climate is temperate generally, it can vary greatly – from glacial conditions on the mountaintops to the near-Mediterranean climate at Switzerland's southern tip. Summers tend to be warm and humid, with periodic rainfall; they are ideal for pastures and grazing. In the mountains, the less humid winters may have week-long periods of stable conditions, while the lower lands tend to suffer the opposite, sometimes seeing little sun for weeks. The wettest conditions persist in the high Alps and in the Ticino canton which have much sun yet heavy bursts of rain periodically. Precipitation tends to be spread moderately throughout the year with a peak in summer. Autumn is the driest season; winter receives less precipitation than summer. Notably, the weather patterns are unstable with few predictable patterns.

Economy

Switzerland's economy is based on a highly qualified labor force performing highly skilled work. The main areas include microtechnology, technology, biotechnology, pharmaceuticals, banking, and insurance. The service sector employs the greatest number of people. Most employees are employed by small and medium-sized enterprises; these enterprises play a critical role in the Swiss economy. The Swiss strive to limit as much as possible the impact that economic activity has on the environment; this is reflected in Switzerland's energy and transport policies. Apprehension over unemployment has been one of the main concerns of the Swiss for several years.

Switzerland has a restricted surface area and virtually no mineral resources. Its economy depends heavily on foreign trade. With a total population of just over 7,500,000, it has a relatively small domestic market, another factor which has encouraged Swiss manufacturers to look abroad. They depend on foreign markets in order to make worthwhile investment in research and development. Switzerland imports raw materials and exports high-quality goods. In 2003 the value of 1 ton of exported goods was 225% more than that of the same amount of imports.

Politics

Switzerland is comprised of 26 cantons; the most recently created canton is the Canton of Jura, which separated from the Canton of Bern in 1979. Swiss citizens are subject to three legal jurisdictions at the commune, canton, and federal levels. The 1848 Federal Constitution provides for a system of direct democracy. Because it is aided by the more commonplace institutions of a parliamentary democracy, at times it is referred to as a half-direct or representative-direct democracy. The instruments of Swiss direct democracy at the federal level, known as civic rights, include the right to submit a constitutional initiative and a referendum – both of which may overturn parliamentary decisions. Via a federal referendum, a group of citizens may challenge a law that has been passed by Parliament if, within 100 days of passage, they can gather 50,000 signatures against it. In this case, during a national vote, voters decide by simple majority whether to accept or reject the law. Eight cantons together can also call a referendum on a federal law.

Switzerland is active in many UN and international organizations; however, it possesses a strong commitment to neutrality. The country's sovereignty and neutrality have been long honored by the European powers. The country was not involved in either of the two World Wars, and its political and economic integration has strengthened ties with its neighbors.

Health

The Swiss population is expected to peak at 8.2 million in 2036 before falling to 8.1 in 2050. The number of people aged 65 and over will increase by 90% in the same period to 2.2 million people; that will be 27% of the population. In 2005 average life expectancy for men was 78.7 years and 83.9 years for women; this represents a slight increase from previous years. The Swiss birth rate in 2005 was 9.77/1,000, down from 10.4 in 2000.

There is a high standard of care in Switzerland and a relatively high health care cost, as they spend the 2nd highest proportion of GDP on health care than any other country. The cost is high particularly for hospital treatment. As one outcome of a major health reform in 1996, health insurance is mandatory in Switzerland; everyone is individually insured, including children. Individuals are able to choose their insurer from a number of authorized operators, who cannot refuse to provide coverage. Those on low incomes and families with children receive a subsidy to their insurance contribution. Accounting for 25% of expenditure, federal, cantonal, and local tax revenue is a key source of health care financing.

Health care provision is a mixture of public, subsidized, private, and fully private. Most GPs are individual practitioners, paid on a fee-for-service basis by insurance companies. Hospitals may be publicly operated, for example by the cantons or local government, or private (for profit or nonprofit). Fees are set by each canton. Patients are free to choose their providers and specialists. Despite efforts to reduce health insurance premiums, the fast growth in health care costs remains a major domestic political concern. Further cost cutting in health care is likely to remain on the political agenda.

Immigration

Switzerland is positioned at the crossroads of Northern and Southern Europe. It is known for its neutrality, a decentralized government, and its ethnic and linguistic diversity – German, French, Italian, and Romansch are all national languages. Today, decisions are made at the local level, as each canton is responsible for certain aspects of migration and integration-related policies.

Switzerland has one of the highest immigration rates on the continent; according to the 2000 Census, 22.4% of the total population of 7.4 million is foreign born. Historically, Switzerland was primarily a destination for employment-seeking French, Germans, and Italians; however, in the latter half of the twentieth century it became home to Eastern European dissidents, Yugoslavian refugees, and asylum seekers from the Middle East, Asia, and Africa.

Although it is not part of the European Union, since the 1990s, Switzerland has forged closer ties with its member countries, thereby making it easier for EU citizens to live and work in Switzerland and vice versa. Switzerland has had to face many of the same issues as its neighboring countries, including growing numbers of asylum applications, integration problems, and rising antiforeigner sentiments. Like the rest of Europe, Switzerland's immigration policy will have to reconcile these concerns with the immigration needed to compensate for the aging population and to ensure future economic growth.

Related Topics

- ► Health outcomes
- ► Health status
- ► Quality of life

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Syphilis

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Syphilis is a sexually transmitted disease that begins on the genitals, but if untreated can spread to the body and brain and eventually result in disfigurement, organ failure, mental illness, and death. Syphilis can also spread from mother to infant during pregnancy (known as congenital syphilis).

Syphilis was first described clearly in 1494 as an outbreak among French troops besieging Naples. Since then syphilis has been the target of many public health campaigns to control its spread and attempt eradication. Syphilis in the brain is referred to as neurosyphilis and has been blamed speculatively for the disfigurement and insanity of a variety of historical figures, including Henry VIII and Adolf Hitler. Since the advent of treatment with penicillin in 1947, it has become an easily treatable disease when diagnosed in the early stages. However, it is also referred to in medical literature as "the great pretender" because in later stages it can mimic many other diseases.

Primary syphilis involves a painless lesion, called a chancre, which can occur on the penis, vulva/vagina, oral or anal regions. It typically lasts for 4–6 weeks, and then heals, giving the false impression that the disease has been cured. The next stage, secondary syphilis, occurs 2–8 weeks later. Symptoms are varied, but it is often associated with a rash that includes the palms and flu-like symptoms. Although patients are contagious when the chancre is expressed, the highest rate of infectiousness is during the secondary syphilis period. The final stage of syphilis (tertiary syphilis) can occur 1–50 years later and can involve any organ in the body.

Congenital syphilis can be devastating when it is untreated. At clinics in Mwanza, Tanzania, syphilis was responsible for 50% of stillbirths. Congenital syphilis is also an important cause of mortality in live infants; in one study 52% of infants with congenital syphilis died during their first year in Haiti.

Epidemiology

Syphilis is present on every continent and tends, like most sexually transmitted infections, to have a higher percentage of cases in urban settings. With the exception of some regions of the United States, syphilis is less common in industrialized nations. It is a particular problem in sub-Saharan Africa, South and Central America, and the developing nations of Southeast Asia.

In Western Europe, the World Health Organization (WHO) estimates that the incidence of new cases is approximately 5 per 100,000 people. This is in contrast to the former Soviet Union where the incidence was estimated at 5–15 per 100,000 in 1990 but in the Russian Federation had risen to more than 250 per 100,000 by 1996. This is partially associated with the loss of free diagnosis and mandatory treatment after the fall of the Soviet Union.

The WHO has global estimates on syphilis only through 1999 when 12.22 million cases were reported worldwide. WHO data from 1999 showed overall syphilis rates of 8% in the South Pacific, 4% in Cambodia, 3.1% in Djibouti, 3% in Morocco, and 2.4% in Sudan. Rates of syphilis in pregnant women were 17.4% in Cameroon and 8.4% in South Africa.

There are very few studies estimating the rate of syphilis infection in immigrants. One looked at Canadian immigrants. From 2000 to 2004, there were 2,001,417 immigration applicants to Canada, which requires syphilis testing for all applicants 15 years or older. Of these, 2,209 (0.001%) were found to have positive syphilis serology. Rates from refugees who have their syphilis testing done in Canada were 50% higher than from “family class” applicants and 4 times the rate of syphilis found in “economic class” immigrants, who often have their syphilis testing performed abroad.

Another study retrospectively examined manual laborers in Thailand who were tested to receive clearance to work abroad. 221,093 workers aged 20–60 were tested at a hospital in Bangkok (59% were men). Of these, 1832 (0.83%) tested positive for the RPR (non-treponemal syphilis test). All had denied previous infection with syphilis and were reported to be “generally healthy in appearance” on exam. Workers who tested positive were referred to clinics for additional diagnosis and treatment. 1426 (77.8% with a positive RPR) were confirmed to have syphilis.

HIV is clearly associated with the international resurgence of syphilis. After declines in syphilis rates in the late 1980s, the late 1990s saw dramatic increases in the spread of syphilis. HIV infection makes people more susceptible to syphilis, and syphilitic lesions make people more susceptible to HIV infection.

Testing

Syphilis testing is almost a universal requirement for immigrants and guest workers. An immigration medical exam should include both blood tests and a physical exam (including genitalia and a neurological exam) to effectively rule out a syphilis infection. Primary syphilis often will be accompanied by negative blood tests and can only be identified by visualizing the chancre on the genitals, anus, or mouth. Patients with very longstanding syphilis infection (tertiary syphilis or neurosyphilis) may have negative blood tests on laboratory screening but will often show signs of organ dysfunction or neurological disturbance on a clinical exam.

The bacterial agent that causes syphilis, *Treponema pallidum pallidum,* cannot be routinely cultured in a laboratory. The tests commonly used to identify patients exposed to syphilis are called non-treponemal tests because they rely on indirect methods for diagnosis, detecting byproducts of the infectious organism. In the United States, the two most common non-treponemal tests are called the Rapid Plasma Reagin (RPR) and the Venereal Diseases Research Laboratory (VDRL) test. Because these tests do not identify the organism that causes syphilis directly, they are both susceptible to false positive results from non-syphilitic conditions. Approximately 1–2% of the general population will test with a false positive result on these tests. Historically there have been numerous reports of people being told they have syphilis during routine testing for marriage licenses or immigration medicals when in fact they had medical conditions such as systemic lupus erythematosus, malaria, Lyme disease, viral infections (including HIV), pregnancy, or other non-syphilitic conditions.

In all situations where a patient has a positive non-treponemal screening test, the result should be followed by a more specific test such as the Fluorescent Treponemal Absorption test (FTA-ABS) or *Treponema pallidum* particle agglutination assay (TPPA), which are highly specific for antibodies to treponemal organisms. However not all patients with positive direct-treponemal tests have had syphilis. These tests can be falsely positive if the patient has another type of (much rarer) treponemal infection such as Yaws, Bejel, or Pinta. There are no routine blood tests to distinguish among the treponemal infections, so the distinction is made by clinical exam and exposure history. In general, anyone who tests positive for syphilis should also be tested for HIV, gonorrhea, and chlamydia.

Treatment

The treatment of syphilis involves injections or infusions of penicillin. In early stages of the disease, this usually requires 1–3 shots. In later stages, such as syphilis involving the central nervous system, it can require weeks of intravenous penicillin.

Syphilis remains a persistent challenge for clinicians and public health practitioners around the world. Although it is usually relatively easy to treat when diagnosed, it remains a disease of particular concern for authorities monitoring immigrant health. This is due to the easy spread of the disease, the possibility of congenital malformation, and the long-term deleterious consequences of untreated syphilis for the health of individuals.

Related Topics

- ► Human immunodeficiency virus
- ► Infectious diseases
- ► Medical examination (for immigration)
- ► Public health
- ► Sex work and sex workers
- ► Sexually transmitted diseases

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T

T Visa

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In the past decade, human trafficking (the exploitation of human beings for the purposes of sex or labor) has emerged as a major global human rights issue. In response to this growing crime, the US Congress passed the Trafficking Victim's Protection Act (TVPA) in 2000 and reauthorized it through the Trafficking Victim's Protection Reauthorization Acts (TVPRA) in 2003, 2005, and 2008. The majority of states now have also passed antihuman trafficking statutes. The TVPA focuses on prevention strategies, prosecution of traffickers, and the protection of victim.

Included in the legislation were two new nonimmigrant visa categories: T and U Visas. To qualify for a T Visa, an adult victim must be certified by a law enforcement agent as having suffered from a severe form of trafficking and must cooperate, or be willing to cooperate, with law enforcement in the of the criminal case. Victims under the age of 18 years are not required to cooperate with law enforcement. A victim who is granted a T Visa may remain in the USA for 4 years from the date of its approval, although the 4 years may be extended if the investigation and prosecution of the case is ongoing, and may request legal permanent residency after 3 years. T Visas are limited to 5,000 per year. The T Visa is accompanied with an automatic employment authorization document and holders are eligible for assistance through the refugee programs administered by Human and Human Services and the Office of Refugee Resettlement.

Related Topics

- ► Immigrant visa status
- ► Immigration status
- ► Sex work and sex workers
- ► Slavery
- ► Trafficking Victims Protection Act

Suggested Readings

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Taiwan

- ► Asia
- ► Chinese

Tajikistan

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Tajikistan is one of the 15 Newly Independent States that were constituted following the disintegration of the USSR and one of the 12 of those Newly Independent

Sana Loue & Martha Sajatovic (eds.), *Encyclopedia of Immigrant Health*, DOI 10.1007/978-1-4419-5659-0,

States that form the Commonwealth of Independent States. Tajikistan was plunged into a civil war following its independence. The cause of that war, which lasted from 1992 to 1997, remains controversial to this day, with some scholar attributing it to ethnic and religious tensions and animosities and others to the lack of economic and military capacity that resulted from the Soviet withdrawal. Regardless of the cause, Tajikistan continues to be viewed as one of the economically and politically weakest states in the post-Soviet sphere.

The poverty that ensued following the civil war continues to this day. Tajik society and government depend heavily on the remittances from Tajik labor migrants who have secured employment outside of the country. Indeed, the remittances from Tajik labor migrants back to their country almost equal the country's GDP, approximately $6–8 billion. It has been estimated that almost every Tajik household relies to some degree on these remittances from family members overseas and that the Tajik government relies on the remittances to fill the gap in social welfare that the government cannot fill.

Experts estimate that between 600,000 and over 1 million Tajik migrants work in the Russian Federation and to a lesser extent in Kazakhstan. Common jobs include public transport drivers, construction workers, retailers, and street sweepers. These are low-skilled, low-paying jobs, and often exist within the informal economy. Despite high unemployment, the local Russian populations often refuse low paid jobs; thus, migrants compete mostly among themselves rather than with Russian citizens.

During times of economic crisis, groups in host or receiving countries may perceive competition for jobs from immigrants. Migrant workers and their families thus become victims of discrimination, exploitation, violence, and xenophobia. According to news reports in December 2008, a group of teenage skinheads killed at least 20 migrants in Moscow. The Moscow Human Rights Bureau, a Russian nongovernmental organization, reported that more than 100 migrants were murdered between January and October 2008, double the number of the previous year.

The poverty that characterizes many Tajik families and the difficulties faced by Tajik migrants who seek employment in other countries has led to some migrants' participation in drug trafficking and commercial sex work. Although the consumption of heroin in Tajikistan has remained relatively low to date, research suggests that a growing number of individuals, and migrants in particular, may be forced by organized criminal networks to carry heroin that reaches Tajikistan from Afghanistan into Russia and the Baltic states for distribution there. Women seeking employment outside of Tajikistan may be forced to work in the sex trade. The vast majority of women interviewed in the International Organization of Migration (IOM) return projects in Tajikistan 2001 say they were deceived about what work they would undertake, or recruited in other illegal, coercive, or deceptive ways.

Migrants returning to Tajikistan from the Russian Federation and other countries may unwittingly bring diseases home to their families. Tajikistan currently has the highest rate of tuberculosis of all countries in Central Asia. Researchers conducting a study of individuals' access to care for tuberculosis in Tajikistan found that 10% of all patients who received treatment in the study area had developed active TB while they were temporary migrant workers in Russia. They were required to return to Tajikistan to seek treatment there, potentially resulting in the exposure and infection of persons with whom they had contact on buses, trains, and airplanes. Additional research suggests that male migrant workers returning to their homes in Tajikistan may expose their wives to sexually transmitted infections that they contracted during unprotected intercourse with commercial sex workers and other sexual partners in the receiving country.

Tajikistan, like all of the CIS countries, is losing many of its most active and qualified urban working force due to the widespread poverty and relative lack of professional opportunities. The emigration to other countries of highly skilled specialists and business people ultimately leads to an exhaustion of the country's potential. The brain drain from countries like Tajikistan has become a national catastrophe.

Related Topics

► Guest worker
► Labor migration
► Occupational health
► Occupational injury
► Poverty

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Tamils

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Tamils are a group of immigrants mainly living in the Indian State of Tamil Nadu and the Northeastern Province of Sri Lanka. Tamil immigrant health must be considered in the historical context of forced migration and the social context of the diaspora, which maintains strong ties to the homeland. Sinhalese majority governments that came to power after Sri Lanka attained independence in 1948 settled Sinhalese in Tamil home lands, enacted discriminatory legislation, and threatened Tamil cultural heritage. Hostilities erupted in series of violent confrontations in 1983, characterized by mob attacks on Tamil civilians and Tamil counter attacks on Sinhalese soldiers. Since then, tens of thousands have died and acts of terrorism, reprisals, detentions, and torture have continued. In the late 1980s, massacres in the North and East of Sri Lanka accounted for 5,000 civilian and militant deaths and forced many Tamils to migrate. According to the U.N. Working Group on Enforced and Involuntary Disappearances, there were 11,513 disappearances between 1980 and 1996.

A mediated peace process initiated in 2002 raised hopes for achieving peace in Sri Lanka. In 2009, however, the Sri Lankan government defeated Tamil militants and placed hundreds of thousands of Tamil civilians in detention camps. With more than one million internally displaced people and more than 900,000 who have sought refuge abroad, Sri Lanka has become one of the world's leading sources of refugees. About one quarter of the world population of Sri Lankan Tamils now live in the diaspora. Although population estimates vary, the greatest numbers (about 250,000) are in Canada, followed by India (150,000), the United Kingdom (110,000), the European Union (110,000), and Australia (30,000).

Among refugees, the predominant health consideration is often psychological distress due to witnessing or experiencing torture, violent conflict, and loss of home and family members. High rates of trauma are reported frequently in refugee populations, and the Tamils are no exception: research shows a prevalence of posttraumatic stress disorder of 12% in the Tamil population in Canada. However, the disease model offers a limited means of understanding Tamil health and well-being. In the Tamil refugee diaspora, mental health outcomes are influenced by complex pre-displacement, displacement, resettlement factors, and systemic factors. Social determinants of Tamil health include deleterious experiences of asylum seekers with detention and legal systems in countries of exile, economic hardship and underemployment, loss of social support networks, as well as demands of existing networks, family conflict, perceived racial and workplace discrimination, and lack of access to culturally appropriate medical services. Social scientists also report that Tamil health, adaptation, and social integration in the diaspora are positively affected by sense of identity, spirituality, and the role of social networks, which demonstrate that, in general, Tamils are proactive and resilient in responding to resettlement stress.

According to one Canadian study, Tamil help seeking for health problems is affected by several intrinsic and extrinsic factors: beliefs that ailments will go away by themselves, and that help is unnecessary or ineffective; mistrust of the formal health care system; linguistic and practical barriers; and the distinction between physical and mental problems, with respondents reporting the likelihood of seeking help for physical symptoms, but not for feelings of sadness, fears, or suicidal thoughts.

There is a paucity of evidence in English on physical health among Tamils, who are usually subsumed in population statistics for South Asians in general. Given the concern that South Asian populations experience a higher risk of heart disease, more sophisticated studies of subpopulation differences and a focus on social and health disparities are needed to determine rates of chronic disease and prevention strategies. For both mental and physical health problems, there are currently inadequate resources in the formal health care systems of countries of resettlement for Tamil communities.

Strong ties to the homeland suggest that Tamil immigrant health is also influenced by the well-being of Sri Lankan Tamils affected by disaster. In December 2004, a massive tsunami struck Asia, including parts of Sri Lanka from which Tamils originate. The loss of life and devastation of entire Tamil villages impacted an estimated one quarter of disapora families. In response, a global outpouring of disaster aid was notable, but in some ways surpassed by Tamil diaspora communities that raised money and delivered aid directly, establishing health clinics and challenging Western assumptions about the best way to deliver culturally appropriate disaster relief. The acute trauma inflicted on the Sri Lankan Tamil population by the tsunami, in addition to the chronic trauma of decades of warfare, was generally observed by scientists and medical practitioners to subside after several months, suggesting that the impact of traumatic events is not irreversible and that Tamil health is promoted by restoring and strengthening psychosocial support within communities.

Related Topics

- ► Canada
- ► Ethnic enclave
- ► Health care utilization
- ► Mental health
- ► Refugee health and screening
- ► South Asians

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TANF

► Temporary Assistance for Needy Families

Telephone Interpretation Services

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Telephone interpretation allows human interpreters to utilize a telephone to facilitate communication between individuals who want to speak to each other but do not speak the same language. Telephone interpretation is typically conducted in a consecutive mode wherein, rather than speaking simultaneously, the interpreter listens to each utterance and then translates it to the other language. Telephone interpretation is often seen in business transactions, governmental functions, and in the healthcare arena.

As the world becomes more global, there is an increasing need to communicate with individuals who speak a different language. The ability to travel with ease and move away from an individual's home country allows interaction with populations that speak a language in which the traveler or immigrant has little or no proficiency. According to the United States 2000 Census, for example, 1 in 30 residents, or 17.5 million adults and 3.4 million children, were limited in their ability to speak English.

The inability to speak and understand the language of the area where one resides often results in an inability to fully participate in society. These individuals may not be fully aware of the governmental programs, societal programs, and activities from which they could benefit. A limited language proficiency also often results in a reduced access to health care, insurance, and assistance with other financial matters. Telephone interpretation services have developed to help address these problems.

Telephone interpretation services provide expedient access to numerous languages, including less common languages such as Farsi and Tagalog, at any time of day or night. The ability to have access to many languages twenty-four hours a day is especially an asset in rural areas where the business or healthcare provider may not have on-site interpreters fluent in the language being spoken.

In the healthcare arena, telephone interpretation may be a good alternative for patients who value their privacy. Depending on the patient's cultural, religious, and social background, he or she may place a high value on their privacy when being examined or discussing health issues. This is especially true when the visit involves the sexual health of the patient. The use of a telephone interpretation service allows for translation without the need to have a third person, usually a member of the same community, in the room while the patient is being examined and discussing his or her health. The utilization of telephone interpretation also permits the patient, especially one who speaks a less common language, to communicate with a healthcare professional without having to rely on a family member to act as a translator. The use of a family member as an interpreter may cause the patient to be less forthcoming about topics like their symptoms or the mechanism of injury. The patient may not feel comfortable requesting specific types of treatment, such as birth control, or reporting abuse if they are forced to use their husband or children as a translator.

There are some circumstances when telephone interpretation is discouraged in a healthcare setting. For example, face-to-face interpretation is optimal when the patient is receiving mental health care. Face-to-face interpretation is also more beneficial when the patient is hard of hearing or a child. Telephone interpretation is also discouraged when the patient is being educated with visual components (i.e., instructing the patient in wound care, blood sugar testing, or equipment use).

Telephone interpretation is provided by for-profit groups, non-for-profit groups, and, in some countries, the government. Countries such as Australia, New Zealand, and South Africa have established telephone interpreting services. In other countries, telephone interpretation services are mainly provided by for-profit companies. The United States is one of the countries where the majority of the telephone interpretation services are provided by for-profit companies that are external to the healthcare provider or organization. However, some hospitals and healthcare systems do provide telephone interpretation services.

Telephone interpretation can be expensive. Insurance companies usually do not pay for telephone interpreters. Likewise, the governments of many countries do not pay for interpretation. In most states in the United States, for instance, Medicare and Medicaid do not reimburse telephone interpretation services. A lack of access to qualified professional interpreters leaves individuals with limited language proficiency with a reduced access to care, a diminished quality of care, and an inability to form a bond with the healthcare provider. A 2002 survey of uninsured Limited English Proficiency patients in the United States found that 32% of those who needed an interpreter but did not get one stated they would not return to the facility if they ever became insured.

Effective communication cannot be had between two parties that are unable to understand each other. In a global world where travel and immigration is common, the need to communicate effectively is growing. Telephone interpretation services provide a quick and efficient means of allowing individuals speaking different languages to communicate with one another.

Related Topics

- ► Domestic violence
- ► English as a Second Language
- ► Health barriers
- ► Language
- ► Limited English proficiency

Suggested Readings

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Temporary Assistance for Needy Families

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Temporary Assistance for Needy Families, or TANF, was created by the enactment of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Public Law 104–193, and became effective as of July 1, 1997. The TANF program replaced the Aid to Families with Dependant Children program. At the time of the enactment of TANF, Congress made the specific finding that the number of individuals receiving aid to families with dependent children (referred to as "AFDC") had more than tripled since 1965. More than two-thirds of the recipients were children.

Congress enacted TANF to: (1) provide assistance to needy families so that children may be cared for in their own homes or in the homes of relatives; (2) end the dependence of needy parents on government benefits by promoting job preparation, work, and marriage; (3) prevent and reduce the incidence of out-of-wedlock pregnancies and establish annual numerical goals for preventing and reducing the incidence of these pregnancies; and (4) encourage the formation and maintenance of two-parent families. TANF provides parents with job preparation, work, and support services to enable them to leave the program and become self-sufficient.

The Federal TANF program is operated by the Administration for Children and Family division of the US Department of Health and Human Services. However, the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 also provides that states shall be given block grants to administer TANF programs on a state level. Each state will then administer its own TANF program and report to the federal government for oversight. Not only are TANF block grants available to the 50 states of USA, but also to the US territories such as Puerto Rico, Guam, the Virgin Islands, and the District of Columbia. TANF block grants are also provided to certain federally recognized tribes and tribal organizations.

On average, in the fiscal year 2009, there were 4,027,329 recipients of TANF services. California was the state with the most recipients in 2009, with a total of 1,307,832. Wyoming was the state with the least recipients with only 577. The 2009 annual TANF recipients have declined from the number of TANF recipients for the fiscal year 1997, the year that the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 went into effect. The TANF recipient rate for fiscal year 1997 was 10,935,125. For fiscal year 1997, Guam had the lowest TANF recipient rate, at 4,528.

States may not use TANF funds to provide assistance to a family – unless the family includes a minor child who resides with a custodial parent or other adult caretaker relative of the child or a pregnant individual. States may require that families receiving TANF assign certain support rights, such as child support payments, to the state, but only while receiving TANF benefits. Parents enrolled in a TANF program may also be required to attend high school or other equivalent training program, if they do not already have a high school education.

There is a 60 month limitation on the length that a family may receive federal assistance services. This 60 month time limitation applies regardless of whether the federal assistance services were consecutive or not, excluding any time that a person was a minor child and not the head of a household or married to the head of a household. The state may grant an exception to the 60 month limitation if the family can show that there is a hardship situation or if the family includes an individual who has been battered or subjected to extreme cruelty. A state shall disregard any month of TANF assistance received by adult while living on an Indian reservation or in an Alaskan native village with 50% unemployment and at least 1,000 individuals were living on the reservation or in the village at that time.

In order to be eligible for benefits, persons applying for federal public benefits, with some exceptions, are required to prove that they are either citizens or a qualified alien. For purposes of TANF, a qualified alien means an alien who, at the time the alien applies for, receives, or attempts to receive a Federal public benefit, is an alien who is lawfully admitted for permanent residence under the Immigration and Nationality Act. There are a number of exceptions to that policy; specifically, the prohibition against non-qualified aliens receiving TANF shall not apply to an alien until 5 years after the date that an alien is admitted to the USA as a refugee under section 207 of the Immigration and Nationality Act, an alien is granted asylum under section 208 of such Act; or an alien's deportation is withheld under section 243(h) of such Act. Additionally, the prohibition against non-qualified aliens receiving TANF shall not apply to an alien who is lawfully admitted to the USA for permanent residence under the Immigration and Nationality Act, and has worked 40 qualifying quarters of coverage as defined under title II of the Social Security Act or can be credited with such qualifying quarters, and did not receive any Federal means-tested public benefit during any such period. Finally, the prohibition against non-qualified aliens receiving TANF shall not apply to an alien who is lawfully residing in any state and is a veteran with a discharge characterized as an honorable discharge and not on account of alienage, is on active duty (other than active duty for training) in the Armed Forces of the USA, or the spouse or unmarried dependent child of such a qualifying veteran.

Related Topics

- ► Domestic violence
- ► Immigration status

Suggested Resources

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Terrorism

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Terrorism is the premeditated, politically or socially motivated use of violence against civilians or noncombatants by national or subnational groups (e.g., Al-Qaeda, FARC, IRA, Sea Shepherd) or clandestine agents with the intention of influencing a population socially and politically. In general, acts of terrorism are designed to induce fear, terror, anger, or panic in a population, thus leading to a societal change. The change is usually achieved by causing casualties, economic damage, destruction of infrastructure, and/or by creating the impression that the government cannot protect its citizens.

Usually, the terrorist acts committed by immigrants are perceived as being based upon radical religious beliefs, be they Christian in Northern Ireland; Zionist in Palestine after World War II; Islamic, as in Al-Qaeda; or cult-like religions/beliefs, such as occurred with Aum Shinrikyo in Japan. The reality is that even those terroristic attacks claimed in the name of religion are also carried out for political purposes, even if the public, media, and politicians do not focus on those reasons. Native or "homegrown" terrorist acts are committed primarily by a single individual or small group that is usually motivated by political/cultural causes or beliefs rather than religious ideology (e.g., Oklahoma City federal building bombing in 1994; attack on Austin, Texas, IRS building in 2010; Basque separatists). Native terrorists (excluding paramilitary groups such as the IRA or FARC) are often perceived by the public as being less of a "long-term threat or danger" compared to foreign terrorists. Many times homegrown terrorists are seen as fringe members of society that are defective in some way (e.g., Maj. Nidal Malik Hasan, aka the Fort Hood Shooter, mental state has been frequently questioned in the media) which may explain why the general public is less fearful of them compared to international terrorists who follow an "outside ideology". However, recently "homegrown" terrorists are beginning to claim radical religious beliefs as seen with the arrest of "Jihad Jane" who was a Pennsylvania suburban house wife who converted to Islam and was arrested for planning domestic and international terroristic acts.

The motivation, success, and acceptability of terrorist groups whether imported or homegrown is a matter of perspective (i.e., one man's terrorist is another man's freedom fighter). Two of the Middle East's now-revered leaders, Menachem Began and Anwar Sadat, both began their political careers as "terrorist/freedom fighters."

Acts of terrorism are designed to create a national psyche of "us versus them," which often negatively affects attitudes toward legal immigration. Acts of terrorism often result in anti-immigration political movements, which potentially alienate and prevent the successful incorporation of immigrants into a society (e.g., Swiss People's Party, "SVP," which used posters depicting minarets as missiles on a Swiss flag to support a referendum to ban construction of minarets). This anti-immigrant sentiment furthers terrorists' goals by creating political tension, alienating, and potentially disfranchising new immigrant populations, which creates opportunities for new member recruitment and further strife.

New and already-established immigrants are targeted for recruitment by terrorist networks. Recruitment is made easier by some immigrants' disenchantment with the new host country and their resultant desire to maintain their cultural identity with their homeland. Data suggest this is particularly true in disaffected second- and third-generation immigrants. Disenchantment may be born from a perceived lack of acceptance/opportunity in the new country, romanticization of their homeland and exigencies associated with a siege mentality developed in the immigrant community based on feelings of religious, linguistic, cultural, and financial isolation. The sense that their children are being isolated and deprived of opportunity can further radicalize immigrants and make them more likely to act out their frustrations in violent or antisocial ways. Legal immigrants are valuable recruits because they have legal status in a country; have passports; can travel freely; learn the infrastructure of the host country; understand its customs and culture; often speak the language; have jobs and access to information; can be placed in potentially critical positions; have ties to two countries, which may make it easier to transmit information overseas or visit abroad; and can supply informational and physical support (e.g., money, safe houses) in the new country.

As well as being the targets of recruitment for terrorists, immigrants are often also the victims of terroristic acts as well. People from 79 different countries died in the World Trade Center attack on September 11, 2001.

Terrorism has impacted global immigration policies. New restrictions on travel and immigration have been implemented by the United States, the European Union, Japan, Australia, New Zealand, and several Middle Eastern and Asian nations, all of whom have expressed concern about the potential for travelers and new immigrants, particularly Muslims, to commit or participate in terrorist acts. For the United States, approximately 50% of new terrorists will attempt to obtain some form of immigration benefits (e.g., student or work visa), while another 40% will attempt to become US citizens through the naturalization process or sham marriage. In addition, approximately two-thirds of individuals, who committed or were planning to commit a terrorist act, had committed some form of immigration fraud. Although the vast majority of legal immigrants are not involved with terrorism, the acts of a few have created a global political environment where there is less tolerance and lenience for the violation of immigration laws.

The primary focus of many countries' terrorism policies is to stop foreign-born terrorists from committing acts of terror in their country and to prevent them from gaining access to legitimate travel documentation and citizenship in other, more friendly and democratic nations (e.g., individuals from Yemen traveling on a European passport are less likely to raise suspicion when traveling to the United States than when traveling on a Yemenese passport). Governmental attempts to control the movement of terrorists across national boundaries results in more detailed visa and travel applications (e.g., fingerprinting) and background checks for immigrants, more time spent processing applications, more expense and application time for the applicant, and more formal bureaucracy for immigrants to contend with when obtaining and renewing their immigrant status. A concrete example of how terrorism has directly affected immigration is the Naturalization Services Passenger Accelerated Service System used by both the United States and Canada, which relies, in part, on fingerprints as a form of biometric identification. This change was mandated by The Patriot Act passed in response to the September 11, 2001 terrorist attacks. Billions of unproductive dollars are now spent annually on airport security as a direct result of the 9/11 attacks and other bombing plots enacted by terrorists.

Recent information about immigrants who have committed terroristic acts will further complicate the lives and penalize nonviolent immigrants, who were once actively sought and encouraged to immigrate. Many terrorists who have committed acts in other countries were well educated (e.g., the doctors who carried out the Glasgow airport attack on June 20, 2007, and the engineer who attempted the December 25, 2009, aircraft bombing from Nigeria). Recent studies found that 62% of international terrorists are college educated. In addition, many terrorists enter their target country on educational visas and blend into university student populations. Approximately 25% of individuals who committed terrorist acts in the United States from 1990 to 2004 had applied for or received a student visa.

The impact of terrorism on immigrants often results in immigrants feeling unwelcome in their new country; requires them to spend more time, energy, and financial resources to obtain immigrant status and to maintain it; and results in them being at risk for being directly involved in terroristic activities through attempts to recruit them into terrorist networks. They may become the victim of violence or discrimination. The recent trend of terrorist organizations to infiltrate countries and attack using educated professionals to carry out specific well-planned attacks produces a backlash and further limits the ability of peaceful immigrants to access jobs and other opportunities, hence increasing their bitterness, resentment, isolation, and potential to be radicalized. As stated by the then-Secretary General of the United Nations, Kofi Annan, after the terrorist attacks on September 11, 2001, "Terrorism affects every society. As the world takes action against it, we have all been reminded of the need to address the conditions that permit the growth of such hatred and depravity."

Related Topics

- ► Assimilation
- ► Cultural background
- ► Department of Homeland Security
- ► Radicalization

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Tetanus

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Tetanus is a nervous system disorder characterized by the prolonged contraction of skeletal muscle fibers caused by a gram positive anaerobic bacillus named *Clostridium tetani*. This bacterium, discovered by Arthur Nicolaier in 1884, produces the tetanospasmin molecule (tetanus toxin). This molecule travels to the spinal cord, causing painful muscular spasms and rigidity that can be triggered by loud noises, light, or other sensory stimuli. The bacterium is usually acquired through a penetrating injury or puncture wound in a person who has not been immunized or has an incomplete immunization. Other patients that can be affected are those with burns, ulcers, or intravenous drug users. Newborns can also be affected, especially those whose umbilical stump were cut under non-sterile conditions or whose mother had never been immunized. Tetanus is not transmitted from person to person. The incubation period ranges from 2 days to several months, with most cases occurring during the first 2 weeks. For newborns, the period of incubation is usually 5–14 days. Largely contaminated wounds are associated with a shorter incubation period, worse prognosis, and more severe disease.

Tetanus can present in four different ways: generalized, localized, cephalic, and neonatal. The most common type of presentation is the generalized tetanus, seen in approximately 80% of cases. One of the most common presenting signs is trismus (lock jaw); it is produced by spasms of the jaw muscle named the masseter. Other muscles of the body can be affected causing risus sardonicus (facial muscle spasms that produce grinning), stiff neck, difficulty swallowing, respiratory deterioration, and opisthotonus, which is a severe spasm that causes arching of the back with the head bending back and heels flexed toward the back. Patients can also have symptoms of autonomic overactivity such as a rapid heart rate, elevated blood pressure, fever, and profuse sweating. Localized tetanus has a milder presentation with muscle contractions in the same body region where the injury or wound occurred. It can eventually progress to the generalized type. Cephalic tetanus is usually seen in patients with head, neck, or face injuries or otitis media (ear infection). Signs and symptoms include difficulty swallowing, trismus, or focal cranial neuropathies with the facial nerve being the most commonly affected. Cephalic tetanus may progress to the generalized type. Neonatal tetanus is a form of generalized tetanus exhibited in newborns that can cause poor sucking and seizures in addition to the muscle spasms.

Tetanus occurs worldwide but is more common in warmer climates. In 1924, P. Descombey developed the tetanus toxoid vaccine, used in World War II, but it was not until the 1940s when immunizations became universal for children in developed countries, leading to a dramatic decrease in the incidence of tetanus. In the USA, the incidence is approximately 0.08–0.16 cases per million population (22–44 cases on average per year). A higher incidence is seen in underdeveloped countries. As per the World Health Organization (WHO) report in 2009, the highest incidence of tetanus occurred in the Democratic Republic of Congo (1,368 cases), Uganda (1,304 cases), and the Philippines (1,022 cases). China also had a markedly high incidence in 2008, with 1,786 cases; all reported cases were of neonatal tetanus. Mortality from generalized tetanus in the USA is approximately 10–30%, but it is higher in patients older than age 60. Neonatal tetanus has the highest mortality, being 25–90% in developing countries.

The treatment of tetanus should be accomplished in an intensive care unit whenever possible, because patients may require mechanical ventilation. Wound cleansing and debridement should be performed and antibiotics such as penicillin G (2–4 million units IV every 4–6 h for adults; 100,000 units/kg/day for children) or metronidazole (500 mg IV every 6–8 h for adults; 30 mg/kg/day for children) should be administered for 7–10 days. Benzodiazepines such as diazepam (10–30 mg starting dose) can be used to control the muscle spasms, and in severe cases, neuromuscular blocking agents such as vecuronium and pancuronium can also be administered. Other drugs such as labetalol, morphine, and clonidine can be used to treat autonomic symptoms. A single dose of Human Tetanus Immune Globulin (TIG) 3,000–6,000 units intramuscularly is recommended. In countries where TIG is not available, equine tetanus antitoxin 1,500–3,000 units intramuscularly can be administered after appropriate sensitivity testing and desensitization, if necessary, is performed. All patients with tetanus should be immunized with three doses of tetanus and diphtheria toxoid vaccine spaced at least 2 weeks apart. Tetanus disease does not confer immunity following recovery. As a preventive measure, all children should be immunized and receive five doses of the tetanus and diphtheria toxoid vaccine prior to school entry with a booster dose given every 10 years as adults. Tetanus prophylaxis should also be administered in routine wound or burn management depending on the patient's immunization status and the quality of the wound.

Related Topics

▶ Immunization

Suggested Readings

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Suggested Resources

Center for Disease Control and Prevention. www.cdc.gov/VACCINES/.

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Thailand

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In the heart of Southeast Asia, Thailand is the modern form of Siam that was established in the mid-fourteenth century. It is the only nation in Southeast Asia never to have been occupied by a European power. With a Gross Domestic Product of US$273.2 billion, Thailand is bordered by poorer neighbors to the north – Burma (Myanmar) ($27.2 billion) and Laos ($5.2 billion) and to the east-Cambodia ($9.2 billion). China is 125 km north of the Thai border across Laos. Thai culture and traditions are strongly influenced by Chinese historical practices and, to a lesser degree, by Indian culture, along with influences from Burma, Laos, and Cambodia.

The country is a kingdom, a constitutional monarchy with King Bhumibol Adulyadej, who has reigned since 1946, making him the world's longest-serving current head of state and the longest-reigning monarch in Thai history. However, during his reign, there have been a number of military coups and political upheavals, the most recent in 2006–2008. Theravada Buddhism is practiced by more than 94.7% of all Thais. Muslims make up 4.6% of the population, primarily in the south. Since 2004, there has been escalating conflict between a separatist Muslim movement and the Buddhist Thai community in southern Thailand, resulting in the deaths of thousands, the burning of more than 300 schools and militarization of the area.

Thailand is the world's 50th largest country in terms of surface area (approximately 513,000 km^2 [198,000 mi^2]), but it is the 21st most-populous country, with approximately 64 million people. About 75% of the population is ethnically Thai, 14% is of Chinese origin, and 3% is ethnically Malay; the rest belong to minority groups including Mons, Khmers, and various hill tribes – many of whom live in very isolated conditions and without ownership of their lands or access to legal systems. One-third of the population lives in urban areas with the majority of those in Bangkok. The overall literacy rate approaches 92%.

Thailand is a newly industrialized country with exports – mostly machinery and electronic components, agricultural commodities, and jewelry – continuing to drive the economy, accounting for as much as three-quarters of GDP. It also has a strong tourism base due to well-known tourist destinations such as Pattaya, Bangkok, and Phuket. It experienced rapid economic growth between 1985 and 1995 and then from 2000 to 2008. Agriculture accounts for 43% of the country's labor force but 12% of GDP. Industry represents 44% of GDP and 20% of its labor pool, with the balance in services. Ten percent of the country lives below the poverty line.

Thailand does have universal health coverage, although there is a strong system of private hospitals and privately funded practitioners as well. A major problem for Thailand is HIV/AIDS and they have had 58,000 people die from AIDS related illnesses since 1984. The prevalence rate is now estimated to be 1.4% of the population. There has been an 83% reduction in new infections from 142,819 in 1991 to 21,260 in 2003. In 2006, at least 80,000 people were receiving drugs to keep HIV under control – approximately 88% of the HIV+ population. A new challenge is coping with H5N1 Avian flu which has infected poultry and people in Thailand.

It is estimated that at any time, 2.2 million legal and illegal immigrants live in Thailand. This population is a mix of Burmese men supplying labor for the construction and seafood industry, women from Cambodia and Vietnam who are performing domestic labor, textile work, and sex work, as well as refugees from regional conflicts. At least 116,000 were Karen, Hmong, and other asylum seekers from Burma alone. There is also a large expatriate community in Thailand of Westerns from the USA and Europe. Recently, the unemployment rate has increased and the Thai government has threatened to deport almost 500,000 Burmese immigrants who did not register by a deadline. There is some fear that they may "go underground" to avoid deportation for political or safety reasons as well as economic ones. This also means they will be reluctant to seek medical attention.

Human trafficking is a serious issue in Thailand which is the only nation dually listed by the UN Office on Drugs and Crime as being one of the top eight importers of human trafficking as well as one of the top eight exporters of exploited human capital. Women and sometimes children are brought to Thailand from China, Laos, and Cambodia for the sex industry or for domestic labor and forced to remain by force or coercion. They are often forced to engage in unsafe sexual practices and their wages as well as their freedom may be stolen from them. Buramese men are brought to Thailand and sold in indentured servitude to work in unsafe conditions, particularly in the seafood industry and construction jobs. Thai women are also trafficked abroad to Europe, the USA, and Australia among others to work in the sex and service industry. A recent United States Senate investigation looked at the trafficking of Burmese refugees through Malaysia into Southern Thailand and found evidence that it is occurring on a systematic basis with women and men who are unable to pay off extortion demands being sold to brothels or fishing boats.

A particular issue for Thai patients is the role of the family and gender roles. Men are expected to support their families while daughters may be seen as relatively transient as they will eventually leave. Despite the fact that men hold much of the outward power, women will often remain strong behind-the-scenes, and it is women who often hold the deeds to property in Thailand. This means that decisions, including treatment decisions, will often be made after consultation in private and sometimes with family elders or religious figures. Thai patients may find the urgency of western health care workers confusing and distressing.

Another issue in Thai culture is *kun na* or saving face. *Mai pen rai* is a very common expression that loosely translates as "it doesn't matter," but really is an attempt to constructively address conflict by implying that the issue at hand is less important than the stress it will cause. Thai place an enormous value on *chai yen* – avoiding the expression of strong feelings; and the expression of strong emotion, especially negative ones is a cause for significant "loss of face" and humiliation. This can be extremely difficult for medical practitioners who are attempting to counsel a choice that is not in line with a family elder or religious figure as patients may disengage from treatment to avoid confrontation or a loss of face for a senior family figure. Treatment discussions are often best held in a calm and controlled setting using open-ended questions and involving as much of the family or respected religious figures as they would like to have present.

Although 95% of Thais identify themselves as Buddhists, in reality there is a high degree of operational syncretism where Hindu Brahmanism, animism, and other spiritual practices are seen as complementary. Many, if not most, businesses and homes will have decorated spirit houses for offerings of incense, flowers, and candles. Thais approach health care with similar views; they may place a Western diagnostic evaluation on a sliding scale with religious or complementary medicine opinions. This can be difficult for science-based health practitioners who have a distinct view of health and illness.

The health experience of Thai immigrants and workers abroad has not been evaluated in a systematic fashion. A Thai postdoctoral student working in Washington DC conducted a series of interviews and a survey of Thai health care experiences. He found that Thais in the USA liked many things about the US healthcare system, but were frustrated by its complexity, cost, and the lack of decisiveness in doctor's recommendations; many voiced confusion and disconnectedness when an American doctor offered them a variety of choices. Thai immigrants reported that they sought care preferentially with Thai doctors or self-medicated using over-the-counter drugs, Chinese medications/therapies such as acupuncture, or familiar medications from Thailand. They went to American hospitals when they felt they needed "technology" or for life-threatening problems.

A second study of Thai women in Brisbane, Australia, found similar results; that the high cost and complexity of health care in Australia compared to the perceived "efficiency and efficacy of Thai practitioners" resulted in women delaying medical attention until they returned to Thailand. They also found that language and cultural barriers led to low participation in preventive health programs for Thai women in Australia.

Thai workers abroad are at risk of being misdiagnosed if they bring health problems with them that are rare in their host country. A hospital in Israel reported 30 Thai agricultural workers who experienced an outbreak of trichinosis (associated with infected pork), a disease that is not well known in the Jewish state.

Another study looked at the health of Thai migrant workers while abroad and found that 32% reported adverse effects on their psychological health and 19% to their physical health, but overall their Thai communities improved due to the workers' contributions sent home. The report concludes that the effects of migration on health were transient and that overseas migration provided indirect health benefits to larger communities (e.g., villages) through economic gain and improvement of infrastructure.

Thailand has a number of local and regional diseases that may impact Thai emigrants who are residing in other areas of the world. Health care providers should consider these issues which may be otherwise unfamiliar to them when evaluating Thai patients. Fevers in Thai patients abroad or in immigrants who have moved to Thailand should be evaluated for dengue, malaria, and chikungunya in the differential diagnosis.

Dengue fever is a viral infection from infected mosquitoes that is the most common cause of fever in travelers returning from South Central Asia. It can occur anywhere in Thailand, but more infections are associated with urban settings. In Thailand, it seems to have an endemic pattern as well as epidemic spikes in outbreaks. When thousands can be affected, it is associated with fever, severe headaches, joint and muscle pain, "bone break fever," rashes, nausea, and vomiting and bleeding. It is potentially fatal in severe cases.

Chikungunya fever is also caused by a virus from infected mosquitoes. Symptoms include sudden fever, joint pain, chills, headache, nausea and vomiting, lower back pain, and a rash. After resolution of the initial infection, Chikungunya survivors may experience a prolonged course (months) of arthralgia or arthritis which can lead to extensive workups for rheumatic disease. The disease is particularly prevalent in the southern region. More than 49,000 cases were documented in 2009.

Malaria is resistant to mefloquine (a common anti-malarial medication) along the eastern (Cambodian and southern Laos) and western (Burmese) border of Thailand. Malaria generally occurs in rural areas of Thailand and is characterized by influenza-like symptoms in intervals. It is often accompanied by anemia and jaundice. Malaria can occur between 7 days and many months after exposure.

Other diseases that can be found in Thailand and the region include: Japanese encephalitis, filariasis, and plague. Fresh water (such as agricultural work) can bring exposure to schistosomiasis and leptospirosis. Measles persists in Thailand, although vaccination coverage has improved. H5N1 avian influenza has been associated with wild and domesticated bird populations in Thailand on a sporadic basis.

Related Topics

- ► Cambodia
- ► Southeast Asia
- ► Trafficking

Suggested Readings

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Tibet

- ► Asia

Tobacco

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Tobacco use is the leading preventable cause of death in the USA. The Centers for Disease Control and Prevention (CDC) estimates that 443,000 deaths annually can be attributed to smoking and secondhand smoke in 2010. The smoking-related diseases that are associated with tobacco use include numerous cancers including cancers of the lung, esophagus, and pancreas; cardiovascular diseases such as heart attacks and strokes; and respiratory diseases like chronic airway obstruction.

Tobacco use in the USA has declined since 1964, when the Surgeon General's Advisory Committee on Smoking and Health published a report which concluded that cigarette smoking was a cause of lung and laryngeal cancer. Since then the proportion of US adult smokers declined from 42% in 1964 to 20.6% in 2009. Nonetheless, 45 million Americans continue to smoke. And while the first Surgeon General's report on smoking was published in 1964, it was not until 1998 that a similar report was published that included an analysis of racial and ethnic differences in tobacco utilization. To date, the Surgeon General's report has not looked specifically at the impact of tobacco use on immigrant populations. The 1998 report, Tobacco Use Among US Racial/Ethnic Minority Groups, did prompt researchers to consider how acculturation affects patterns of tobacco use among immigrants to the USA.

Immigrants and Tobacco Use

Smoking rates among immigrants differ from those of nonimmigrants. In general, immigrant assimilation is positively associated with tobacco use; however, there is a lack of large data sources available to illustrate the diversity of immigrant populations. When smoking prevalence is reported only by race or ethnic categories, the heterogeneity of immigrant groups is obscured. An analysis of National Health Interview Survey data revealed that while immigrants demonstrated significantly lower smoking rates than nonimmigrants, rates varied according to country of birth.

Acculturation is an important variable in assessing immigrant tobacco use. A recent analysis of electronic medical records found that prevalence of tobacco use increased considerably with acculturation among women, particularly Laotian/Hmong, and Mexican-born Spanish speakers, while changing little among men. Some of the disparity is related to gender differences in the native cultures, where female smoking rates may be much lower. A review of studies assessing acculturation and smoking among Hispanic women underscored the gender-specific nature of the relationship. Another analysis of female Hispanic smokers noted that while acculturation is associated with smoking, having a less cohesive family structure was an important component as well.

A related concept involves generational differences. Being foreign-born appears to have a protective effect against smoking. An analysis by Acevedo-Garcia (2005) found that the odds of being a smoker were highest among US-born individuals of US-born parents and lowest among foreign-born individuals. Again, the complexity of the relationship between immigrant status and tobacco use is revealed through a closer look at the data. The analysis also found that being foreign born and being second generation with two immigrant parents was especially protective against smoking for females as compared to males, racial and ethnic minorities compared to Whites, and low-income individuals compared to high income individuals.

This generation-specific gradient applies not only to use of tobacco, but also in regards to whether an individual supports smoke-free policies (e.g., banning smoking in a public place). Data from the Current Population Survey Tobacco Use Supplement indicated that immigrants exhibited stronger support for banning cigarettes in every venue (including malls, restaurants, indoor workplaces, bars, hospitals, and sporting events), although the support eroded with greater assimilation into the USA.

Unfortunately, any protective factor conferred to foreign-born immigrants may be at risk due to targeted marketing by the tobacco industry. While researchers lack detailed and specific large data sources, a review of tobacco industry documents revealed that three distinct strategies have been aimed at immigrant populations. These strategies included marketing geographically in immigrant communities, segmentation based on immigrants' assimilation status, and coordinated marketing focused on countries of origin. The industry used information on immigrant populations to tailor marketing strategies and increase tobacco use.

Related Topics

- ► Acculturation
- ► Cancer
- ► Cancer prevention
- ► Cardiovascular disease
- ► Cardiovascular risk factors
- ► Health care

Suggested Readings

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Tobacco Control

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Cigarette smoking is a major cause of disease worldwide. Approximately, 5.4 million deaths each year are caused by tobacco use. The World Health Organization (WHO) estimates that every 6.5 sec a current or former smoker dies. Tobacco use is the single most preventable cause of disease, disability, and death in the USA. Each year an estimated 443,000 deaths occur as a result of cigarette smoking, representing nearly one in every five deaths. Lung cancer, atherosclerotic cardiovascular disease, and chronic obstructive pulmonary disease are responsible for the majority of these deaths. Despite these risks, nearly 43.4 million US adults smoke cigarettes. Another 126 million nonsmoking Americans are exposed to secondhand smoke, resulting in an estimated 49,000 tobacco-related deaths. In addition, the economic burden of tobacco use in the USA exceeds $193 billion per year, with $96 billion in medical expenditures, and another $97 billion in lost productivity. Annually, secondhand smoke costs more than $10 billion in health care expenditures.

Health Effects of Smoking and Health Benefits of Smoking Cessation

The Center for Disease Control (CDC) estimates that due to smoking adult male smokers lose an average of 13.2 years of life, and female smokers lose an average of 14.5 years of life. Ceasing tobacco use has major and immediate health benefits for persons of all ages. Statistically, former smokers live longer than persons who continue smoking. As compared to those who continue to smoke, those who stop smoking before age 50 reduce their risk by one half of dying over the next 15 years. It is estimated that cigarette smoking accounts for at least 30% of cancer deaths and that tobacco is responsible for nearly 90% of lung cancer cases. Lung cancer is the leading cause of cancer death among both men and women, is one of the most difficult cancers to treat, and is hard to detect in the earliest, most treatable stage. From the point of cessation, the risk of lung cancer begins to reduce within 5 years. It may also reduce the risk of other cancers, such as cancers of the head, neck, esophagus, stomach, kidney, pancreas, colon, rectum, and bladder. Tobacco cessation is advantageous even after one cancer is diagnosed, as it reduces the risk of acquiring a second cancer and may improve survival from the first.

Cancers account for about 50% of the deaths related to smoking. Tobacco is a major cause also of atherosclerotic cardiovascular disease, including: heart disease, peripheral vascular disease, stroke, and abdominal aortic aneurysm. Tobacco use doubles the risk of developing heart disease. One year after quitting smoking, the risk of dying from heart disease is reduced by one half and continues to decline over time. Some studies have shown that within 2 years of stopping smoking, the risk of heart attack was reduced to the rate of nonsmokers.

Smoking increases the risk of long-term lung diseases such as chronic obstructive pulmonary disease (COPD). Most of the lung damage caused by smoking is not reversible, but quitting smoking can reduce further lung damage. Chronic cough and sputum (phlegm coughed up from the lungs) are reduced in most smokers within 1 year after tobacco cessation. Children exposed to secondhand smoke are more likely to develop asthma or sudden infant death syndrome (SIDS).

Additionally, smoking causes or worsens other conditions, increases the risk for osteoporosis, and increases the risk of hip fracture in women. Stopping smoking begins to reverse this risk in about 10 years. Pregnant smokers have an increased risk of miscarriage, early delivery, stillbirth, and delivering a low birth weight infant. Smoking causes premature skin wrinkling and increases the risk of sexual problems (e.g., infertility, impotence).

Nicotine Addiction

Smoking is recognized as a chronic, addictive disease. Addiction, characterized by the compulsive seeking or use of a substance despite harmful consequences, is accompanied frequently by adverse physical and psychological dependence. It is estimated that 85% of US smokers are addicted, while nicotine is the addictive drug in tobacco that produces dependence. Although it is reported that approximately 70% of smokers want to quit, and 35% attempt to quit each year, less than 5% succeed. The low rate of successful quitting and the high rate of relapse are related to the effect of nicotine addiction.

Discomforts of Tobacco Cessation

The health benefits of smoking cessation far exceed any adverse psychological or physical effects that may proceed quitting. Symptoms of withdrawal are common, peak in the first 3 days, and decrease over the next 3–4 weeks. Withdrawal symptoms may include irritability, anxiety, difficulty concentrating, increased appetite, difficulty sleeping, frustration, anger, and restlessness. Episodic cravings for cigarettes may persist for many months but will go away if ignored. Some people who stop smoking experience depression, which may be severe enough to require counseling or treatment. Weight gain can occur during the cessation process, because people tend to eat more after quitting. Typically, people gain 2–5 lb in the first 2 weeks, followed by an additional 4–7 lb over the next 4–5 months. The benefits of quitting smoking are much greater than the drawbacks presented with weight gain, and an exercise program and reasonable diet can minimize weight gain.

Preparing to Quit

After deciding to quit smoking, the first step is to set a quit date. Sometimes those who smoke fewer cigarettes are able to quit gradually, but stopping “cold turkey” is more successful in general. Other steps that may help in preparing to quit include telling family, friends, and colleagues of one’s plan to quit; eliciting support; reviewing previous attempts at cessation; preparing to deal with nicotine withdrawal symptoms; preparing to deal with things that trigger smoking (e.g., current smokers, stress, and alcohol); and talking to a health care provider.

Tobacco Cessation Interventions-Behavioral Modifications and Medications

Tobacco dependence is a chronic condition that often requires repeated interventions. The most effective interventions involve a combination of counseling and FDA-approved cessation medications. Health care providers play a pivotal role in encouraging smokers to quit and in providing or referring patients to appropriate counseling and treatment. Brief clinical interventions, even of 5 min or less, and counseling are effective cessation treatments. The first step in the process, identification and assessment of tobacco use status, separates patients into three treatment categories: patients willing to quit, patients unwilling to quit at this time, and patients who have quit using tobacco recently. Patients willing to quit should be treated with the “5 As”: Ask about tobacco use, Advise to quit, Assess willingness to quit, Assist in quit attempt, and Arrange adequate follow-up. The “5 Rs”: Relevance, Risks, Rewards, Roadblocks, and Repetition are designed to motivate smokers who are unwilling to quit at this time. Patients who have quit using tobacco recently should be provided relapse prevention treatment.

Approaching changes in behavior through problem solving, skills training, and social support increases one’s chances of successful cessation, and using behavioral changes in conjunction with a medication further increases rates of success. Pharmacological treatments to help with tobacco cessation include nicotine replacement therapies, buproprion (Zyban® and Wellbutrin®) and varenicline tartrate (Chantix®). Clonidine, an antihypertensive medication, and nortriptyline, a tricyclic antidepressant, are considered second-line smoking cessation drugs that have shown a modest benefit in increasing smoking cessation rates. However, use is limited by significant adverse side effects. Hypnosis and acupuncture are popular tobacco cessation methods; however, scientific support is weak for these methods.

Nicotine replacement therapy is designed to reduce the intensity of withdrawal symptoms. It is safe, even in people with known heart disease; however, using nicotine replacement therapy while smoking is not recommended. Nicotine is available in several forms: as a gum, lozenge, patch, nasal spray, or inhaler. None of these is significantly superior to another. Combinations of therapies are more effective generally than one form alone. Withdrawal symptoms are not prevented by nicotine replacement therapy, but the intensity of the symptoms can be reduced.

Varenicline tartrate is a prescription medication that works in the brain to reduce nicotine withdrawal symptoms and cigarette cravings. In several studies, it was more effective than buproprion and placebo. Common side effects of varenicline include nausea and abnormal dreams. In 2007, the FDA reported a small number of people who developed suicidal thoughts and aggressive and erratic behavior during treatment with varenicline. Although some of these suicidal thoughts and abnormal behavior may have been due to quitting smoking, the report states that not all such patients had discontinued smoking.

Bupropion is an antidepressant that is well tolerated usually, but may cause dry mouth and difficulty sleeping. The drug is not recommended for those who have a seizure disorder, head trauma, eating disorder, or who drink excessively.

Tobacco Control

Through a combination of economic, legal, educational, social, and clinical strategies, comprehensive tobacco control programs aim to reduce tobacco use and its associated diseases, disability, economic costs, and death. For example, increases in excise taxes, restrictions on smoking in public places, prevention and cessation programs, and effective antitobacco media campaigns have all been effective interventions to reduce tobacco use. Raising the price of cigarettes is effective in preventing tobacco use amongst adolescents and young adults and in increasing cessation amongst adults. Furthermore, revenue from excise taxes can be used by the government for tobacco control programs. Comprehensive smoke-free laws serve to reduce exposure to secondhand smoke, to reduce the social acceptability of smoking, and to encourage smokers to cut back or quit. The most effective smoking cessation interventions involve a combination of counseling and the use of FDA-approved cessation medications. Integrating population-wide cessation services into comprehensive tobacco control programs has shown great promise. Examples include toll-free telephone services such as the national service 1-800-QUITNOW and the American Cancer Society's Quitline® program 1-877-YES-QUIT. Effective antitobacco media campaigns have included messages that highlight the negative consequences of tobacco use, expose the industry's deceptive marketing tactics, and emphasize social norms that reduce the acceptability of smoking.

There is growing evidence that comprehensive tobacco control programs reduce smoking prevalence and negative health-related outcomes. To sustain the tremendous gains in reducing tobacco use in the USA, continued support of these programs is paramount, despite severe local, state, and national budget cuts.

Related Topics

- ► Addiction and substance abuse
- ► Cancer
- ► Cancer health disparities
- ► Cancer incidence
- ► Cancer mortality
- ► Cancer prevention
- ► Cancer screening
- ► Lifestyle
- ► Life expectancy
- ► Substance use

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Suggested Resources

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Tobacco Use

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Tobacco is one of the most common preventable causes of death. It is estimated that tobacco use kills five million people each year worldwide. Most people use tobacco by smoking cigarettes, cigars, or pipes, but there are also several forms of smokeless tobacco, such as chewing tobacco, moist snuff, or dry snuff. In recent decades an increasing amount of information about tobacco use among immigrant populations and how this behavior changes became available. This information will, among other things, provide information relevant for prevention of future use of Tobacco.

Among immigrant populations in "Western countries," smoking rates vary largely. Most data are available from the USA and some European countries.

The US estimates for 2008 show that, compared to 22% of the non-Hispanic Whites and about 21.3% of the adult African Americans, 15.8% of the Hispanics smoke cigarettes. Among Asian populations smoking rates are about 10% although these figures differ largely between several subpopulations. One study from Canada found that 20.8% of Ethiopian immigrants smoke regularly. Figures about smoking rates in Europe reveal that among the largest immigrant populations, smoking rates vary between 15% among Moroccans in the Netherlands and 47% among Polish migrants in Ireland and about 44–50% among Turks in the Netherlands and Germany. These figures should be compared to the figures of the general populations, i.e., 23.6% in Ireland (above age 15) and 28% in the Netherlands (above age 15) and 27% and Germany, respectively. Figures about cigar smoking are less common. US estimates from 2005 show that 4.6% of the Hispanics and 1.8% of the Asian Americans smoke cigars compared to 5.8% of the general population.

Regarding smokeless tobacco the percentages of use seem to be lower than among the host population, except for the South Asian immigrants. While the prevalence is 0.6% among Asian Americans and 1.3% among the US Hispanics (compared to the US Whites (4.30%)), among South Asians in the UK 9% of men and 16% of women reported using chewing tobacco. This pattern can be explained by tobacco use habits in their countries of origin. Among US youth, percentages ranged from 2.0% among Asian American middle school students to 4.7% among Hispanic middle school students, compared to 10.3% among White high school students and 2.8% among middle school White students.

Historically, tobacco use is more prevalent among males than among females, and in many developing countries this is still the case. In line with these "historic trends," in some immigrant populations female tobacco smoking is still low. For example, among Indian, Pakistani, and Bangladeshi the prevalence of smoking is 5%, 5%, and 2%, respectively, while the smoking rates among men were 20%, 29%, and 40%. A similar pattern was found among Moroccan migrants in the Netherlands. In other groups, such as Turkish migrants in Europe, tobacco smoking is more or less similar to the host population in women and especially high among men; percentages between 40% and 60% were found. In the USA, gender differences are found among Asian Americans (6.1% vs 20.6%) and Hispanics (11.1% vs 21.1).

Although smoking rates are low in some female migrant populations, we can expect an increase in tobacco use in these groups. In recent decades there is increasing knowledge about changes in tobacco use of immigrants towards the tobacco use in the host population. Most knowledge about this topic concerns Hispanics in the USA, but also studies from other groups show similar associations. It appeared that immigrant women, who are more integrated into the host population, are more frequent smokers than those who are less integrated. Among men, however, these associations of smoking patterns with acculturation ("level of integration") are generally not found or are in the other direction, i.e., smoking rates are higher among less integrated men. This might be explained by the fact that smoking is already more prevalent for them in their home country than it was for women.

Changes in smoking prevalence are also found among the younger migrants or migrants' offspring. Among youth in the USA, smoking rates among the Hispanics are highest (16.7%) compared to 7.3% among Asian Americans. Generally it was found that among females born in the host population, the prevalence of tobacco use is higher than in migrants themselves. For example, a larger percentage of Turkish females born in the Netherlands smoke than their migrant peers born in the country of origin. However, in this particular study the percentages among males born in the Netherlands were lower than in those born in Turkey and seem to converge to the smoking rates among the host population. Similar trends were found among Turkish migrants in Germany.

As known among the Western majority population, tobacco use has been associated with socioeconomic status. It is well known from the general population that the prevalence of tobacco use of people in a lower socioeconomic position is higher than among those in a higher socioeconomic position. Also among immigrant populations, associations with education level or poverty have been found, though these associations vary among several groups and gender. For example, in the Turkish and Surinamese migrants in the Netherlands, smoking rates among males are similar to those in the host population and appeared to be higher in the lower education level groups. However, in some age groups, women, especially the higher educated, smoke cigarettes. This pattern seems to be in line with smoking patterns in countries of origin and can be understood in light of the tobacco epidemic, a model that described the smoking through populations across the world as going through four stages. According to this model, smoking increases rapidly from less than 15% among men in the first stage to a peak of 50–80% among men in the second stage. In these stages female prevalence lags behind that of men by one or two decades, but increases rapidly in the second stage. From the third stage onward, a decline in smoking prevalence occurs among men to a percentage of 40% by the end of this stage and also female smoking starts to decline at the end of this stage, reaching a maximum of 35–40%. The fourth stage is characterized by a slow decline in smoking prevalence for both sexes. In this phase an increasing number of prevention programs can be observed. While Western countries are in the last stage, implying that especially more lower educated people smoke, countries where migrants come from are in earlier stages in which a positive association of socioeconomic position with smoking among women have been found.

In conclusion, tobacco use among migrants varies between migrants from different countries and seems to change by influences from both the country of origin and the host population. This information provides insight into how to target those populations most at risk for smoking prevention or smoking cessation interventions.

Related Topics

- ▶ Acculturation
- ▶ Asian Americans
- ▶ Behavioral health
- ▶ Cancer prevention
- ▶ Cardiovascular risk factors
- ▶ Cultural background
- ▶ Disease prevention
- ▶ Ethnic minority group
- ▶ First generation immigrants
- ▶ Foreign-born
- ▶ Germany
- ▶ Health determinants
- ▶ Health education
- ▶ Health promotion
- ▶ Hispanics
- ▶ Latinos
- ▶ Lifestyle
- ▶ Migration
- ▶ Poverty
- ▶ Public health
- ▶ Risk factors for disease
- ▶ Smoking
- ▶ South Asians
- ▶ Substance use
- ▶ Tobacco
- ▶ Tobacco control
- ▶ Women

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Suggested Resources

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Torture

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Torture is the deliberate infliction of severe physical or mental pain or suffering on a person for the purpose of intimidating, coercing, punishing, securing information or a confession, or for any reason based on discrimination. According to international law, torture relates to acts – other than pain or suffering resulting from lawful sanctions – that are performed by persons acting in an official capacity or with their awareness. However, torture occurs in other contexts also, such as crime, domestic violence, and ritual abuse. Examples of torture methods include severe beating, sexual abuse, sensory or sleep deprivation, restraint or being held in uncomfortable positions, extreme temperatures, deafening noises, solitary confinement, and other forms of physical and psychological abuse.

There are at least 400,000 survivors of torture living in the USA. Although torture is illegal under international law and under domestic laws of most countries, it is a standard practice still in more than 100 countries. The US government has documented that 5–35% of refugees arriving in the USA are victims of torture. Torture survivors come to the USA in numerous ways, some with and some without authorization from the US government. International law forbids states to return individuals to their home country if there is reason to believe they will be tortured. The USA offers protection and resettlement to refugees who are processed abroad, as well as asylum and other forms of relief to those already in the country. Generally, asylum seekers are required to apply for asylum within 1 year of their arrival.

Upon their arrival, persons may not suffer from physical scars and debilitating injuries only, but may also develop mental health disorders, including depression and posttraumatic stress disorder (PTSD) – an anxiety disorder that occurs as a result of experiencing a traumatic event. Common symptoms among torture survivors include difficulty concentrating, anxiety, depression, avoidance, emotional numbing, guilt, memories and nightmares of the torture, flashbacks, sleep problems, fatigue, irritability, hypersensitivity and exaggerated startle response, thoughts of suicide, chronic pain in muscles and joints, illness, and other long-term effects. These symptoms can be lifelong and irreparable if not treated by trained professionals.

Nevertheless, generally refugees and immigrants do not report themselves as survivors of torture, and frequently physical or mental health problems resulting from torture remain undetected. In addition to cultural attitudes regarding trauma, various emotions affect survivors' willingness to seek treatment – these include shame, humiliation, and fear of deportation to their home country. Although increasing in recent years, health care providers' knowledge of proper screening and methods to effectively treat torture survivors remains limited.

Often torture survivors have backgrounds as community leaders or grassroots activists; studies have shown that survivors tend to have earned high levels of education and public recognition in their country of origin. Treatment centers report that survivors come from a wide variety of occupations and professions including business, labor, religious, farm, and human rights leaders; attorneys and journalists; university professors and students; and physicians and nurses. The commonality is that they were targeted because of what they thought, said, did, or represented. Perpetrators of politically motivated torture seek to silence opposition by crushing their will and by discouraging others from engaging in public life. This affects the survivor's identity and sense of self profoundly, despite strong personality traits and leadership abilities. The trauma of torture may worsen through the process of escape as survivors may have to cope with the fear that they might be forced to return; potential separation from family members; and the overwhelming nature of adjusting to a new society, culture, and language. Additionally, they may face the challenges of limited finances; poor access to adequate housing, food, and health care; and, depending on their immigration status, no authorization to work from the US government.

Torture can affect all members of a survivor's family, as the survivor's vulnerable mental state and resulting behavior are likely to impact daily family life. Frequently, children of survivors experience learning and behavioral problems, mood swings, violent play or artwork, frequent complaints of pain or illness, fear and anxiety, or avoidance of anything reminding them of the traumatic event.

Mental health care, counseling, and treatment can assist survivors and their family to recover from the trauma, work through the bereavement process, rebuild trust in others, reconnect with family, build skills and confidence, and integrate into their communities. Numerous medical and human rights organizations and centers throughout the USA offer torture survivors specialized treatment and services. Recognizing that many refugees entering the USA have suffered torture, through the Torture Victims Relief Act of 1998 (TVRA), the US government provides funding for treatment and rehabilitative services to assist survivors. Treatment programs vary and may include services from physicians, nurses, psychiatrists, psychologists, counselors, social workers, and religious chaplains. In addition to receiving mental health treatment, these programs work with survivors to ensure that they have stable housing, adequate food and clothing, and access to legal services to help with the challenges of the immigration process.

Some survivors are victimized again or exploited as newcomers to the USA. For example, employers may seek to underpay or overwork them, or – knowing that immigrants may fear deportation if they involve the authorities – perpetrators may rob or abuse them. Treatment programs can assist survivors in avoiding or dealing with such predicaments.

Torture survivors have experienced unthinkable trauma that is likely to impact them psychologically; the effect is long-lasting for some. With proper attention and care, however, survivors can rise beyond their experience of suffering and become integral parts of society.

Related Topics

- ▶ Asylum
- ▶ Depression
- ▶ Emigration
- ▶ First generation immigrants
- ▶ Foreign-born
- ▶ Genocide
- ▶ Global health
- ▶ Limited English proficiency
- ▶ Posttraumatic stress disorder
- ▶ Refugee
- ▶ Refugee camp
- ▶ Refugee health and screening
- ▶ Refugee resettlement
- ▶ Social service needs
- ▶ Translation services
- ▶ Trauma exposure
- ▶ United Nations High Commissioner for Refugees
- ▶ Vulnerable populations

Suggested Resources

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Traditional Chinese Medicine

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Introduction

Classical or traditional Chinese medicine (TCM) refers to the cumulative practices beginning in the first century BC that there were passed down by a small group of the literate minority in China. Since 1949, state-regulated medical practice has come gradually to be divided between biomedicine and a greatly modernized form of the classical art called TCM, and combinations of the two.

Dating back more than 5,000 years, traditional Chinese medicine is grounded in Taoism, which at turns has been defined as both a religion and a philosophy. Taoism was evolved by Lao-tzu and Chuang-tzu, who advocated a life of complete simplicity, naturalness, and of noninterference with the course of natural events. In many of China's medical facilities, TCM is practiced today alongside Western medicine.

Concepts

Traditional Chinese medicine holds a view of the world and the human body that is indicative of the ancient Chinese perception of humans as interconnected with nature and subject to its forces. The human body is regarded as an organic entity – with the various organs, tissues, and other parts having distinct functions, while maintaining a state of interdependence as well. As a consequence, health and disease are viewed relative to the degree that these functions are balanced.

The theoretical framework of TCM is comprised of three key concepts: the Yin-Yang theory, the life force qi, and the eight principles by which symptoms are analyzed and categorized. The Yin-Yang theory holds that all phenomena consist of two opposing yet complementary aspects, which can be defined in a variety of ways, for example, up and down, left and right, hot and cold, and stillness and movement. Furthermore, the theory posits that all developments derive from the movements of yin and yang; this interplay provides the origin of both birth and destruction. The theory, which is central to TCM, holds that the two forces shape the world and all of life.

TCM practitioners contend that within all living things is a vital energy or life force called qi (pronounced "chee"). They propose that qi, as it circulates through a system of bodily pathways called meridians, is influenced by the opposing forces of yin and yang, and that this qi is the life force that regulates one's spiritual, emotional, mental, and physical health. They view health as an ongoing process of maintaining balance and harmony in the circulation of qi.

The TCM approach to medicine employs eight principles by which to analyze and categorize symptoms. The eight principles can be viewed as opposing forces and include cold/heat, interior/exterior, excess/deficiency, and yin/yang. Traditional Chinese medicine employs also the theory of five elements – fire, earth, metal, water, and wood. The elements correspond to particular organs and bodily tissues and are used to explain bodily mechanisms.

Treatment

Practitioners of TCM, emphasizing individualized treatment, used four methods primarily to evaluate a patient's condition: (a) observing, paying particular attention to the tongue; (b) hearing/smelling; (c) asking/interviewing; and (d) touching/palpating, focusing especially on the pulse. Today's TCM practitioners use a variety of therapies to promote well-being and to treat disease; the most commonly used therapies are Chinese herbal medicine and acupuncture. A pharmacological reference book used by TCM practitioners, the *Chinese Materia Medica*, contains hundreds of medicinal substances, including plants, minerals, and animal products – all classified by their perceived action in the body. Herbs are combined usually in formulas and given as teas, capsules, tinctures, or powders. Acupuncture is used to stimulate specific points on the body. This is accomplished by inserting thin metal needles through the skin, as practitioners seek to remove blockages in the flow of qi. Other TCM therapies include moxibustion, burning a cone or stick of dried herb, flowers, leaves, bark, fruit, seeds, stems, or roots on or near the skin; cupping, applying a heated cup to the skin to create a slight suction; Chinese massage; mind–body therapies such as qi gong and tai chi; and dietary therapy.

Popularity

In the United States, TCM falls under the category of complementary and alternative medicine (CAM). While not considered at present to be part of conventional medicine, CAM is comprised of a variety of diverse medical and health care systems, practices, and products that appear to be gaining acceptance and use, if not by the medical community at large, than by the more than three million adults who turn to TCM-related therapies each year. It should be noted that complementary medicine is used in conjunction with conventional medicine, while alternative medicine is used in place of conventional medicine.

Although it is unknown the exact number of those in the United States who use TCM, in 1997 it was estimated that more than one million patients were served each year by approximately 10,000 practitioners who employed one or more TCM therapies. The 2007 National Health Interview Survey included questions on the use of various therapies related to TCM, and an estimated 3.1 million US adults reported that they had used acupuncture within the most recent 12 months. Furthermore, approximately 17% of adults reported using natural products, including herbs – giving it the distinction of being the most commonly used therapy.

Related Topics

► Acupressure
► Acupuncture
► Cupping

Suggested Readings

Halpern, G. & Miller, A. H. (2002). *Medicinal mushrooms ancient remedies for modern ailments.* New York: M.Evans & Company

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Suggested Resources

For information on the Acupuncture and Integrative Medicine College. Berkeley: http://aimc.edu/

For information on the Institute of Chinese Herbology. http://www.ich – herbschool.com/

For information on the National Center for Complementary and Alternative Medicine. http://nccam.nih.gov/

National Institutes of Health Consensus Panel. *Acupuncture: National Institutes of Health Consensus development conference statement.* http://consensus.nih.gov/1997/1997acupuncture107html.htm

Trafficking

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Human trafficking is a form of exploitation that involves controlling and transporting people through the use of force, deception, or coercion. The end result is that people are moved, often by smuggling or under false pretences such as tourist visas, from one area or nation into another. The nature of the exploitation is often forced labor for little or no pay in unsafe conditions. Other reasons for trafficking include involuntary prostitution, forced marriage, recruiting child soldiers, and the trafficking of babies and children for adoption. It is reported to be the third most profitable criminal activity in the world after drug and gun smuggling and resulted in estimated profits of US$31 billion in 2008.

Credible estimates of the number of people moved by human traffickers each year ranges from 500,000 to 4 million depending on the definitions used. Most United Nations and United States government data suggest that the number is greater than 1.5 million people annually, although that figure may be heavily weighted to count only women and children, whereas the larger estimate of four million includes men trafficked primarily to be exploited for labor purposes.

Citizens of Albania, Belarus, Bulgaria, China, Moldova, Nigeria, Thailand, and Ukraine are reported as the most likely to be the victims of trafficking; the most common destinations for human trafficking operations are Belgium, Germany, Israel, Italy, Japan, the Netherlands, Thailand, Turkey, and the United States. Thailand is notably listed as both a source of victims and a destination; Thai women are primarily sent to Japan, Malaysia, Singapore, Taiwan, Hong Kong, Bahrain, Australia, South Africa, Europe, and the United States, chiefly for sexual exploitation, but also to some destinations for sweatshop labor. Men, especially migrant workers from Burma (Myanmar), are trafficked into Thailand to commercial fisheries, seafood processing plants, and for farm, industrial, and construction labor. This pattern shows how trafficking can mimic the supply and demand of a labor market in response to economic conditions.

However trafficking is more than a black market for unscrupulous suppliers and employers to obtain cheap labor; it also represents a form of control. This is demonstrated by the trafficking of women between Cambodia and Vietnam for exploitation as forced sex workers; both nations are relatively poor, but the flow of trafficked women goes both ways. There are two reasons for this. First, agents in both places act as way-stations to move the women on to industrialized nations. Second, within each local sex industry, the foreign women are perceived to be more compliant and less resistant when they are in a strange country with unfamiliar language, customs, and geography. In a foreign land, they are unaware of resources to help them escape and may be subject to prosecution as illegal immigrants if they approach the police. The victims feel isolated and may see their captors as their only hope for survival, putting the captor in a powerful situation both physically and psychologically. Even the victims' employers or customers, who do not speak their language, may not realize that they are unwilling participants.

Internationally, these activities are performed by a disparate collection of entities from individuals seeking personal gain to well-established organized crime and militaristic enterprises. Combating human trafficking is difficult due to discordant national laws, prosecutorial incentives, social-cultural practices, and economic conditions. Although trafficking is most intense when nations of disparate economic status are in close proximity (e.g., Italy and Albania, Burma and Thailand), the low costs associated with international travel mean that it has expanded well beyond being a border issue.

Who Are the Victims of Human Trafficking?

In most cases, victims of trafficking are distinguishable by their experience: Women describe being promised jobs in the hospitality industry, modelling, or domestic labor and find themselves forced to work as prostitutes. These women tell stories of various forms of coercion: being beaten, starved when they do not cooperate, raped, locked in brothels, having their families threatened, having their passports or money taken, threatened with police prosecution as illegal immigrants, and having the wages of their sex work confiscated. In some cases, they are required to service as many as 20–30 men each day. Other women find themselves sold to individuals as wives, sexual slaves, domestic laborers, or a combination of roles. Migrant workers (legal or otherwise) are reclassified as victims of trafficking when they are transported to a new area and forced to maintain their jobs against their will or when they unknowningly enter indentured servitude. Illegal immigrants are frequently caught in this predicament, as the smugglers who bring them into the country (for an up-front fee) announce upon arrival that the debt has ballooned upwards; this is usually accompanied by threats or violence.

Targets of human trafficking can be surprisingly varied. Many victims are poorly educated, impoverished, and desperate to support themselves or their families, or they are refugees fleeing persecution or conflict. There are numerous accounts of children and orphans being sold by families to traffickers; this sometimes occurs when a child is sold to a brothel procurer for a sum against the child's future earnings in the brothel. There is also outright kidnapping and transportation, primarily of women and children. However, some victims are tricked by sophisticated con artists into thinking they are seeking legitimate opportunities for immigration or employment.

Like all criminal activities, there are gray areas in trafficking; for example, some impoverished villages will take on a collective debt to send one or more of its members, often illegally, to a nation where there is perceived to be lucrative work. Knowing of the debt, the individuals may undertake work in unsafe conditions, suffer harassment or deprivation, or engage in sex work to pay back the original debt. The debt may be at usurious interest rates and owed to illegal lenders, the smuggling across borders may be illegal, and the work may be exploitive. But it is not clear that if the exploitation is not directly linked to the transport of people as a criminal enterprise as to whether or not it is human trafficking. Some would argue that there must be a combination of movement from one area to another by deception/coercion/force as well as ongoing pressure to maintain an exploitative position in order to be trafficking. Others argue that it is too narrow a definition. It is also crucial to realize that trafficking does not require transport across national borders; it can involve enterprises intra-nationally from one region to another, and this is noted to occur in Thailand, China, Russia, and other nations with a diverse range of cultures and large geographic expanse.

Children make almost 20% of human trafficking victims according to the United Nations Office on Drugs and Crime (UNODC). Children are trafficked for begging, prostitution, street vending, selling flowers, and cheap labor, as well as to be put up for adoption or to act as soldiers. The children frequently are placed into debt bondage to beg or sell, or they form parts of organized begging rings, and this happens even when there is no family debt or economic hardship. In Cambodia, a local nongovernmental agency study found that 76% of trafficked children sent to Thailand came from families who owned land, 93% of families owned their own house and had no debt on the land or house, and 47% stated that their mother was the facilitator. Primarily but not exclusively used in sub-Saharan Africa and Southeast Asia, child soldiers can be strongly indoctrinated in the military unit as family and are sometimes taught that their leaders have god-like powers. In these cases, the children are told they are fighting for a divine cause and can be used effectively as suicide squads and human shields. Men are primarily trafficked for exploitation in dangerous jobs such as mining and quarrying in areas with unsafe conditions but also for agriculture, light industry, household labor, and the sex industry.

Who Are Human Traffickers?

Like many criminal enterprises, the operators range from individual entrepreneurs (such as pimps and local drug dealers) to complex multinational organizations that systematically transport and exploit migrant workers (e.g., some subcontractors in the seafood and textile industry). According to the UN, almost 80% of the activity is centered around sex workers, and trade is commonly carried out by small to medium organized crime syndicates who specialize in target regions (e.g., Moldavia) and send their victims to specific distribution regions (e.g., particular brothels in Italy or the Netherlands). In Southeast Asia, this activity seems to be specialized work of its own, while in Europe many of the organizations involved are also smuggling and transporting drugs, and the trafficking is a sideline. It has been reported that women and men have been forced to act as drug smugglers (referred to as "drug mules") by either transporting or ingesting sealed packets of drugs to be excreted at their destination, where they are then pressed into service as sex workers.

In warzones, captives may be transported and sold by military forces. War seems to attract human traffickers, as they supply men for involuntary conscription and women for sex slavery, sometimes to both sides of a conflict, with little fear of authority. Narco-terrorist groups are reported to kidnap and coerce workers across borders to participate in drug harvest and production, using their armed forces to keep the workers under control. Recent natural disasters such as the 2005 Boxing Day tsunami and 2010 earthquake in Haiti have also shown that human traffickers see any chaotic circumstances as an opportunity to profit, particularly in terms of trafficking children.

Human trafficking is almost universally condemned, and most international organizations have a statement of position on trafficking, but there is little coordination in efforts to combat it. Involved in the fight are at least eight agencies and units of the United Nations – primarily the UNODC, the UN Inter-Agency Project on Human Trafficking (UNIAP – focusing on nations bordering the Mekong region), the UN High Commissioner on Refugees, and the UN Children's Fund (UNICEF). Also involved are the European Union, Interpol, the Association of Southeast Asian Nations, several agencies of the United States Government which offer international support, and many nongovernmental organizations which operate internationally to increase awareness and locally to help victims of trafficking. Unfortunately, the cumulative budgets of these agencies and organizations are less than 0.5% of the profit cleared by traffickers.

If human traffickers are prosecuted, it is commonly when the activity is discovered during drug raids rather than as a target of investigations into trafficking itself. Human trafficking is rarely a primary target for investigation and prosecution for many reasons: It is not recognized, the impact is not understood, the victims are seen as being "from somewhere else" or illegal immigrants, or the local authorities are under-resourced or corrupt. Human trafficking as an enterprise is illegal in most countries, and there are many bilateral and multilateral national agreements against it, but they have had limited practical effect.

The impact of trafficking can be devastating. In Africa and Asia, it is a major contributor to the spread of HIV; sex workers who are trafficked may be prohibited from using condoms or from being tested because the brothel owner can charge a higher fee for unprotected sex. Young girls may be trafficked specifically to sell their virginity or for violent sexual practices that result in permanent physical as well as psychological damage. Trafficking puts men, women, and children into occupational risk where injury or death is common due to unsafe conditions; because the immigration status of these workers is questionable, usually they are not eligible for local health care resources and end up destitute on the street. On a larger scale, human trafficking is disruptive to the efforts of organized labor and corporations that attempt to follow national standards and laws for occupational safety regulations or provide benefits for their employees. When competing with companies that use labor from human trafficking, legal enterprises will always be at a financial disadvantage. On a purely economic level, the same principle applies to brothel owners and explains why so much of human trafficking is associated with the sex industry; brothels with women who are victims of human trafficking provide worse conditions and allow unsafe practices, thus undercutting the fees of other sex workers.

Related Topics

- ▶ Eastern Europe
- ▶ Irregular immigration
- ▶ Labor migration
- ▶ Posttraumatic stress disorder
- ▶ Prostitution
- ▶ Sex work and sex workers
- ▶ Southeast Asia
- ▶ T visa
- ▶ Trafficking Victims Protection Act
- ▶ U visa
- ▶ Violence

Suggested Resources

A non-governmental organization website (formerly supported by the US Department of State). http://www.humantrafficking.org

Belser, P. et al. *Forced Labor and Human Trafficking: Estimating the profits. Cornell University/International Labor Organization.* Retrieved March 3, 2010, from http://digitalcommons.ilr.cornell.edu/forcedlabor/17/

UN Office on Drugs and Crime Human Trafficking and migrant smuggling website: http://www.unodc.org/unodc/en/human-trafficking/index.htmlhttp://www.unodc.org/unodc/en/human-trafficking/index.html

United Nations Education, Scientific and Cultural Organization. *Statistics project on human trafficking.* Retrieved on March 3, 2010, from http://www.unescobkk.org/index.php?id=1022

United States Department of State. (2009). *Trafficking in persons report 2009 – Cambodia.* Retrieved March 9, 2010, from http://www.unhcr.org/refworld/docid/4a4214c82d.html

Trafficking Victims Protection Act

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Overview

In the past decade, human trafficking has emerged as a major criminal and social justice issue, both in the United States and abroad. Largely due to the scarcity of empirical studies on human trafficking, there is some lack of agreement on statistics of human trafficking. However, the US Department of State's 2008 *Trafficking in Persons Report* (*TIP*) estimated that there are 800,000 victims of human trafficking worldwide, and the Polaris Project, one of the major US antihuman trafficking organizations, estimates 200,000 American minors are at risk for human trafficking. The attention paid to human trafficking in the 1990s, positioned the United States as a global leader in efforts to understand the human trafficking issue and ensure effective responses from human rights and victim-center perspectives.

Landmark acts such as the Trafficking Victims Protection Act (TVPA), signed by President Clinton in 2000, and the Trafficking Victims Protection Reauthorization Acts of 2003, 2005, and 2008 have set domestic and international standards for various aspects of human trafficking, including prevention, prosecution of traffickers, and protection of victims. Each reauthorization reflects our growing understanding of this crime and provides for new and enhanced mechanisms to address the new main types of trafficking: forced labor or sex trafficking. Mechanisms include the continued and additional allocation of resources to combat the issue, approaches for improvement in collaborative efforts between law enforcement and social services, the expansion and clarity of vulnerable groups and definitions of victims, a call for additional research and evaluation, and the assurance of assistance for all victims.

Relevance for Immigrant Communities

International victims of human trafficking fall into two broad categories: those trafficked for sex and those trafficked for labor. Women and children trafficked into sex industries are often forced into activities such as prostitution and pornography. Since female victims and male perpetrators are the foundation of the sex trafficking trade, the roles of victims and perpetrators merit gender-focused strategies to combat sex trafficking. Victims of labor trafficking may be forced into domestic servitude or industrial labor. One crucial component in labor trafficking is migration. Industries that demand cheap labor – agriculture, construction, fisheries, manufacturing, and construction – encourage migration of unskilled workers. Victims may also be trafficked to maintain panhandling operations. In the absence of standards to protect their human rights, migrants become particularly vulnerable to exploitation. While sex trafficking receives a great deal of attention, some believe that labor trafficking is actually in greater demand, and that law enforcement agencies in border states are more than twice as likely to have investigated human trafficking cases than non-border states. Victims that are certified by law enforcement are entitled to legal remedies including the T Visa.

Related Topics

- ► Labor migration
- ► Sex work and sex workers
- ► T visa
- ► Trafficking
- ► U visa

Suggested Readings

Banzon, M. Y. (2005). Combating trafficking in persons through gender-focused strategy. *United Nations Publications, 42*(1), 56.

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Feingold, D. A. (2005). Human trafficking. *Foreign Policy, 150*, 26–30.

Richards, K. (2004). The trafficking of migrant workers: What are the links between labour trafficking and corruption? *International Migration, 42*(5), 147–168.

Suggested Resources

Farrell, A., McDevitt, J., & Fahy, S. (2008). *Understanding and improving law enforcement responses to human trafficking.* Boston: Institute on Race and Justice at Northeastern University. Retrieved March 1, 2009, from http://www.ojp.usdoj.gov/nij/

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National Human Trafficking Resource Center & Hotline 1.888.3737.888

Polaris Project Website: http://www.polarisproject.org

U.S. Department of State. *Trafficking in persons report* (*TIP*). http://www.state.gov/g/tip/rls/tiprpt/2009/

The U.S. Department of Justice, Office of Justice Programs, & Bureau of Justice Statistics. (2007–2008). *Characteristics of suspected human trafficking incidents, 2007–2008.* Washington, DC: Author. http://www.ojp.usdoj.gov/bjs/pub/pdf/cshti08.pdf

Trafficking Victims Protection Reauthorization Act

► Trafficking Victims Protection Act

Transcultural Psychiatry

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Transcultural psychiatry is a branch of psychiatry concerned with the cultural context of mental illness. Although there is a belief in the universality of major mental illnesses such as mood disorders and schizophrenia, cultural factors shape the manifestation and explanatory model of a given illness, as well as its diagnosis and treatment approach. For example, Caucasian Americans with depression commonly describe feelings of sadness and guilt, while Asian Americans may focus more on somatic symptoms, such as pain or fatigue. There are some syndromes that appear to manifest only in specific societies or cultural areas and do not clearly fit into the diagnostic categories of Western psychiatry. These are referred to as culture-bound, or culture-specific syndromes in Western psychiatry. One example is *Amok*, an illness described in Malaysia in which an individual, typically a male with no history of aggressive behavior, will acquire a weapon and attempt to kill or seriously injure anyone he encounters.

Transcultural psychiatry was first established as a distinct, yet interconnected discipline in 1956 when the departments of psychiatry and anthropology at McGill University published *Transcultural Research in Mental Health Problems* under the guidance of Eric Wittkower. Wittkower, a psychiatrist who served the British during World War II, observed the profound effects of culture and environment on individuals during the war. He and other psychiatrists began to see that much of the mental illness they encountered was related to the wider sociocultural context.

Over the next several decades, transcultural psychiatry societies began to form around the world. Members emphasized the role of culture in psychiatric assessment and promoted equal access to mental health care regardless of race, gender, or culture. There was also a movement toward uncovering racism in psychiatry and conducting culturally appropriate research. Until recently, the majority of research subjects in psychiatry have been Caucasian males. When Western psychiatry became more biologically oriented in the 1980s and attempted to establish universal mental illness categories in the American Psychiatric Association's *Diagnostic and Statistical Manual* (*DSM*), there was a shift away from the social sciences and a schism developed between psychiatry and anthropology. Anthropologists continued to emphasize the importance of understanding disease in terms of a patient's culture within the framework of cultural relativism, a concept introduced by Arthur Kleinman. Cultural relativism is the idea that culture not only shapes illness as an experience, it shapes the very way we conceive illness. Kleinman argued that Western psychiatry imposes Western categories of mental illness as if they were not culturally derived.

With the development of the fourth edition of the *Diagnostic and Statistical Manual* (DSM) in the 1990s, renewed attention was given to the role of culture in psychiatric assessment. Culture-bound syndromes were described in DSM-IV and several of the most common syndromes were listed. Today transcultural psychiatry encompasses ideas common to both Western, biologically oriented psychiatry and cultural relativism, and providers attempt to modify treatment in accordance with cultural variation. For example, transcultural psychiatrists recognize the potential for interethnic variation in response to drugs, and attempt to involve indigenous healers when appropriate. A belief in the universality of the major psychiatric illnesses is tempered with a need to understand illness in terms of local culture.

Related Topics

- ► Amok
- ► Culture-specific diagnoses
- ► Mood disorders
- ► Pibloktoq
- ► Schizophrenia

Suggested Readings

Al-Issa, I. (1995). *Handbook of culture and mental illness: An international perspective*. Madison: International Universities Press.

American Psychological Association. (2000). *Diagnostic and statistical manual*, 4th edition, text revision (DSM-IV-TR). Washington, DC: Author.

Bains, J. (2005). Race, culture, and psychiatry: A history of transcultural psychiatry. *History of Psychiatry, 16*, 139–154.

Bhugra, D., & Bhui, K. (2007). *Culture and mental health: A comprehensive textbook*. New York: Oxford University Press.

Gaw, A. (2001). *Concise guide to cross-cultural psychiatry*. Washington, DC: American Psychiatric Press.

Geogipoulos, A. M., & Rosenbaum, J. F. (2005). *Perspectives in cross-cultural psychiatry*. Philadelphia: Lippincott Williams & Wilkins.

Suggested Resources

The Foundation for Psychocultural Research. http://www.thefpr.org/

World Health Organization. http://www.who.int/topics/mental_disorders/en/

Transitions

- ► Cultural adaptation resources
- ► Culture shock

Translation Services

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Introduction

Since the Immigration and Nationality Act of 1965, the number of first-generation immigrants living in the United States has quadrupled to more than 38 million in 2007. Greater than 17% of the US population speaks a language other than English at home, and these numbers are increasing. Affordable housing, jobs, and access to health services consistently are reported as chief among immigrants' needs. While there are a variety of social services aimed at meeting these, a primary barrier to access to these services, especially health care, is language. It is critical that the growing numbers of limited English proficient (LEP) residents be able to communicate with their health care providers.

Role of Translation Services

In no sector are translation services needed more than in the area of health care. Research has shown that compared to individuals who are proficient in English, individuals with limited English proficiency are more likely to go without needed medical care. All patients, immigrant and native-born alike, come to the health care setting with varying degrees of health literacy skills. For the immigrant, culture and language create the context in which he or she must acquire and apply health literacy skills. Given the growing proportion of US residents with limited English proficiency, it is crucial in health care settings that potential language barriers are addressed.

Translation Services and Quality of Experience

In terms of how non-Western immigrants assess the quality of their experience with Western medicine, recent studies have suggested that patients with limited English proficiency frequently wish to discuss the use of non-Western medical practices with their providers, but that they encounter significant barriers. Language and quality of translator services are two such obstacles. Studies indicate that patients place a high value on the quality of the interpreter services, preferring to use professional translators rather than family members, and preferring same gender translators.

Providing Translation Services

With the passage of Executive Order 13166 (EO 13166) – Improving Access to Services for Persons with Limited English Proficiency – each federal agency is tasked with taking steps to provide access to its federally conducted activities. EO 13166 was designed to provide persons who have limited English proficiency (LEP) with greater access to federal programs and activities. This order has had significant impact on health care organizations that are supported in whole or in part by federal dollars. They are required to provide at no cost to the patient/consumer with LEP, language assistance services – including bilingual staff and interpreter services at all points of contact during all hours of operation. The order further mandates that translator services: (1) must be provided to patients, in their preferred language, both verbal offers and written notices informing them of their right to receive language assistance services; (2) must assure the competence of language assistance provided to LEP patients by interpreters and bilingual staff; (3) must make available easily understood patient-related materials and post signage in the languages of the commonly encountered group and/or groups represented in the service area; and (4) must ensure that data on the individual patient's race, ethnicity, and spoken and written language are collected in health records, integrated into the organization's management information systems, and periodically updated.

Outcomes

Multiple studies document that quality of care is compromised when LEP patients need but do not receive interpreter services. Their quality of care is inferior, and more interpreter errors occur – often due to the use of untrained or ad hoc interpreters. Inadequate interpreter or translator services can have serious consequences for patients. Research has shown this is especially true for patients with mental disorders. Trained professional interpreters and bilingual health care providers positively affect LEP patients' satisfaction, quality of care, and health outcomes. Evidence suggests that optimal communication, patient satisfaction, and the fewest interpreter errors occur when LEP patients have access to trained professional interpreters or bilingual providers.

Related Topics

- ► Access to care
- ► Cultural adaptation resources
- ► Health barriers
- ► Health care
- ► Health care utilization
- ► Health literacy
- ► Health outcomes
- ► Health services utilization
- ► Language
- ► Limited English proficiency
- ► Physician–patient communication
- ► Refugee health and screening

Suggested Readings

Flores, G. (2005). The impact of medical interpreter services on the quality of health care: A systematic review. *Medical Care Research & Review, 62*(3), 255–299. doi:10.1177/1077558705275416.

Galbis-Reig, D. (2002). Assessing medical translation services on the internet. *Internet Journal of Law, Healthcare & Ethics, 1*(1), 11. Retrieved from Academic Search Premier database.

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Singleton, K., & Krause, E. (2009). Understanding cultural and linguistic barriers to health literacy. *Online Journal of Issues in Nursing, 14*(3), 2. Retrieved from Academic Search Premier database.

Suggested Resources

For information on international medical interpreter services: http://www.imiaweb.org

For information on limited English proficiency: http://www.justice.gov

Transnational Community

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The social pathways by which international migrants move between countries are typically well worn, following previously established networks of relatives and friends. This commonly manifests in the creation of communities where substantial numbers of people are from a single "sending" community. For example, in Plymouth, Indiana most of the people of Mexican origin originated from the small town of Santiago Capitiro, in the Central Mexican state of Guanajuato. Since migration typically follows established social pathways, what started as a single individual temporarily leaving to work in the USA eventually led to over 1200 people from that one *pueblacito* (small town) who have settled permanently in Plymouth. However, while they have settled in Plymouth they maintain significant ties and involvements back in Capitiro. The end result illustrates the principle outlined by anthropologist Glick Schiller et al., that Capitiro and Plymouth have become intertwined within a larger "transnational social field" composed of family ties, social networks, clubs, and associations of co-nationals (paisanos), and participation in government programs of Mexico, all of which allow people to stay socially, politically, and economically involved in more than one community. What makes this situation "transnational" is that people maintain economic, political, and social involvements in both countries simultaneously.

Even when people are not physically present they can use other means, notably financial remittances, to stay involved in their home community. The Mexican government actually initiated a program to encourage investment back home. Known as "tres por uno" (3 for 1), it matches each dollar intended for community infrastructure projects with three dollars from the federal, state, and municipal government. Researchers in the Mexican Migration Project identified a common pattern among Mexican immigrants in the USA, who joined social clubs with co-nationals and invested their savings and remittances in a home, business, or community improvement, a practice that signified continued membership in their home community.

The increasingly common practice of living transnational lives has pushed the boundaries of understanding the meaning of community. Transnational migrants are in fact constituting multiple sites of what were originally specific, geographically bounded communities. The annual festivals in the "hometown" often become times when its citizens from transnational branch communities celebrate and reestablish their communal identity.

Transnational lives are also stretching our understanding of political loyalty. People in transnational communities claim to be able to make significant contributions to social and political institutions in both societies, not limited to one or the other. In fact both Haiti and Mexico consider their citizens who live in the USA to be important actors in the political and economic life of the nation.

Transnational migration creates different types of family configurations. Migration in general is challenging for families. Transnational communities often have families in which one or more parent is gone for significant amounts of time. It is not uncommon for children to be under the care of extended family, grandparents, or aunts, as parents seek to find means to secure the longer term well-being of the family through labor migration.

Transnational communities are not new, but the pace of migration, globalization, and means by which people can move and participate in multiple communities is unprecedented. More than ever, in the words of anthropologist Karen Richman, communities have become "intimately linked" through migration. Ultimately, the ability to understand the lives of immigrants is realized through understanding the transnational and "multi-sited" nature of their lives.

Related Topics

- ► Chain migration
- ► Immigrant visa status
- ► Immigration status

Suggested Readings

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Transnational Competence

- ► Cultural competence
- ► Cultural humility

Transnational Health

- ► Border health
- ► Cross-cultural health
- ► Cross-cultural medicine

Trauma

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Trauma encompasses both physical trauma and emotional trauma. It can be caused by a natural disaster, by intentional acts of individuals, or as the result of an accident. Common causes of trauma include being present in a war area; being the victim of a terrorist act; being caught in a natural disaster such as a fire, hurricane, earthquake, tornado; undergoing a surgical procedure; and experiencing the divorce from or death of a loved one.

Trauma and traumatism have often been confused. Trauma is the wound made by an injury, whereas traumatism is its result. The term traumatology refers to the study of natural traumas and of traumas caused by people and of their psychobiological consequences. At one time, the term "trauma" was used in medicine, especially in surgery, to designate the lesion caused by an external aggression. Freud utilized this term in the psychoanalytical context and attributed its cause to three possible explanations: violent shock, burglary, and the negative effect of an external factor on the body. Some psychologists have defined trauma as an event of extremely large intensity that manifests in an individual's life and goes beyond the individual's power to adapt. Another definition refers to an influx of excessive excitation that goes beyond the tolerability level of the individual.

Immigrants are potentially vulnerable to trauma due to their increased exposure to social, economic, and professional instability. Immigrants' poverty, lack of employment opportunities, lack of health insurance and adequate health care, and discrimination by individuals of their receiving countries may result in their increased vulnerability to physical and psychological trauma.

Immigrants may experience psychological trauma from the first moment they come into contact with the new society, depending upon the level of risk factors mentioned above; untreated, the trauma can develop into a more or less disabling mental illness. According to the *Diagnostic and Statistical Manual* published by the American Psychiatric Association, psychoemotional trauma is known as posttraumatic stress disorder.

Psychological trauma is a very intense emotion that results in a permanent psychological change, often evidenced by the person's excessive sensitivity to subsequent emotions. A psychological trauma represents a disorder in the individual's psychological life, *generating long-term pathogenic effects*. The fourth edition of the *Diagnostic and Statistical Manual* and the tenth edition of the *International Classification of Disease*, both of which are used for diagnostic classification purposes, support the idea that a trauma relates to an event that has already passed when the symptoms of the disorder appear. A trauma is not just an external stress, nor is it a simple state of mind; rather, it appears when the new event meets the experience that the individual has undergone. When the traumatic conditions of the environment and the subjective meaning that the individual attributes to these conditions interact, we can talk about a traumatic situation. The shock reaction has three stages:

1. The shock stage occurs 1 h to one week following the event. After the event has passed, the individual becomes aware of the proportion of the event. This stage is characterized by: apparent sensitivity, negation, alteration of time perception.
2. The action stage, which appears after a period of time has passed since the event, lasts up to 2 weeks. The individual has the following reactions: anger, self-doubt, depression, feelings of helplessness, inability to see the positive side of things, sleep disorders, irritability, hypervigilance, and frequent flashbacks from the traumatic situation.
3. During the relief stage, some types of behavior from the action stage may still persist and help may be needed. Drugs and alcohol must be avoided during this period.

Posttraumatic stress syndrome symptoms can manifest in the following ways: nightmares or flashbacks from the trauma, meaning that the individual has the impression that the accident is happening again; avoidance of places and things that can stir memories; the so-called paralyzed trauma and lack of interest for certain things; shivering; a continuous feeling of dissatisfaction; insomnia; and lack of concentration. Some people may experience depression or feelings of guilt or anger. In the case of children, posttraumatic reactions take the form of repetitive actions. These symptoms can appear shortly after the trauma or they can disappear and then appear again.

The symptoms can last for months and sometimes they are so serious that they can affect the individual's personal and professional life. Initially, the individual may deny or be unaware of the loss (of psychosocial balance, persons, bodily integrity, etc.). It appears as a reaction to the initial shock when the individual's life is deeply affected. In most cases, survivors remain self-focused for a long period of time. Then, in order to be able to deal with questions such as "Who am I?" "Why did this happen to me?" "What is happening with my life?" "Will I be able to deal with my new life?" the individual denies his or her own feelings. In trying to hide his or her emotions from others, the individual may become depressed, work excessively, or consume excessive quantities of alcohol or drugs. The social support of friends and family members may be critical to the individual's recovery.

Psychological trauma situations may be classified based on the level of severity, the number of traumatic circumstances, and the manner of action of the event (direct or indirect). According to the gravity level of the traumatogenic factors, we can distinguish:

- Mild trauma situations, such as a change of school for children or moderate family fights in the case of adults
- Medium trauma situations, e.g., school expulsion or the birth of a sibling in the case of a child or the diagnosis of a chronic disease in the case of an adult
- Severe trauma situations, such as the separation, death, or divorce of one's parents, or an undesired pregnancy
- Extremely severe trauma situations, such as experiencing sexual abuse, bodily injury, or the death of a spouse
- Catastrophic trauma situations, such as the death of a child, a spouse's suicide or attempted suicide, or a natural disaster

Trauma can also be classified based on the accumulation of traumatizing events.

Monotrauma refers to a single, uncommon situation that the individual experiences. *Polytrauma* appears when there are multiple trauma circumstances that last in time. They can occur either simultaneously (coexistence of trauma events) or sequentially. When events occur sequentially, the effects may be cumulative, remaining at the subliminal level of the individual's mind, or sequential, so that there is a certain coherence in these sequential events. Each new event determines a chain reaction that is amplified when a new event occurs.

We can also distinguish between direct trauma, when the victim is the traumatized person; secondary trauma (indirect trauma), when persons from the victim's group are affected; tertiary trauma (indirect trauma), when future generations are affected; and vicarious trauma, affecting those who help those affected directly, such as firefighters and police officers. In some cases, the trauma may be both direct and vicarious, as in the case of emergency medical personnel who must tend to the traumatized victims of a disaster and who are traumatized themselves by the sight of what they must deal with.

Trauma is also classifiable based on the relationship between the perpetrator and the victim. Simple trauma situations involve an event in which the victim is unknown to the criminal. Complex trauma situations refer to situations in which the criminal is someone familiar to the victim.

Clinicians must also consider the possibility of an adaptation disorder. The predominant symptoms that characterize an adaptation disorder are feelings of depression, anxiety, behavioral disorders (battering, vandalism, reckless driving), or other maladaptive reactions (physical problems, academic or professional inhibition, social isolation). An adaptation disorder can last no more than 6 months, even though the triggering factors are still going on or have consequences that are still going on.

Individuals may respond to traumatic events using different trauma coping styles. These include:

- Instrumental coping, which is a defense mechanism that the person uses when he or she wants to solve the problem
- Expressive coping, that is, an attempt to communicate about the trauma
- Cognitive restructuring coping, which can be positive (the person's attempt to understand better what has happened, to explain the cause, to overcome the situation) or negative (negation or fragmentation)
- Resilient coping, or an attempt to repel the event

Other coping strategies that may be beneficial for some individuals include a regular eating, sleeping, and working schedule; allowing extra time to accomplish current duties; the mental repetition of the positive acts that the person would do in case "this happens again"; participating in recreational exercises such as nature walks or trips; understanding the psychological basis for physical symptoms (for example, shoulder pains can be interpreted as "carrying a burden which is too heavy"); having therapeutic massage for release of body tension; describing personal experiences in diaries or personal letters; avoiding the transformation of the event into an obsession, by reading about it in newspapers, magazines, or by watching television or listening to radio reports; becoming aware of the fact that people need various periods of time to recover after a trauma; learning relaxation techniques such as progressive muscle relaxation; joining a support group; and forgiving the person who caused the trauma. Unfortunately, many of these strategies are not often available to those immigrants who lack a stable social and financial situation that would allow them to have access to specialized services.

Related Topics

► Posttraumatic stress disorder
► Torture
► Trafficking
► Trauma exposure
► Violence

Suggested Readings

American Psychiatric Association. (2000). *Diagnostic and statistical manual, text revision (DSM-IV-TR)* (4th ed.). Washington, DC: Author.

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Suggested Resources

National Center for PTSD. http://www.ptsd.va.gov/

Trauma Survivors Network. http://www.traumasurvivorsnetwork.org/

Trauma Exposure

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Trauma exposure varies widely for immigrants. It is defined as witnessing or experiencing real or perceived life-threatening events. Traumatic events include war, acts of terrorism, torture, natural disasters, sexual violence, physical abuse, accidents, community violence, and political violence. Trauma exposure includes the death of friends and family, whether or not one witnessed the death. It can include traumatic separation and loss; some traumatic separations are related to uncertainty regarding a loved one's status. When natural disasters, wars, and other life disruptions occur, it may not be clear whether family members are alive or dead. This question will never be resolved for some, thus requiring immigrants to learn to live with the uncertainty.

Community violence is violence in the larger community, violence that one witnesses or experiences that is perpetrated by people who are not related intimately to the victim. Political violence is related to political goals; this includes people acting violently to change their government. However, for most immigrants and refugees it refers to governments using violence to control the populace. Trauma exposure may lead to a variety of mental and physical health problems. Previous trauma exposure may be exacerbated by experiences related to the migration process. Trauma exposure and individual migrant experiences are influenced by age, culture, and other life experiences. Assessment of the impact of trauma exposure is complicated by cultural and language differences.

Refugees in particular are likely to have trauma exposure, and often they experience multiple incidents of trauma exposure. Research identifies over 50% of refugee populations as experiencing some form of trauma prior to migration, with many refugees experiencing multiple traumas. Many refugees are coping well despite their trauma exposure; however, trauma exposure is an important predictor of mental health status. Approximately 10% of refugees will have a diagnosable mental disorder; the most common mental disorders diagnosed in refugees are posttraumatic stress disorder (PTSD), anxiety disorders, and depression. The most common mental disorders diagnosed in child and adolescent refugees include PTSD, anxiety, depression, attention deficit disorder, and behavior disorders. Non-refugee immigrants may have similar trauma exposure as refugees, but the exposure is less likely to be identified.

The migration process is a stressful experience for many immigrants. Even when the migration is voluntary, the process of leaving familiar surroundings and expectations can be stressful. Complications of previous trauma exposure can make adjustment more difficult. Refugees who are detained as part of their migration process experience high levels of mental health problems. Furthermore, prolonged uncertainty concerning immigration status increases the impact of previous trauma exposure. The long-term impact of trauma exposure is mediated by other factors at the individual, family, and community level.

Because children are in the developing stages, they are impacted by trauma differently than adults; they are particularly vulnerable to experiencing long-term effects. Children may experience changes in their biological stress systems, brain development, and language acquisition; they may show signs of trauma-related psychological problems including increased arousal, intrusion/reexperiencing, avoidance, dissociation, and difficulty with mood regulation. Children's abilities to meet the demands of new environments may be compromised; in these instances, additional services will be important to support their successful transition. All of these effects have implications for children who immigrate following trauma exposure. Children experience trauma differently also because of their lack of status and power – because they do not have access to the same options as adults and their coping options are more limited. Trauma exposure in childhood places one at greater risk for future problems. These children are at increased risk of anxiety, depression, trust issues, PTSD, and behavior problems (including problem behaviors that resemble Attention Deficit Disorder or Attention Deficit Hyperactivity Disorder).

An example of trauma exposure involves the *Lost Boys of Sudan*. Following civil war in Sudan, where they witnessed much violence, lost family members, and feared for their lives, many young children fled to Ethiopia. The migration was a stressful experience, with risk of death by starvation or attack by animals. After arriving in Ethiopia, the refugees were displaced again when the refugee camps were attacked by the Ethiopian government and rebels; people fled back to Sudan and ran the same risks in the return journey. Violence continued upon their return to Sudan. Many survivors were able to make it to a refugee camp in Kenya where they were able to begin focusing on the future, not just on survival. From Kenya, many of the young men immigrated to the United States where they have struggled to successfully transition into a new culture, with very different expectations and dynamics. The *Lost Boys of Sudan* illustrates well the resilience and stressors of many immigrants who have trauma exposure.

Assessing the impact of trauma exposure on immigrants is complicated by cultural, language, and literacy difficulties. People from different cultures may interpret and respond differently to standardized instruments, even when they are translated into their native language. Translation of psychological concepts can be difficult for languages that have no comparable concepts. Cultural norms regarding child development, adult roles, appropriate behavior, or expression of emotion may all impact how trauma exposure is viewed or how reactions to trauma exposure are expressed. Standardized instruments may not be normed on a particular cultural group. Immigrants may have difficulty communicating about their experiences. Government representatives with whom immigrants interact during migration may have limited understanding of trauma exposure and its repercussions. Complicating the dynamics surrounding government officials, prior to migration some immigrants have been traumatized by government officials in their country of origin, leading them to distrust people in official roles. It is important to train screeners who are working in official positions to be sensitive toward the possible experiences that people may be bringing with them.

Related Topics

- ► Ambiguous loss
- ► Anxiety
- ► Battered spouse
- ► Child abuse
- ► Child health and mortality
- ► Child rearing
- ► Convention Against Torture
- ► Depression
- ► Disasters
- ► Discrimination
- ► Domestic violence
- ► Ethnic cleansing
- ► Eugenics
- ► Family reunification
- ► Family violence
- ► Gender-based violence
- ► Grief and grieving
- ► Hague Convention on Child Abduction
- ► Human rights
- ► Internment
- ► Intimate partner violence
- ► Posttraumatic stress disorder
- ► Prostitution
- ► Refugee
- ► Refugee camp
- ► Refugee health and screening
- ► Refugee youth
- ► Resilience
- ► Terrorism
- ► Torture
- ► Trafficking
- ► Trauma
- ► Unaccompanied minors
- ► Violence
- ► War-affected children
- ► Youth antisocial behavior

Suggested Readings

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Robjant, K., Hassan, R., & Katona, C. (2009). Mental health implications of detaining asylum seekers: Systematic review. *The British Journal of Psychiatry, 194*, 306–312.

Suggested Resources

National Center for Children in Poverty. (2007). *Policy briefs and information regarding children and trauma*. Retrieved June 15, 2011, from http://www.nccp.org/publications/pub_737.html

National Center for PTSD website, has links to assessment tools and additional information regarding trauma and trauma reactions. Retrieved June 15, 2011, from www.ptsd.va.gov

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Travel and Travel Health

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International travel is undertaken by a large, and ever increasing, number of people for wide ranging purposes. More people travel greater distances and at greater speeds than ever before. Travelers are exposed to a variety of health risks in unfamiliar environments. Most of these risks can be avoided if proper precautions are taken prior, during, and after travel.

The number of people traveling internationally is increasing every year. According to statistics from the World Tourism Organization (UNWTO), international tourist arrivals in the year 2008 reached 922 million. International arrivals are expected to reach one billion by 2010 and 1.6 billion by 2020. In 2008, more than half of all international arrivals were motivated by leisure, recreation, and holidays – a total of 467 million. Business travel accounted for some 15% of arrivals and travel for other purposes (visiting friends and relatives, religious reasons/pilgrimages, health treatment, etc.) for 27%. Slightly more than half of arrivals (52%) traveled by air transport in 2008 while the remainder arrived at their destinations by surface transport (48%) – road (39%), rail (3%) or over water (6%).

International travel can pose various risks to health, depending both on the characteristics of the traveler and on the type of travel. Travelers may encounter sudden and significant changes in altitude, humidity, temperature, and microbes, which can result in ill-health. In addition, serious health risks may arise in areas where accommodation is of poor quality, hygiene and sanitation are inadequate, medical services are not well developed, and clean water is unavailable. Accidents are the most common cause of morbidity and mortality in travelers, but it is also important to protect travelers against exposure to infectious diseases. All individuals planning travel should receive advice on the potential hazards in their chosen destinations and understand how best to protect their health and minimize the risk of acquiring disease. Forward planning, appropriate preventive measures, and careful precautions can substantially reduce the risk of accidents and illness. Although the medical profession and travel industry can provide extensive help and advice, it is the traveler's responsibility to ask for information, to understand the risks involved, and to take the necessary precautions for the journey.

According to the United Nations, international migration rose from 120 million in 1990 to more than 200 million in 2006. In many countries immigrants now constitute more than 20% of the population. Immigrants increasingly travel to their place of origin to visit friends and relatives. Travel to visit friends and relatives accounts for a major portion of the international journeys that take place annually. Generally this type of immigrant travel refers to citizens from a developing country who immigrate to an industrialized country, then subsequently return to their home countries for the purpose of visiting friends and relatives.

Compared with tourists to the same destinations, immigrants who travel to visit friends and relatives are at increased risk of travel-related diseases. These include malaria, hepatitis A and B, typhoid fever, rabies, tuberculosis, and diseases normally preventable by routine childhood immunization. It is estimated that immigrants who travel to visit friends and relatives account for more than half the total imported malaria cases in Europe and North America. The increased risk for immigrants is related to a number of factors, including higher risk of exposure and insufficient protective measures. Most immigrants returning home to visit family or friends are less likely to seek pre-travel advice or to be adequately vaccinated. Additionally, immigrants returning to their home countries are more likely to stay in remote rural areas, have close contact with local populations, consume high-risk food and beverages, undertake last-minute travel due to deaths or other family emergencies, and make trips of greater duration.

Because of familiarity with their place of origin, immigrants may perceive less risk, which may result in lower rates of pre-departure vaccinations and use of prophylactic measures such as antimalarial medications. The cost of pre-travel consultation, which is often not covered by health insurance programs, may be burdensome for immigrants. Also, access to travel medicine services may be hampered by cultural and linguistic limitations. Improving the access of immigrants to pre-travel health counseling is of increasing public health importance. Primary healthcare providers need to become more aware of the increased risks faced by immigrants. Strategies are needed to increase the awareness among immigrants of travel-related health risks and to facilitate uptake of pre-travel health advice regarding vaccinations and other preventive measures.

Related Topics

- ► Health care
- ► Intestinal parasites
- ► Risk perception
- ► Sanitation

Suggested Resources

Centers for Disease Control and Prevention (CDC). (2010). *Health information for international travel 2010*. Maryland Heights: Mosby. Retrieved May 7, 2010, from http://wwwnc.cdc.gov/travel/content/yellowbook/home-2010.aspx

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Tuberculosis

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Tuberculosis is one of the oldest conditions caused by bacteria from Mycoacteriaceae group, order Actynomicetales, named *Mycobacterium tuberculosis*.

Under the microscope, *M. tuberculosis* is a rod-shaped, non-spore-forming, thin aerobic bacterium measuring 0.5 µm by 3 µm. *M. tuberculosis* is neutral on Gram's staining. However, once stained, the bacilli cannot be decolorized by acid alcohol.

The World Health Organization estimates that 9.27 million new cases of TB occurred in 2007 (139 per 100,000 population), compared with 9.24 million new cases (140 per 100,000 population) in 2006. Of these 9.27 million new cases, an estimated 44% or 4.1 million (61 per 100,000 population) were new smear positive cases. India, China, Indonesia, Nigeria, and South Africa are the top five regions affected by tuberculosis. The 2007 report indicated that 55% of the cases were spread across Asia (Southeast Asia and Western Pacific regions) and 31% were in the African Region. The other Americas and the European and Eastern Mediterranean regions are less affected by this disease. In Africa, the reported rates of tuberculosis infections are highly linked with HIV coinfection.

The spread of this condition was recognized mostly during the late 1980s and early 1990s in industrialized countries. The primary cause of disease transmission was emigration from regions with a high prevalence of tuberculosis. In United States, European descendents are likely to develop this disease due to rare exposure. In contrast, first-generation immigrants are at an increased risk of developing an active form of tuberculosis. In the United States and various other places, tuberculosis is a disease affecting disadvantaged/marginalized, sometimes HIV-infected and/or immigrant populations.

Economic disadvantages, poverty, and a weak health care infrastructure are strongly correlated with increased numbers of tuberculosis.

Organs Affected by Tuberculosis

In most cases, this condition affects the lungs, but theoretically it can affect all body organs (lymph-node, pleura, genitor urinary, skeleton, meninges, gastrointestinal tract, etc.). This disease is spread by air through droplet nuclei by patients with active lung tuberculosis.

Tuberculosis can be classified into primary and postprimary/secondary infection.

Primary Tuberculosis

Primary pulmonary tuberculosis occurs in individuals that were not previously exposed to *M. tuberculosis*.

The primary lesion is small size, round or polygonal, usually peripheral and in more than half the cases is accompanied by hilar or paratracheal lymphadenopathy. In most of the cases, the lesion heals spontaneously and may later be evident as a small calcified nodule (*Ghon lesion*). Although mostly described in children, the primary infection can be encountered in adults too.

The primary infection may be self-healing, may become a latent infection with a potential of reactivation, or, in children and persons with impaired immunity, may progress to clinical illness.

Secondary Tuberculosis

Postprimary infection is often called secondary or adult-type infection. It is a reactivation of a latent infection and it primarily affects the apical and posterior segments of the upper pulmonary lobes. The lesions are represented by pulmonary infiltrates, nodular opacities, cavities with liquefied necrotic contents that are ultimately discharged into the airways, resulting in satellite lesions within the lungs and calcifications.

Signs and Symptoms

Tuberculosis is a consumptive disease. Latent tuberculosis causes no symptoms and it is not contagious. The presence of an active tuberculosis infection is usually discovered due to a cough lasting 3 or more weeks accompanied by discolored or bloody sputum, unexplained weight loss, fatigue, slight fever, night sweats, chills, loss of appetite, and painful breathing or coughing. When it involves another organ like vertebrae, joints, muscles, urinary tract, lymphatic system, or bone marrow the symptoms are similar to other conditions affecting those body parts. Children in particular may not display all such symptoms.

Risk Factors

Risk factors include lowered immunity due to immunosuppressant conditions (i.e., recent infections, fibrotic lesions, HIV, diabetes, silicosis, hemodialysis or renal failure treatments, and others), contact with someone with active tuberculosis, substance abuse, malnutrition, and increased age. Added to these, immigrants from regions with high rates of TB – Africa, Asia, Latin America, multidrug-resistant tuberculosis regions, individuals coming from refugee camps and those who are experiencing a lack of medical care or extreme poverty are also at increased risk. Health care workers, personnel living and working in residential care facilities, and international travelers may also be exposed to greater risk.

Immigrants are often exposed to the above-mentioned risks, therefore the incidence of tuberculosis is increased among this group of population.

Prevention and Treatment

Preventive measures include educational programs to minimize the transmission risks as much as possible, vaccination (BCG vaccine) and screening tests (skin testing when Mantoux reaction is sought, X-rays).

Treatment

Untreated, active lung tuberculosis is contagious. With treatment, improvement in patients' health is expected within weeks and is evidenced by weight gain, defervescence, and decreased cough.

In the absence of treatment, the disease may cause death in 5 months in more than half of the infected individuals. Treatment of this condition consists of more than one anti-tuberculosis agent and must be administered for months. Periodic control is required.

Bacteriologic evaluation to monitor the response to tuberculosis treatment is the less invasive procedure. Negative sputum from previously confirmed tuberculosis-infected patients is sought.

Efficient treatment will result in a negative sputum test in more than 80% patients after the second month of drug administration. At the end of the third month, the remaining 20% of the treated patients will be expected to show test culture negative for sputum. If a case of positive cultures occurs after 3 months of treatment, drug resistance can be suspected and adjustment of the therapeutic scheme is required. At the end of the treatment, negative sputum must document the cure. After treatment, follow-up monitoring should be performed by sputum collection at 2, 5, and 6 months to determine if the cure is consistent or if there is a relapse.

For extrapulmonary tuberculosis, clinical exams and radiographic documentation are clear. At the end of the treatment, radiographic examination is useful only for comparative purposes.

HIV-associated tuberculosis requires precautions due to interactions with antiretroviral agents. According to Raviglione and O'Brien, Rifampin (one of the drugs used in the treatment of tuberculosis) is known to be a potent inducer of cytochrome P450 system's enzymes and lowers many HIV protease inhibitors. In HIV cases, Rifabutin interferes less with the treatment for HIV/AIDS.

Multidrug-resistant strains are challenging therapeutic regimens. Multidrug-resistant strains appear due to spontaneous point mutations that occur in mycobacterial genome. Although the danger of a strain being resistant to more than one drug is less, the danger exists and demands modified treatment schemes. This danger is reported to be increased in regions like Asia and the Soviet Union. In the United States, the rate was declining to 1% in the past decade. Resistance rates are higher among foreign-born and HIV-infected patients.

In conclusion, the treatment for this disease is not only long term, but also complex due to potential drug-associated toxicity. Treatment requires strict monitoring and patient adherence to the prescribed regimen. These restrictions are often difficult for immigrants confronted with extreme poverty, marginalization, and poor access to medical services due to lack of medical insurance.

Related Topics

- ► Acquired immune deficiency syndrome
- ► Health education
- ► Immunization
- ► Nutrition
- ► Poverty
- ► Refugee health and screening
- ► World Health Organization

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TVPA/TVPRA

► Trafficking Victims Protection Act

Typhoid

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Typhoid fever has as an etiological agent *Salmonella enterica serovar typhi*. It is transmitted by the ingestion of food or water contaminated with the feces of an infected person. *S. enterica* serovar *typhi* is a Gram-negative short bacillus, part of the Enterobacteriacae family. This type of fever has been given several different names including gastric fever, the bends, abdominal typhus, infantile remittent fever, slow fever, and nervous fever. The name "typhoid" was first given by Louis in 1829, as a derivative from typhus.

Epidemiology

The World Health Organization identifies typhoid fever as a serious public health problem because of an estimated 16–33 million cases annually resulting in 216,000 deaths in endemic areas. Its incidence is highest in children and young adults between 5 and 19 years old.

Typhoid fever has disappeared from high-income countries, but it remains a public health problem in several Asian regions of the former USSR and in parts of South and Southeast Asia, Africa, and South America. In the last outbreak in the Democratic Republic of Congo, between September 27, 2004, and January 2005, approximately 42,564 cases of typhoid fever were reported, including 214 deaths and 696 cases of peritonitis and intestinal perforations. Incidence is up to 198 per 100,000 in the Mekong, Vietnam, and 980 per 100,000 in Delhi, India.

Persons infected with typhoid can become healthy carriers of the disease and responsible for spread of - disease. The most famous case was Typhoid Mary (Mary Mallon) who was an immigrant and a healthy carrier (in the urinary bladder) of *Salmonella typhi*. She spread the disease and infected 53 people, three of whom died.

Clinical Presentation

Typhoid fever has four stages, after an incubation period for 14 days:

1. In the first week, patients experience increased temperature, fever, headache (nonspecific symptoms). During this time, the bacteria go through gastric acid barriers (patients with low gastric acidity need less bacteria to develop an infection), spread to the intestine, then in lymph nodes where they multiply and spread through the bloodstream from where they reach targeted organs such as kidney, spleen, liver, and bone marrow.
2. During the second week, patients experience high fever, delirium (which results in the name “nervous fever” attached to this illness), hepatosplenomegaly, rose spots on the lower chest and abdomen in around one third of patients, diarrhea (approximately eight/day).
3. In the third week, complications such as intestinal hemorrhage or intestinal perforation emerge.
4. In the fourth week all symptoms decrease, the patient can be cured or can remain a chronic carrier (they suffer no symptoms, but they are capable of infecting others).

Laboratory Diagnosis

Specimen collection for direct diagnosis includes blood for blood culture, stool for stool culture, bone marrow for culture, and urine for urine culture. When the direct diagnosis is not possible, we can perform indirect diagnosis that consists of detecting antibodies against O somatic antigen and H flagella antigen.

Treatment and Prophylaxis

The first-line treatment is a fluoroquinolone; other choices are ampicillin, chloramphenicol, and trimethoprim-sulfametoxazole.

There are multiresistant strains of *S. typhi* increasing the risk for people living in regions with high endemic disease and to travelers. Strains resistant to chloramphenicol and other recommended antibiotics (ampicillin, cotrimoxazole, and even ciprofloxacin) have become prevalent in several areas of the world.

Prophylaxis is possible by avoiding drinking and eating contaminated food or water and through vaccination (the vaccines are not 100% efficient and other preventive measures are necessary).

There are two vaccines available:

1. Ty21a (Vivotif Berna, Swiss Serum and Vaccine Institute) live attenuated vaccine (oral). This vaccine is not indicated for children younger than 6 years of age. It has to be administrated in four doses, given 2 days apart. The last dose should be given at least 1 week before travel to allow the vaccine time to work. Another dose is needed every 5 years for people who remain at risk.
2. ViCPS (Typhim Vi, Pasteur Merieux) is a subcutaneous or an intramuscular injection. This is not indicated for children younger than 2 years old. For people who travel, one dose provides protection and it should be administered at least 2 weeks before travel to allow the vaccine time to work. Also, a booster dose is needed every 2 years for people who remain at risk. Vaccination is

recommended for travelers to parts of the world where typhoid is common, people in close contact with a typhoid carrier, and laboratory workers who work with *S. typhi*.

Related Topics

► Quarantine

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Suggested Resources

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http://www.cdc.gov/ncidod/dbmd/diseaseinfo/typhoidfever

U

U Visa

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U visas are a nonimmigrant classification created under the Battered Immigrant Women Protection Act, enacted as part of the United States' Victims of Trafficking and Violence Act of 2000. Congress intended U visas to both aid law enforcement in detecting, investigating, and prosecuting certain criminal activity committed against undocumented immigrants, and to protect domestic violence victims consistent with the humanitarian interests of the USA. Congress created the U visa classification to protect certain categories of immigrants who were not covered under the Violence Against Women Act, including domestic violence victims abused by a lawful permanent resident or citizen in a dating relationship and immigrants' spouses, children, and intimate partners victimized by an undocumented perpetrator.

U visa petitioners must prove four threshold eligibility requirements. A petitioner must show (1) that she "suffered substantial physical or mental abuse" as a victim of certain qualifying criminal activity, a term that is defined broadly under the statute and includes domestic- violence-related offenses; (2) that she "possesses credible and reliable information" proving her knowledge of the relevant criminal activity; (3) that she "has been helpful, is being helpful, or is likely to be helpful" to the enumerated law enforcement, judicial, or service-providers with authority to investigate or prosecute the criminal activity; and (4) that the criminal activity violated a law of the USA. Successful U visa petitioners obtain temporary lawful status. Petitioners may also obtain derivative lawful status for qualifying family members (e.g., parents, children, spouses). Three years after the U visa holder obtains nonimmigrant status she may then petition for lawful permanent resident status if she meets eligibility requirements, most notably by proving that she has maintained a continuous presence in the USA for 3 years and that she has not "unreasonably refused to provide assistance" to investigating authorities. These primary legal benefits, in turn, support additional secondary benefits that petitioners can obtain with their lawful status, such as access to health care services, better wages, and housing.

While indeed the U visa classification is accessible to a wide range of petitioners, both male and female, it is perhaps most frequently used in the context of domestic violence. Abusers often use the victim's undocumented status as a further weapon of psychological or physical abuse, which jeopardizes many petitioners' ability to seek derivative lawful status under other statutes as a spouse or child of a citizen, for example. U visas are therefore powerful tools for domestic violence victims to seek lawful status without the abuser's assistance. Indeed Congress intended that U visas would position petitioners to report abuse without fear of negative immigration consequences – either from the government, law enforcement, or the abuser.

The "substantial physical or mental abuse" element reveals most directly the physical and psychological health implications involved for U visa petitioners. Petitioners can prove this element by presenting evidence of physical or mental abuse as statutorily defined to include injury or harm to the victim's body, or harm to or impairment of the emotional or psychological soundness of the victim. These terms are broadly interpreted by the US Citizenship Immigration Services (USCIS), the federal agency with U visa implementing authority, yet petitioners must meet the modifying requirement of "substantial" abuse. USCIS interprets "substantial" abuse to describe both

Sana Loue & Martha Sajatovic (eds.), *Encyclopedia of Immigrant Health*, DOI 10.1007/978-1-4419-5659-0,

the severity of the *injury* suffered by the victim and the severity of the *abuse* used by the perpetrator. USCIS weighs the substantial abuse requirement on a case-by-case basis, considering the following factors although no one factor is dispositive: the nature of the injury inflicted or suffered; the severity of the perpetrator's conduct; the severity of the harm suffered; the duration of the infliction of harm; and the extent of permanent or serious harm to the appearance, health, or physical or mental soundness of the victim. USCIS reviews the degree of harm suffered by the individual victim based on the individual victim's experience, allowing USCIS to consider the victim's preexisting physical or mental conditions and the extent to which existing medical conditions were aggravated by the abuse. USCIS considers the substantial physical or mental abuse requirement under a totality of the circumstances approach, allowing petitioners to cumulate a series of abusive acts to meet the substantial requirement, even where no single act of abuse on its own meets the test.

U visa petitioners must submit certain required documentation to prove these requirements, such as a signed detailed petitioner affidavit describing the basis for her petition, including the details substantiating her claim of substantial physical or mental abuse. Other materials are strongly encouraged, including health care provider records documenting the diagnosis and treatments of physical or psychological injury resulting from the criminal activity; affidavits from advocates, social workers, counselors, or mental health professionals that document any physical and mental abuse or injury that the applicant has suffered; copies of any police reports on domestic violence or sexual assault; affidavits from witnesses with knowledge of the harm or injury; and photographs showing injuries or damage from the criminal activity.

Related Topics

- ► Intimate partner violence
- ► Violence Against Women Act

Suggested Readings

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Unaccompanied Minors

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In immigration, "unaccompanied minors" refers to a diverse population of migrant children who are noncitizens, under the age of adult legal status in their receiving country, and are not with a legally responsible adult. Unaccompanied minors may not have been seen as minors in their sending countries – they may have had adult status there. There are four general categories of unaccompanied minors: (1) refugees, (2) solo migrants, (3) those separated from family following migration, (4) trafficking victims. Regardless of the category to which they belong, unaccompanied minors have often overcome many hardships prior to their arrival in a new country. They may have fled persecution, human rights abuses, war, and other violence. Because unaccompanied minors do not have adult legal status, there are specific concerns since they are a very vulnerable population.

Historically, unaccompanied minors have been refugees who arrived in their new countries through planned resettlement programs. Many unaccompanied minors were relocated to new countries during and following World War II. Since then the practice has continued, usually where there is war or political unrest. For example, in the 1980s, unaccompanied refugee minors came from Southeast Asian countries to the United States, with their relocation supported by the US government and private aid groups. When a government identifies refugee children overseas and selects them for resettlement, there is a screening process and services are provided to help with the transition. In the United States, the government agency in charge of unaccompanied refugee minors is the Office of Refugee Resettlement (ORR), which works closely with two organizations, the Lutheran Immigration Refugee Service (LIRS) and the United States Conference of Catholic Bishops (USCCB). Other countries usually have similar arrangements to address the situations of unaccompanied refugee minors who are identified prior to migration. These unaccompanied minors who are participants in organized refugee programs will have access to support for long-term care: foster homes and other housing opportunities, food, clothing, medical care, education, language training, counseling, and other forms of support and necessities. Although these forms of support may be officially available to unaccompanied refugee minors, they are not always easy for the minors to access, and their availability is not uniform. The number of such refugees throughout the world has increased dramatically in recent years, and continues to grow; at least half of the world's refugees are estimated to be children below the age of 18.

Another group of unaccompanied minors are individual children who have traveled to a new country on their own to join family members who are already there, to escape the problems in their home country, or to take advantage of perceived economic opportunities. Children who are refugees but arrive without the support of an organized refugee program will find it difficult to navigate the legal systems surrounding asylum programs, and they will often lack the documentation to support their claims of refugee status. Children who are seeking to join family members who are already in the new country may be stopped at the international border, and detained and deported at that point. Even if they are able to cross the border successfully, they may not be able to navigate in the new country or find their family members. Some children believe that there are economic opportunities that will allow them to provide for their family, only to discover that the opportunities are nonexistent or are unavailable to them as minors. They may fall prey to criminals after they arrive.

Children may become unaccompanied minors following immigration. This usually occurs due to some form of separation from their family. If a family has entered the country without documentation, then some family members may be more vulnerable to detention, separation, and deportation. Depending on national laws regarding citizenship, children may be considered citizens while their parents are considered illegal immigrants, which means that children may be able to legally stay in the country but without their parents. If children are separated from their parents when their parents are detained or deported, they may or may not have other external supports in the community. Children are vulnerable following their parents' detention or deportation and may become homeless or victims of exploitation by adults or older children. Children have limited ability to access resources in the community. If children are themselves detained or processed for deportation, they are often separated from their family and may be held in juvenile facilities with children who have committed a variety of violent crimes, or even in adult criminal facilities. Children may be held for extended periods of time – months or years – in detention facilities.

Unaccompanied minors may be children who were trafficked and brought to a new country by adults who were intending to exploit them. Children are trafficked for profit all around the world, although it may take different forms in different places. International traffickers will bring a child into a country, and the child may subsequently escape or be abandoned by the trafficker, becoming an unaccompanied minor. Traffickers may lie to families about the opportunity that is being given to the child and children may be forced or coerced into accompanying the trafficker. Children who are trafficked may be sexually exploited or used in pornography; forced to labor in homes, farms or factories; or forced to beg. They are physically confined, starved, threatened, beaten, and abused. It is difficult to estimate the number of children who are trafficked. UNHCR (United Nations High Commissioner for Refugees) has protection guidelines regarding trafficking. The guidelines provide nations with policy recommendations for addressing these situations.

How countries deal with unaccompanied minors varies widely – some countries have specific policies regarding the disposition of unaccompanied minors that are based on immigration status; other countries uniformly detain all unaccompanied minors in jail-like facilities; other countries place them in foster homes following the same practices that would be applied for native children. The legal claims of unaccompanied minors usually follow the same guidelines that are followed for anyone seeking to immigrate. Unaccompanied minors may or may not be able to adequately use any legal counsel provided for them – they usually will not have any documentation to substantiate their identity, any claims for asylum, or their history. Language barriers can also limit unaccompanied minors' abilities to advocate for themselves or use the services available to them. United Nations policy stresses that it is important in making decisions regarding unaccompanied minors to keep the best interests of the child in mind. "No matter their status, children must be treated as children first and their best interests professionally identified and respected" (UNHCR 2008).

Related Topics

- ▶ Asylum
- ▶ Immigrant visa status
- ▶ Refugee youth
- ▶ Trafficking
- ▶ Trafficking Victims Protection Act
- ▶ Undocumented

Suggested Resources

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Undocumented

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Undocumented migrants are foreign citizens who enter or stay in a country without the appropriate documentation. They may have managed to cross borders undetected or entered into the receiving country using fraudulent documentation ("illegal entry"). Others, after entering using legal documentation, remain in the country beyond the period for which entry was granted or otherwise violate the terms of entry and stay without authorization (e.g., working in violation of some or all of the conditions attached to their immigration status) ("overstay"). They differ from those with pending applications, though failed asylum seekers or immigrants who have no further right to appeal may become undocumented if they do not leave the country when instructed. The status is temporary and may change over time, whether leading to regularization or the opposite. Alternative terms often used include *migrants in an irregular situation* or *irregular, unauthorized, unregistered, clandestine, noncompliant, semi-compliant,* or *illegal migrants, aliens, or nonnationals.* Despite a certain ambiguity of the term (i.e., it refers both to migrants who have not been documented and those without documents), "undocumented migrant" is often preferred over "illegal migrant" as, in most countries, residing without appropriate documentation is considered an administrative infraction rather than a criminal offense.

It is difficult to obtain accurate estimates on the number of undocumented migrants globally and by country. Existing estimates suggest that 30–40 million or 15–20% of all migrants are undocumented worldwide. In 2009, the CLANDESTINO project estimated that there were up to four million undocumented migrants across the European Union (EU), almost half of the level of irregular residence previously assumed. Depending on the source, estimates in the USA range between 7 and 15 million or more, with 12 million undocumented workers being a figure often used. Around 3.5 million children, many of whom are US-born citizens, live in families where at least one member is undocumented. In Canada, another major immigrant-receiving country, estimates of undocumented people are particularly vague, with 200,000 to half-a-million being the figures most frequently quoted. Unlike the USA, where undocumented migration is associated with clandestine border crossing, in Canada the majority of undocumented migrants initially entered through authorized legal channels.

Most undocumented migrants access health care through hospital emergency units and community organizations and health clinics. Undocumented migrants at landings or at public health centers run by Médecins Sans Frontières in several countries often present with problems related to their journey (e.g., trauma and dehydration), their living and working conditions, social exclusion (e.g., depression), and changes in eating habits (e.g., gastritis and duodenal ulcers). Research has shown pervasive feelings of fear and isolation among undocumented migrants linked to domestic violence (due to stress about papers), alcohol and substance abuse, depression, anxiety, and other mental health conditions. Children and youth, as well as smuggled and trafficked women, face significant physical and psychological health risks.

Lack of legal status and health insurance are major barriers of access to health care. Undocumented migrants will delay seeking care unless extremely sick for fear of exposure or deportation. Thus, victims of domestic violence rarely report it and children entitled to care do not always receive it due to their family's reluctance to approach the government if the head of the family or another family member is undocumented. Other barriers include inability to pay, long wait lists at centers that offer care, and lack of professionally trained interpreters and information on the system.

Research has shown that delayed care often aggravates minor health conditions, with particularly negative consequences for chronic conditions (e.g., hypertension and diabetes), infectious diseases, acute mental health problems (e.g., posttraumatic stress disorder and depression), and developmental problems in children (e.g., autism). Difficulties in accessing antenatal care in this population have led to serious complications of eclampsia and ectopic pregnancy, complicated labors and an increased rate of cesarean sections. Moreover, for undocumented women, pregnancy and birth render employment impossible, generate high health care costs, and disrupt precarious housing arrangements.

Exposure to hazardous living and working conditions and poor access to health care constitutes a public health challenge that transit and host countries increasingly have to deal with. Whereas some countries, such as Austria and Sweden, provide services to undocumented migrants on a payment basis only, others, such as Spain and Portugal, offer full access to healthcare. Generally, however, undocumented migrants are only entitled to emergency care or "immediately necessary" services.

Related Topics

► Illegal immigration

► Illegal Immigration Reform and Immigrant Responsibility Act of 1996 (U.S.)

► Irregular immigration

► Trafficking

Suggested Readings

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Rousseau, C., ter Kuile, S., Munoz, M., Nadeau, L., Ouimet, M. J., Kirmayer, L., et al. (2008). Health care access for refugee and immigrant with precarious status: Public health and human right challenges. *Canadian Journal of Public Health, 99*(4), 290–292.

Suggested Resources

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UNHCR

► United Nations High Commissioner for Refugees

United Kingdom

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Introduction

The UK has a publicly funded health care system that provides most medical services to citizens free of charge at the point of service. Free medical care is also provided to most legal residents, including immigrants and refugees. Certain services such as emergencies and treatment for certain communicable diseases are free regardless of citizenship. Despite this, immigrants and asylum seekers may face several barriers to accessing care in the UK. Calls for immigration reform have increased in recent years among members of the UK's major political parties, so changes may occur that improve or limit access to care for immigrants in the near future.

National Health Service

The National Health Service (NHS) is one of the oldest universal health care systems in the world. It was established after the World War II in 1948. The model was based on a system devised by social reformer William Beveridge, and implemented through the leadership of the minister of health, Nye Bevan. The system nationalized the hospitals, allowed general practioners (GPs) to remain independent, and made the government the payer for all fees. Private care and private insurance are allowed to coexist in the UK, but private care accounts for less than 3% of total health care services. Since its inception, health care services have been free at the point of service without co-payments, coinsurance, or deductibles. The exception is a small co-pay for vision correction and on prescription drugs. However, certain groups such as children, pregnant women, the chronically ill, and the elderly are exempt from co-pays on prescription drugs, and these users represent 85% of all prescription drug orders filled.

UK residents pay for the NHS through general taxation. A national sales tax in the UK runs from 15% to 17.5% and the marginal tax rates are higher in the UK than in the USA, a developed country that does not have universal health care.

The NHS is actually a collection of four health systems, run independently by England, Scotland, Wales, and Northern Ireland. However, many citizens are unaware of the distinction as there is great coordination between the systems and citizens of one area can usually seek care in another area.

Certain health services are provided to all persons, including immigrants, regardless of citizenship. These include treatment for accidents and emergencies, compulsory psychiatric treatment, treatment for certain communicable diseases, and family planning services.

Other NHS treatments are available to immigrants who meet certain criteria. If they are establishing permanent residence in the UK or have been living in the UK legally for 12 months then they are entitled to health care. Students, refugees, asylum seekers, and detained immigrants may also be eligible for free medical care from the NHS.

The National Institute for Health and Clinical Excellence, or NICE, is the government agency that provides recommendations of what services and drugs the NHS should pay for and which they should not. Since this is a form of rationing, in some cases persons are denied care that they or their physicians would like. Immigrants may find that certain treatments available in their native land are not available in the UK or require an out-of-pocket payment.

Immigrants may also have to deal with longer wait periods than they would in their country of origin for treatment of certain types of conditions. Acute conditions are treated immediately. Cardiac problems are usually addressed the same day, and cancer within a few weeks. However, treatment for certain chronic conditions and "elective" procedures may require the patient to wait for months.

Immigration to UK

The current political state known as the UK of Great Britain and Northern Ireland, which includes England, Wales, Scotland, and Northern Ireland, was created in 1922. This entry will focus on immigration policies from that date to the present.

Immigration during this period has been substantial with most immigrants originating from Ireland or former British colonies, including India, Bangladesh, Pakistan, the Carribbean, South Africa, Kenya, and Hong Kong. Until the British Nationality Act of 1981, citizens of commonwealth nations were deemed to be British subjects, but this is no longer the case.

Immigration is also heavy from countries in the European Union due to agreements with the other EU countries that require that citizens of any EU country have a right to work in other EU countries. Currently about 11% of the UK population is foreign-born.

In response to fears of rising immigration from eastern European countries, the conservative-liberal coalition has moved to cap the number of non-EU immigrants allowed to enter the UK each year. Some have expressed concern that this will negatively affect care for all UK citizens as the system is dependent on physicians originating from former British colonies such as India and Pakistan. A 2005 report found that in 2003, 29.4% of NHS doctors were foreign-born and that 43.5% of nurses recruited to the NHS after 1999 were born outside the UK.

Emigrants to the EU and Abroad

Citizens of the UK, who migrate to other countries, may still be eligible for health care under the National Health Service. However, because the NHS is paid for through the taxpayers, rules are in place to prevent people from “free-riding.” Persons who have been citizens of the UK for at least 10 years are eligible for care under the NHS, provided they have not lived abroad for more than 5 consecutive years. UK state pensioners living abroad seasonally are eligible for care, provided they do not spend more than half of the year outside of the UK.

Medical Care of Asylum Seekers and Refugees

Refugees seeking asylum in the UK have been a focus of policy-makers in recent decades, with both Conservative and Labour Party officials claiming that too many refugees are entering the country each year. The case they make is that refugees are choosing to migrate to the UK because it has some of the most generous health benefits. International law requires refugee migrants to seek asylum in the first country they enter that will grant asylum. Critics claim that refugees are taking advantage of this rule, by “shopping” for countries that offer generous benefits, such as the UK.

Asylum seekers have a right to access free physician visits and hospital care from the National Health Service while their applications are being processed. Additional support may be available through the UK Border Agency such as prescription drug benefits, dental care, and vision and eye care. Persons with HIV, tuberculosis, or severe mental health diseases may be eligible for additional care.

A systematic review of studies focusing on asylum seeker mental health found high levels of mental health problems reported among detainees in all studies. Suicide ideation, anxiety, depression, and posttraumatic stress disorder were commonly reported. Longer detention time was positively associated with severity of distress. Longitudinal results have shown that the negative impact of detention persists even after release.

A High Court ruling found that failed asylum seekers were still granted a right to NHS services provided they lived in the UK for more than 1 year. However, in March 2009, this decision was overturned by the Court of Appeals, and failed asylum seekers no longer have a right to NHS services free of charge, other than emergency services and certain other care that is offered to everyone.

Conclusion

The UK has one of the most comprehensive health care systems in the world in that it provides universal coverage and also operates most of the health care facilities. This system is favorable to documented immigrants and refugees in that it provides access to health care that they may not be able to afford out of pocket. The UK has strict immigration policies, so foreign-born persons may find it difficult to move to the UK unless they are deemed to be highly skilled workers sponsored by an employer, or students. Undocumented immigrants and failed asylum seekers still residing in the UK may have difficulty obtaining care under the NHS, but certain emergency services, mental health services, and treatment of communicable diseases can still be obtained free of charge. Immigration policies and immigration health policies in the UK are likely to change over the next several years as it continues to be a hot-button issue among policy-makers and voters. These changes may adversely affect immigrant access to the NHS.

Related Topics

- ► Asylum
- ► Colonialism
- ► European Court of Human Rights
- ► European Union
- ► International Health Regulations
- ► Refugee
- ► Socialized medicine
- ► United Nations High Commissioner for Refugees

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United Nations Convention on the Rights of the Child

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People have rights that are extended to them whether they are in their native country or have immigrated to a new land. These rights are civil, political, economical, social, and cultural. They belong to all human beings including children and young people. Since children are particularly vulnerable, it is widely accepted that they need special attention and protection.

In the early twentieth century the United Nations (UN) recognized that children were living in exceptionally difficult conditions in all countries around the world and that international cooperation was needed to remedy this situation. The Declaration of the Rights of the Child of 1924 was one of the first documents that stemmed from this joint initiative. Since then the United Nations has put forth several provisions which include the Declaration of the Rights of the Child, adopted on November 20, 1959, as well as the Convention on the Rights of the Child, adopted on September 2, 1990. The Convention is the most widely ratified human rights treaty in history.

It took an international elected body of independent experts over 10 years to negotiate the Convention on the Rights of the Child ("the Convention"). The result is a document that takes into account the importance of tradition and cultural values for the protection and harmonious development of the child.

The Convention of the Rights of the Child became international law on September 2, 1990. As of April 2010, 194 states acknowledge this international law. The United Nations General Assembly added two optional protocols on May 25, 2000. Protocol One restricts the involvement of children in any military conflict and was adopted on July 12, 2002. As of April 2010, 132 states have acknowledged Protocol One. Protocol Two prohibits the sale of children, child pornography, and child prostitution and was adopted on January 18, 2002. As of April 2010, 137 states have acknowledged Protocol Two.

The Convention emphasizes that the best interests of the child shall be primary. The Convention spells out provisions, protection, and participation that should be considered. These considerations are the right to life and to a name, identity, family, and nationality; freedoms of thought, speech, conscience, and religion, and freedoms of privacy and assembly; the right to regulate activities pertaining to parenting and the care of a child which includes physical safety, foster care and adoption, mental and physical disability, health care, and social and economic security; education, participation in their culture, and play; and the right to be free from exploitation and abuse, including physical and sexual abuse, economic and sexual exploitation, exposure to addictive drugs, and warfare. These rights are extended to children no matter what their country of origin is or their color, language, race, religion, or sex.

The Convention defines a "child" as a person below the age of 18, unless State law recognizes a different age of majority. States can define appropriate ages for majority such as when a child can become employed and complete his/her education. The Convention has clearly defined that those under 18 years of age be prohibited from life imprisonment or capital punishment.

Compliance with the Convention is monitored through the UN Committee on the Rights of the Child. Governments that have ratified this Convention are required to submit regular reports on the status of children's rights in their country. The committee, which consists of internationally elected representatives, monitors and reviews the reports submitted by the governments.

The United States (US) government played an active role in the development of the Convention on the Rights of the Child and signed it on February 16, 1995. However, as of November 2009, the US has not ratified the Convention. There are several views on why this has not been done, but most feel it is partly due to the potential conflict with the US Constitution. In early 2009, there was an attempt by the State Department to review the Convention, but to date this has not been initiated. Because of this, the Convention has never been sent to the US Senate for ratification. The US has signed and ratified both optional protocols to the Convention.

Due to the Supremacy Clause in Article VI of the US Constitution, all treaties the US ratifies are considered the supreme law of the land. This would make any preexisting state and federal statutes null and void. This has created a conflict for ratifying the Convention. Parental rights groups feel the Convention would give the government a right to meddle in child rearing. Political and religious groups feel there is an issue of national control over domestic policies. The Obama administration has noted these objections constitute legitimate concerns. One answer could be addressed through the Reservations, Understandings, and Declarations (RUDs) process through which the US can sign a RUD that can hinder or negate responsibilities they would otherwise be bound to follow.

Most majority Muslim nations express reservations on some provisions of the Convention that are incompatible with Islamic Sharia law. This has been accomplished through the filing of RUDs which allows Islamic law to prevail.

Children will always be our future. They will be the future global leaders who set public policy and implement laws. Whether children are raised in the country of their birth or immigrants in another location, the rights of a child's health and well-being have been laid out by the Convention on the Rights of the Child.

Related Topics

- ▶ Adoption
- ▶ Child
- ▶ Child abuse
- ▶ Child development
- ▶ Child health and mortality
- ▶ Child health care access
- ▶ Child labor
- ▶ Childhood injuries
- ▶ Child rearing
- ▶ Family reunification
- ▶ Identity

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United Nations High Commissioner for Refugees

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The League of Nations was established in 1919 at the end of World War I. In 1921, it created the position of High Commissioner to deal with the large numbers of persons who had been displaced during World War I, the Russian Revolution, and the collapse of the Ottoman Empire. The Office of the High Commissioner was charged with the responsibility of defining the status of the refugee, helping refugees to find employment, and protecting refugees from continued expulsion. But persecution, political violence, natural disasters, armed conflict, and other catastrophic events continue to make it necessary for millions of people to flee their homes and seek protection in other countries.

In 1945, the League of Nations was replaced by its successor organization, the United Nations. The United Nations replaced the Office of the High Commissioner with the International Refugee Organization (IRO) in 1947. The International Refugee Organization only addressed the needs of refugees from Europe. Accordingly, in 1951, the United Nations High Commissioner for Refugees (UNHCR) was created and addressed refugee problems around the world. This office was established to give legal, social, economic, and political aid to refugees.

The definition of a refugee now follows the construction of the United Nations convention and is defined as a person who, "owing to a well founded fear of being persecuted for reasons of race, religion, nationality, membership in a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such a fear, is unwilling to avail himself of the protection of that country." Today the UNHCR provides refugees with material support such as food, shelter, healthcare, education, and other related social services and works in conjunction with other United Nations agencies, peacekeepers, military forces, regional agencies, human rights organizations, and other international and local organizations and agencies. As an example of the assistance provided to refugees, refugees living with HIV in Botswana are being provided with treatment under a special UNHCR program.

Yet, measures to relieve the plight of those experiencing forced migration, internal displacement or asylum have drastically diminished in relation to the growing scale of the problem. Although the annual budget of the United Nations High Commissioner for Refugees rose to $1 billion in 1997 through voluntary government contributions, the agency is increasingly unable to meet the present demand for food and shelter to support refugees, or to invest in rehabilitation or repatriation of these refugees.

More recently, the UNHCR has undergone some harsh charges that it is simply a pawn of state and capitalist interests. The UNHCR has also been the focus of charges that it has acted as an imperialistic opportunist and has betrayed its fundamental values in pursuit of institutional predominance in the international humanitarian field. As a result, the UNHCR is a conflicted organization, torn between its legal and human rights obligations and its need to appease the Western states that pay its bills.

The UNHCR's current emphasis appears in recent years to have broadened to include issues related to security of refugees: social security, economic security, and environmental security, and the all-inclusive "human security." This new emphasis reflects the UNHCR's continuing evolution from aid/development to legal protection to repatriation and, finally, to human security. The ability of the organization to undergo evolution had been envisioned for the UNHCR from the beginning. Because of its ability to adapt to changing circumstances and address the needs of refugees, the office was awarded the Nobel Prize for Peace in 1954 and again in 1981.

Related Topics

- ► Asylum
- ► Disasters
- ► Displaced populations
- ► Refugee

Suggested Resources

Website for UNHCR. http://www.unhcr.org

United States

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Introduction

The United States is a country of immigrants. Nearly every person living in the United States is a descendent of immigrants that arrived in the past few centuries, or is an immigrant themselves. Despite this shared history of immigration among US residents, foreign-born persons in the United States face structural, cultural, and political barriers that impact their health and limit access to quality care. This entry will provide a profile of immigrants in the United States today, discuss the health of the immigrant population, and describe the US system of payers and providers and how it relates to immigrants' ability to access care. Finally, it will look at health care reform and other recent policy changes and its impact on immigrant health.

Profile of US Immigrants Today

As of 2008, there were approximately 39 million immigrants living in the United States, accounting for 13% of the total population. Among these foreign-born persons, 31% are naturalized citizens and 38% are lawfully residing noncitizens. An estimated 11.9 million persons are undocumented immigrants, representing 4% of the population and 5.4% of the workforce. The primary reason that persons immigrate to the United States is to find employment.

Naturalized citizens are immigrants who qualified for and passed a citizenship test. These may include children of US citizens born abroad, documented permanent residents who have lived in the US for 5 years, or spouses of US citizens. These people are considered US citizens and have the same rights and privileges as US-born citizens. Lawfully residing noncitizens, or "legal immigrants," include permanent residents that have a visa. These persons are not citizens, but do have access to many public programs. Refugees are also considered lawful noncitizen immigrants. Undocumented noncitizen immigrants are sometimes referred to as "illegal immigrants" or "illegal aliens" because they are often in the country illegally and subject to deportation. These citizens cannot access most public programs such as Medicaid and Medicare. Immigrants to the United States come from all over the globe. The majority of foreign-born persons living in the United States today have come from Latin America (54.6%), with Mexico alone accounting for 31.3% of the immigrant population. East/Southeast Asia (17.6%), Europe (12.5%), South Asia (5.5%), and the Middle East (3.5%) round out the top five regions of origin.

Fewer persons emigrate from the United States than immigrate to the country, and this has been true throughout the history of the nation. Even still, the State Department estimates over 5 million Americans currently live abroad. Additionally, many foreign-born persons in the United States will migrate back to their native countries at some point. Despite this, issues related to the emigration of US citizens from the United States are rarely studied including issues related to the health of these migrants. The focus of this entry will therefore be on the health of immigrants to the United States.

Immigrant Health and Hispanic/Immigrant Health Paradox

Health disparities exist in the United States, and low socioeconomic status is often associated with poorer health outcomes and reduced access to care. However, while immigrants, especially undocumented immigrants, tend to have a low socioeconomic status, they surprisingly score better on a variety of leading health indicators compared to domestic-born citizens. This phenomenon has been called the "immigrant paradox," or more commonly the "Hispanic paradox." One review study found foreign-born persons in general to have better outcomes than the US-born population in many health indicators including mortality, perinatal health, body-mass-index, heart disease, diabetes, cancers, mental health, injuries, and infectious disease.

Several theories have been offered to explain this paradox, including the "salmon bias," whereby immigrants return to their homeland before dying and hence are not included in US mortality statistics, and the healthy migrant hypotheses, which assert that the healthiest persons are the ones most likely to immigrate to a foreign country. Neither of these hypotheses has been able to fully explain the paradox. Cultural differences between immigrants and US-born citizens, as well as health behaviors before and immediately after migration, have been offered as an explanation. There is some evidence that the protective effects of immigration disappear over time as immigrants become more assimilated into American culture. This is especially true in the case of overweight and obesity.

Overview of Health Care in the United States

The health care system in the United States is not centralized at the payer or provider level. This is in contrast to most developed nations which have some sort of single-payer system (e.g., Canadian Medicare) or have a government-run health system (e.g., UK's National Health Service). In the United States most Americans receive coverage through private and not-for-profit insurance plans. Because the federal tax code allows health insurance premiums to be purchased as a pretax deduction, the majority of Americans receive their insurance as a benefit through their employers. Others purchase it as individuals on the open market. An estimated 46 million persons in the United States did not have health insurance coverage in 2009, and 22% of these uninsured were immigrants. According to the Kaiser Family Foundation, 47% of immigrants (legal and documented) are uninsured.

Naturalized citizens and lawful noncitizens generally have access to private and public health insurance similar to US-born citizens. That is, they can receive private health insurance as a benefit from their employer. They also qualify for Medicaid, a public program for low income individuals and families, if they meet the eligibility requirements, and can receive Medicare, a public program for individuals over 65 years or who meet other special criteria, provided they have been here at least 5 years and they or a spouse have paid at least 10 years into the system or pay a monthly premium. Since the passage of welfare reform laws in 1996, most lawful noncitizens must be in the country for 5 years before they are eligible for Medicaid and the Children's Health Insurance Program (CHIP). Some states allow legal noncitizens to enroll in Medicaid during their first 5 years in the country, but these programs do not receive federal matching funds.

Undocumented immigrants on the other hand do not qualify for public health insurance, and rarely receive employer-sponsored health insurance. Many of these immigrants work in low-wage industries that typically do not provide employer-sponsored insurance, or they are paid "under the table," meaning unofficially and not on the records of the employer, and not offered benefits. Their main option for having health coverage is purchasing it on the individual market. As this is one of the most expensive ways to buy insurance, and most undocumented immigrants have low incomes, very few can afford to purchase private insurance.

Most health care in the United States is provided by private health care providers, including private hospitals and private-practice physicians. Exceptions are the Veterans Affairs hospital system, which provides care for veterans of foreign wars, public hospitals that receive support from the federal, state, and local level, and not-for-profit community clinics which provide care for the poor and uninsured, including immigrants. Noncitizen immigrants, both undocumented and documented, have access to public and private health care providers, provided they have the means to pay. All persons who show up to emergency departments must be treated regardless of their ability to pay. For this reason, emergency departments have become a primary source of care for the uninsured, including immigrants.

Health Care Reform and Immigration

The Patient Protection and Affordable Care Act (PPACA) and Reconciliation Act of 2010, both signed into law in early 2010, made the largest reforms to health care in the United States since Medicare was passed in 1965. Among the changes in this law are provisions creating state-run insurance exchanges, where individuals and employees of small businesses may purchase private insurance plans. Persons purchasing insurance through this mechanism will receive income-dependent federal subsidies to help offset premium costs. The Medicaid program was expanded to cover all persons with income below 133% the federal poverty line (FPL), resulting in an increase in approximately 15 million enrollees when fully enacted. These reforms become fully enacted in 2014.

Naturalized citizens and lawful noncitizens will be able to purchase insurance on these exchanges and will be eligible to receive federal subsidies. Additionally, lawful noncitizens with incomes below 133% FPL will be eligible to enroll in Medicaid, provided they have continuously resided in the United States for at least 5 years. Naturalized citizens have the same access to Medicaid as US-born citizens.

Undocumented immigrants are not eligible for Medicaid or federal insurance subsidies. Furthermore, undocumented immigrants are banned from purchasing insurance policies on the exchange, even if they have the economic means to do so. This is concerning to undocumented immigrants that purchase individual private plans, as it is questionable whether this insurance market will exist after 2014. Many experts believe that insurance companies will offer all of their individual private plans through the exchanges. Undocumented immigrants wishing to purchase insurance, will in effect, become a niche market. This niche market may be too risky for insurance companies since they cannot deny coverage based on pre-existing conditions and undocumented immigrants are exempt from the individual coverage mandate. This would allow undocumented immigrants to purchase health insurance only at the time they needed it.

Border Health and the Recent Political Climate

Politicians and the public have taken an increased interest in recent years concerning the flow of undocumented immigrants into the United States along the US-Mexico border. The United States has increased border security through fences, surveillance equipment, and border patrol agents. Because border security is not one continuous system, but rather a patchwork, immigrants often try to cross in certain areas that may have less security, but may feature more inhospitable terrain. As a result, the act of migrating into the United States can pose a health risk as well. In 2009, 417 known deaths occurred among persons trying to cross the US-Mexico border. Many of them die in the deserts of Arizona or by drowning in the Rio Grande trying to enter through Texas.

The Development, Relief and Education for Alien Minors Act, or DREAM Act, is a bill first introduced in 2001 and reintroduced in 2010 in the 111th Congress that creates a pathway for persons who entered the country illegally as children to become citizens by completing 2 years of college, or 2 years of military service. Such a law would allow millions of undocumented immigrants in the United States to become citizens, and hence improving access to jobs, health insurance, and public insurance programs.

Most legislative efforts in recent years have moved toward restricting access to health care and public programs rather than expanding it for immigrants. Arizona passed a tough anti-immigration law in April 2010, causing many to fear that medical professionals will be required to report suspected undocumented immigrants who show up to their practice. The law may also have the effect of suppressing undocumented immigrants from utilizing health care services for fear of deportation. Opposition to the Arizona immigration law was widespread with many prominent voices calling for a boycott of the state. However, a Pew Research Poll showed public support for the law by a 59-32 margin. Given the popularity of such measures and budget shortfalls in most states, politicians may pass more laws designed to restrict lawful and undocumented immigrants' access to public resources and health care services.

Conclusion

Health disparities in terms of access and quality of care exist in the United States, and these disparities are often tied to low socioeconomic status. Immigrants, especially undocumented immigrants, tend to be of lower socioeconomic status than natural-born citizens. Despite the "Hispanic paradox" whereby many undocumented immigrants perform better in several leading health indicators, access to care remains a problem. Federal and state laws create barriers that prevent most undocumented immigrants from obtaining health insurance. Lack of universal health insurance and rising health care costs also prevent many lawful noncitizens from obtaining health coverage as well for financial reasons. Immigrant health is not only affected by laws pertaining to the health care system, but also the social, cultural, and political attitudes toward immigrants in the United States.

Related Topics

- ▶ Assimilation
- ▶ Ellis Island
- ▶ Health care access
- ▶ Health insurance
- ▶ Healthy immigrant
- ▶ Hispanic health paradox
- ▶ Illegal immigration
- ▶ Illegal Immigration Reform and Immigrant Responsibility Act of 1996 (U.S.)
- ▶ Immigration Act of 1924 (U.S.)
- ▶ Immigration Act of 1990 (U.S.)
- ▶ Immigration and Nationality Act Amendments of 1965 (U.S.)
- ▶ Immigration and Nationality Act of 1952 (U.S.)
- ▶ Immigration Reform and Control Act of 1986 (U.S.)
- ▶ Labor migration
- ▶ Latinos
- ▶ Medicaid
- ▶ Medicare
- ▶ Melting pot
- ▶ Mexico
- ▶ Undocumented
- ▶ U.S.–Mexico border

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Suggested Resources

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Urban Institute. Publications on immigration. http://www.urban.org/immigrants/index.cfm. Accessed November 29, 2010.

Universal Declaration of Human Rights

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The Universal Declaration of Human Rights (UDHR) is regarded as one of the most pivotal documents of the last half century. The Declaration deems all people are entitled to basic human rights regardless of civil, political, economic, social, or cultural status. Although not a treaty, the UDHR has served as a human rights template incorporated into international treaties. For instance, the International Covenant on Civil and Political Rights and the International Covenants on Economic, Social, and Cultural Rights were ratified in 1966 and established many of the protections delineated by the UDHR. Together these covenants and the UDHR comprise the International Bill of Rights.

History paved the road for the evolution of the UDHR and provides insight into its relevance and impact. By the mid-1940s, society had lived through the devastation of two world wars and a fervent vision for a postwar era of justice and peace evolved. As a result, the recently formed United Nations established the Commission on Human Rights, which was comprised of 18 states and chaired by the former first lady Mrs. Eleanor Roosevelt. The drafting subcommittee was comprised of representatives from Australia, Chile, China, France, Lebanon, United Kingdom, USSR, and the United States. The Declaration framework was structured on core principles of nondiscrimination, social and economic responsibility, and political civil responsibility. After a 2-year drafting process, on December 10, 1948, the UDHR was adopted by the United Nations.

The UDHR consists of 30 articles relating to civil, political, economic, social, and cultural rights. The first three articles define the rights of the individual. Specifically, articles 1–5 cover freedom, liberty, and security, and in addition, ban slavery and torture. Articles 6–9 ensure equal protection and nondiscrimination, and ban random seizure and confinement. Articles 10–11 establish a right to fair public hearing, due process by an impartial tribunal, and presumed innocence until proven guilty.

Articles 12–17 recognize the right of an individual in society. For example, articles 12–15 protect the right to nationality or change in citizenship, the free movement within a state or between states, and to seek asylum from persecution. Articles 16–17 involve the right to marriage, family, and sole or community property ownership.

Articles 18–21 emphasize civil and political freedoms. In particular, articles 18–21 address the right to freedom of religion and expression, peaceful assembly, and the right to vote. Finally, articles 22–27 delineate social, economic, and cultural rights.

In summary, the UDHR revolutionized the landscape of international law, by inspiring the development of several core treaties with UDHR origins: (1) Convention on the Rights of a Child; (2) United Nations Convention Against Torture; (3) Convention Against All Forms of Discrimination Against Women; and (4) Convention Against All Forms of Racial Discrimination. Equally impressive was the reaffirmation of the UDHR at the Second Human Rights World Conference by 171 countries in 1993. Continued public awareness regarding the UDHR is paramount, as evident with its translation into over 360 languages. In addition, human right violations can be reported via a 24-h United Nations facsimile hotline.

Related Topics

- ► European Court of Human Rights
- ► Human rights

Suggested Resources

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U.S.–Mexico Border

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The border between the United States and Mexico extends approximately 2,000 miles from the southern tip of Texas to California. On the United States side, it extends along the states of Texas, New Mexico, Arizona, and California; and on the Mexico side, the states of Baja California, Sonora, Chihuahua, Coahuila, Nuevo León, and Tamaulipas. In the United States, Texas has the longest stretch of the border, while California has the shortest. In Mexico, Chihuahua has the longest stretch of the border, while Nuevo León has the shortest.

On March 2, 1836, the Texas Declaration of Independence was signed, creating the Republic of Texas. The Republic of Texas lasted only until 1845 when, on March 1, 1845, United States President John Tyler signed a bill that authorized the United States to annex the Republic of Texas. The continuous conflicts in the Texas region in the mid 1800s and the US annexation of Texas eventually led to the Mexican-American War (1846–1848), which ended with the Treaty of Guadalupe Hidalgo.

The Treaty of Guadalupe Hidalgo gave the United States undisputed control of Texas, established the US–Mexican border as the Rio Grande River, and ceded to the United States the states of California, Nevada, Utah, and portions of the states of Colorado, Arizona, New Mexico, and Wyoming. From the Treaty, Mexico received $18,250,000 and the United States agreed to assume $3.25-million in debts the Mexican government owed to United States.

Five years later the Gadsden Purchase, named after James Gadsden, US Ambassador to Mexico at that time, completed the formation of the US–Mexico border. The Gadsden Purchase was signed by President Franklin Pierce on June 24, 1853, and ratified on April 25, 1854. It added southern Arizona and southwestern New Mexico to the United States and completed the US–Mexico border as we know it today.

Established in 1889, the International Boundary and Water Commission (IBWC) has responsibility for applying the boundary and water treaties between the United States and Mexico. The IBWC is an international body composed of the United States Section and the Mexican Section, each headed by an Engineer-Commissioner appointed by his/her respective president. Each Section is administered independently of the other. The United States Section of the International Boundary and Water Commission (USIBWC) is a federal government agency headquartered in El Paso, Texas. The USIBWC operates under the foreign policy guidance of the Department of State. The Mexican Section is under the administrative supervision of the Mexican Ministry of Foreign Affairs and is headquartered in Ciudad Juarez, Chihuahua, Mexico.

Trade Relations

Mexico is the third largest US trading partner, after Canada and China; and the United States is Mexico's largest trading partner. The United States bought more than 80% of all Mexican exports in 2008. The total trade between the two countries exceeded $367 billion in 2007. This stable trading relationship is due in part to the North American Free Trade Agreement (NAFTA), which is an agreement signed by the governments of the United States, Canada, and Mexico creating a trilateral trade bloc in North America. NAFTA went into effect on January 1, 1994. The Agreement gradually eliminates tariffs and dissolves many other trade barriers, for example quotas. NAFTA is structured to stimulate the border region's industrial growth. Such growth has historically brought about numerous environmental problems. Therefore, NAFTA established two agencies to help deal with the vast environmental concerns along the US–Mexican border. The first such program is the Border Environment Cooperation Commission (BECC), a binational organization that helps develop environmental infrastructure projects related to wastewater treatment, the prevention of water pollution, and the management of municipal solid waste. The other program is the NADBank, which was set up to work in conjunction with the BECC, guaranteeing loans for projects certified by the environmental commission. Both the United States and the Mexican governments supply the funds to the NADBank.

Immigration

Mexico accounts for approximately a third of all foreign-born residents living in the United States, and nearly two-thirds of all Hispanic immigrants to the United States. Of all people who leave Mexico to reside elsewhere, the United States is their principle destination. Recent data indicate there has been a substantial decrease in the number of new arrivals from Mexico to the United States. The flow of Mexican immigrants to the United States began to decrease in the mid-2000s, and has continued to do so through early 2009. This trend can also be found in data from the US Border Patrol, which tends to show that apprehensions of Mexicans attempting to cross illegally into the United States decreased by one-third between 2006 and 2008.

In 2008, an estimated 11.9 million unauthorized immigrants lived in the United States. The majority of these undocumented immigrants are from Mexico. The undocumented immigrant population grew rapidly from 1990 to 2006 but has now stabilized. There were approximately 8.3 million undocumented immigrants in the US labor force as of March 2008. Unauthorized immigrants make up approximately 4% of the nation's population and account for almost five and half percent of the US workforce. In 2005, over 1.2 million illegal immigrants were apprehended by the US Border Patrol, which apprehends about one out of every four illegal border crossers.

Tunnel passages across the US–Mexico border are another challenge as the smuggling of drugs, weapons, and immigrants also takes place through such tunnels. One tunnel running from San Diego to Tijuana was particularly advanced at one-half a mile long, 60–80 ft deep, and 8 ft tall with a concrete floor. That particular tunnel was wired for electricity and had drainage. The California entry was hidden in a very modern warehouse.

The Department of Homeland Security was established on November 25, 2002, by the Homeland Security Act of 2002. On March 1, 2003, the US Department of Homeland Security (DHS) took over the control of the Immigration and Naturalization Service (INS). Some of the agencies now under the Department of Homeland Security are: the United States Citizenship and Immigration Services, which processes citizenship, residency, and asylum requests; the US Customs and Border Protection, which staffs border checkpoints, collects tariffs, and patrols the border; and the US Immigration and Customs Enforcement, which conducts long-term investigations of border violations. The United States Border Patrol is a federal law enforcement agency within US Customs and Border Protection (CBP). The US Border Patrol has just over 20,000 agents and is primarily responsible for immigration and border law enforcement. There are 20 Border Patrol sectors; the Southern Border Sector covers the US–Mexico border, among others.

The US–Mexico border is guarded by over 17,000 border patrol agents. Yet, those agents only have effective control of less than 700 of the 2,000 miles of the border. In an effort to increase security of the US border and decrease illegal immigration into the United States, the Secure Fence Act of 2006 was enacted. The Secure Fence Act of 2006 is to establish operational control over the international land and maritime borders of the United States. The Secure Fence Act of 2006 authorized the systematic surveillance of the international land and maritime borders of the United States, including the use of unmanned aerial vehicles, ground-based sensors, satellites, radar coverage, and cameras; it also authorizes physical infrastructure enhancements to prevent unlawful entry by undocumented individuals into the United States and facilitates access to the international land and maritime borders by United States Customs and Border Protection, such as additional checkpoints, all-weather access roads, and vehicle barriers. The Act also allows for more than 700 miles of double-reinforced fence to be built along the US–Mexico border. Additional fencing was authorized for the states of California, Arizona, New Mexico, and Texas, which have experienced significant illegal drug trafficking and immigration.

A program called “Texas Virtual Border Watch” was created by the State of Texas to allow anyone with internet access to observe and report on the US–Mexico border via their computer. The program was funded by the Texas governor’s criminal justice office, at a cost of $2 million in its first year. The trial version of the Texas Virtual Border Watch received approximately 2,780 reports of suspicious activity by November 2008. The site has users around the world, including Australia. From November 2008 to February 2009, the program has been credited for four drug busts yielding 1,500 pounds of marijuana, and 30 incidents where illegal immigrants were repelled.

Related Topics

- ▶ Bureau of Immigration and Customs Enforcement
- ▶ Department of Homeland Security
- ▶ Hispanics
- ▶ Illegal Immigration Reform and Immigrant Responsibility Act of 1996 (U.S.)
- ▶ Immigration and Naturalization Service
- ▶ Immigration Reform and Control Act of 1986 (U.S.)
- ▶ Mexico
- ▶ Undocumented
- ▶ United States

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Suggested Resources

BlueServo. http://www.texasborderwatch.com

Department of Homeland Security. Preserving our freedoms, protecting America. http://www.dhs.gov/index.shtm

Legal Information Institute at Cornell Law School. U.S. Code: Home. http://uscode.law.cornell.edu/uscode

Library of Congress. http://www.thomas.gov

Pew Hispanic Center, Pew Research Center Project. http://pewhispanic.org

U.S. Immigration and Customs Enforcement. http://www.ice.gov/index.htm

V

Vatican City

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Vatican City, officially titled *Stato Della Citta del Vaticano*, is a walled enclave within the city of Rome, with a surface area of approximately 44 ha and a population of approximately 800. Its significance as the center of Roman Catholicism; its architecture, art, museums, gardens, and historical significance; and its proximity to the center of Rome make it a popular tourist destination. Its importance for immigrant health has two main aspects, as a center of health for those residing within the state, and as a source of moral guidance for those of the Catholic faith elsewhere in the world.

Regarding the first aspect, primary care physicians and other health professionals within the Vatican provide care for residents of Vatican City only, under the Governance of the Department of Health and Welfare. Health needs of visitors are best met in the adjacent precincts of Rome. An exception is the Vatican Pharmacy (*Famacia Vaticana*). By virtue of being the only pharmacy in Vatican City, it provides its medicines duty-free (since the Vatican has no taxes). It caters to approximately 2,000 customers each day. The Pharmacy is located behind the central post office, which is also the Vatican supermarket. There are no contraceptives or abortifacients available within the pharmacy, since the Catholic Church opposes the use of both.

Regarding the second aspect, the leadership of the Church in various health domains is expressed in the work of various organizations. For example, The Pontifical Council for Health Pastoral Care has as its aim to "stimulate and promote the work of formation, study, and action carried out by the diverse Catholic International Organizations in the health care field as well as other groups and associations which work in this sector, on different levels and in different ways." The Pontifical Academies offer a lead for other Catholic Institutes worldwide on ethical issues. National organizations, for example, Catholic Health Australia, provide care and seek to influence policy decisions based on Catholic teaching.

Its special religious character notwithstanding, the Vatican has, through the dissemination of the Catholic faith through the Church, coordinated healthcare efforts throughout the world where there is need. Hence the influence of the Vatican for immigrant health extends well beyond the borders of the Vatican City itself.

Related Topics

- ► Christianity
- ► Italy
- ► Religion, religiosity, and spirituality

Suggested Resources

The Roman Curia Homepage. http://www.vatican.va/roman_curia/pontifical_academies/acdlife/index.htm
The Vatican City-State Homepage. http://www.vaticanstate.va/EN/homepage.htm

VAWA

- ► Violence Against Women Act

Sana Loue & Martha Sajatovic (eds.), *Encyclopedia of Immigrant Health*, DOI 10.1007/978-1-4419-5659-0,

Veil

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A veil is a garment or an item of clothing, worn mostly but not exclusively by women, that is intended to cover all or specific parts of the human body. The veil can refer to a headscarf (*hijab*), or a face veil (*lithma*) that women usually wear just under their eyes, or an all-enveloping cloak that covers the body from head to toe (*burka*). Veiling practices can be found in all major world religions – Judaism, Christianity, and Islam. Veiling practices in religious traditions are typically associated with formal prayer and ritual, where veiling symbolizes the piety, honor, modesty, and respectability of the person, their family, and the religiously marked space and/or ritual. Other religious interpretations and appropriations of the veil are less literal, characterizing the veil as the metaphysical separation between human beings or the world, and God.

Despite the existence of veiling practices in all contemporary religious communities, in recent decades, veiling practices among Muslim women have dominated public discourse and media attention globally, and especially in the West. Indeed, most of all of recent scholarship on the veil maintains a case study and analytic focus on veiling practices amongst Muslim women, and in constructing Islamic "otherness" and difference from the West. For example, according to Leila Ahmed, veiling signifies to many Westerners the oppression of women, the degradation of women by Islam, and the backwardness of Islam. Scholars have discussed the wearing of the veil in public among Muslim women to examine the social status and the subordinate position of women in contemporary Muslim societies and cultures. Such hegemonic understandings have contributed to a fetishizing of the veil and contributed to anti-Islamic sentiments in Europe and North America. The wearing of head scarves and especially face coverings by Muslim women has provoked controversy and raised volatile and contentious political debate over the assimilation of Muslims in France in an era of globalization and religious transnationalism. The recent debate over the use of headscarves in universities and government buildings in Turkey has similarly led to a reconsideration of the meanings of modernity and tradition in Turkey. Hate crimes directed against hijab-wearing women in major cities in the United States following 9/11 have contributed to a fetishizing of Muslim "otherness" (or un-Americanness) through dress and outward appearance.

Recent research has problematized such conventional and reductive understandings of the veil and veiling practices in contemporary Muslim communities that equate the veil solely with female oppression and subordination in patriarchical Muslim societies and cultures. Rather, these studies emphasize the need to view veiling within historical, sociocultural, and geopolitical contexts and specificities. Meanings and significance of the veil vary cross-culturally, such that any universalizing statement risks a reductive understanding of the veil, and veiling practices. One study of lower middle class women in Cairo, Egypt, found that for the majority of these hijab-wearing women, the hijab is a symbol of free will and agency. These women reject dominant, western understandings of the veil as a symbol of female subordination and subjugation, and as an expression of boundaries that restrict the freedom and mobility of women. As women enter the Egyptian work place in increasing numbers, the hijab creates the means for women's freedom from the space of the home, enabling them to move about in public, and enter occupations in mainstream economy. Veiling bridges the gap between tradition and modernity, and is more than just a simple revival of Islamic tradition or fundamentalism. For example, as hijabs become more fashionable, the head covering has come to symbolize the new ways for being a modern Muslim woman, and illustrate the ways in which Muslim women are accommodating tradition.

The use of the veiling garments as sites of consumption and style are not limited to Egypt but can be found among Muslim communities globally. Another study based on ethnographic research in Egypt, Sudan, and Jordan found that veiling references gendered segregation and notions of privacy in the public arena, the identity of the group and rank, respectability, and power.

Recent scholarship has also examined the discursive production of the hijab in popular culture and state ideologies of nationhood and belonging. Shirazi, for example, shows how the connection between hijab and jihad was constructed through the use of postage stamps, billboards, banners, and poster art and film that depicted women as supporters of the Islamists in Iran. According to Shirazi, the veiled woman has become a symbol in Iran of the country's defense against cultural Westernization.

Related Topics

- ► Christianity
- ► Islam
- ► Judaism
- ► Muslim
- ► Women

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Vendetta

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Vendetta is the Italian word for a social phenomenon that is also known as blood vengeance, blood feud, or simply as feud. Generally speaking, a vendetta is a conflict between families which cannot or is not solved by law. Hence, vendettas are common in societies with no or hardly any monopoly of force in the hand of the state. But vendettas also appear in policed societies, often being a phenomenon connected with migration. Here vendettas impress police, medical, or social workers by the amount of emotions and physical force that seem to play a central role in them.

On the other hand "vendetta" is quite a slippery term. Sometimes literature or movies on the subject give the impression that a vendetta is part of an unofficial set of strict rules. The Albanian word "kanun," which describes the traditional set of ideas that surround vendetta, emphasizes that point of view. But these unwritten "codes of honor" are themselves very much subject to linguistic and social change.

The Italian word has its roots in the verb *vendicare,* which means "to take revenge." It is uncertain whether *vendicare* can etymologically be traced back to *vim* (force) but this would make perfect sense as people who commit a vendetta often resort to violence. The word "feud" on the other hand obviously goes back to an Indo-Germanic root meaning "enmity" or "wrath."

The social roots of blood feud can be retraced at least to the Bronze Age. The universal basis of every blood feud is the idea that only blood may wash away blood. "Whoever sheds the blood of men by men shall his blood be shed" is the Biblical explanation of this concept, found at Genesis 9:6. From a sociological point of view, vendetta is (1) a mechanism that serves to keep violence from spreading into society as it limits its use to the conflicting parties alone, (2) a way to maintain a social equilibrium in tribal societies, and, most importantly, (3) a tool of security management in societies that do not have a police force that is concerned about public order.

Keywords to vendetta are family, honor, and manliness. One might feel tempted to follow William Shakespeare ("what is honor? A word") and regard them as a mere words. But these words stand for legal traditions that have been in effect from ancient times to our days. As these terms change meaning and importance in the course of the different social histories, also the words vendetta or blood feud as such actually describe various traditional forms of conflict management.

In Albanian, for example, the word *besa* stands as much for honor as it stands for hospitality and thus describes a network of people who are ready to defend each other against offenders. The Turkish language has two words for honor: *Namus* and *Şeref.* While *Şeref* is the kind of honor one can gain and lose individually, *Namus* describes the honor of a family. And the Sicilian ideal of the *uomo d'onore* (man of honor) is one of the many examples of a culture in which each man is obligated to prove his manliness, for example, by avenging himself when wronged.

Migration brings together different cultural interpretations of family, honor, and manliness. The results of such encounters can be astonishing. The killing of Hatun Sürücü by her brothers in Berlin in 2005, for example, was also openly applauded by non-Kurdish youths. They were mainly impressed by what they understood as a defense of honor and manliness. This shows that a cultural background might explain one part of blood feud in modern societies. But social integration or the absence thereof is another important key to understanding vendetta. In 1952, the French doctor Frantz Fanon described what he called the "North African Syndrome": When asked to localize their pain, Fanon's immigrant patients (mostly from Algeria and Morocco) answered that their entire body hurt. Fanon interpreted this as a neurosis caused by their disregard by the French majority. Such a painfully felt lack of integration might indeed reinforce family bonds in migrant milieus and reinvigorate even long forgotten ideas of blood vengeance.

Immigration often is a family business. Migrants in most cases tend to immigrate into social contexts they know from their home countries. At an early stage of migration a certain cultural segregation is thus to be regarded as normal. Family ties at this stage of migration are very tight. Immigrants coming from a cultural background that encourages blood feud might feel even more bound to its unwritten rules. In Germany, for example, this is the case with some Kurdish, Lebanese, and Turkish families.

The most famous form of vendetta has been depicted in many movies about Sicilian families in North America. Pino Arlacchi argued that vendetta has – in the hands of Mafiosi – been transformed into a market on which violence is traded. But still, the main ingredients of a vendetta constitute components of today's Mafia: kinship, security, honor, and readiness to use violence in order to defend it honor and family. Mafia families describe themselves as *coscas* (artichokes). Like the leafs of an artichoke, the members of a *cosca* cover and protect each other from the outside world. The picture of the artichoke might help to understand why it sometimes is extremely difficult to even talk to people with a cultural background that favors blood feud.

Honor killings are another social phenomenon that can be connected with vendetta. The notion of honor describes the capacity of a family to defend itself against any kind of intrusion or offense in those societies that rely on blood feud as legal tool. But this notion loses its sense in policed societies. The campaign "honor is protecting my sister's freedom" operated by the nongovernmental organization *Terre des femmes* in Germany quite successfully helps youths from different cultural backgrounds to give a new meaning to honor, one of the key components of vendetta.

Related Topics

- ► Domestic violence
- ► Family
- ► Machismo/Macho
- ► Violence

Suggested Readings

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http://www.frauenrechte.de/tdf/pdf/EU-Studie_Ehrenmord.pdf
http://www.stophonourkillings.com/?q=node

Vietnam

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Vietnam's history is one of struggle against outside control. It is essential to have a minimal understanding of recent Vietnamese history and culture to be able to address the health needs of Vietnamese immigrants. Records suggest that Vietnam was a subject state to China for almost 1,000 years until the tenth century. It remained free for much of the next 900 years but in a state of persistent conflict with neighbors and sometimes within its borders. It was during this period that Vietnam began to adopt Buddhism. In the nineteenth century, the French invaded, imposed colonial control, and propagated Christianity. During this time, calls for self-rule were ignored or suppressed by the French who established a plantation economy and ruled primarily from the south of the country.

World War II

The Japanese occupied Vietnam during World War II under the auspices of the Vichy French regime that was beholden to Nazi Germany. Ho Chi Minh, considered the founder of modern Vietnam, established a Communist movement for the long-term goal of overthrowing the French after the war. He initially allied himself with the Chinese Nationalists and USA against the Japanese occupiers. As the war neared its conclusion, the Japanese overthrew the French colonialists and declared Vietnam to be independent. Simultaneously, in 1945 a severe famine struck Vietnam killing one to two million people out of a population of ten million, and led to social instability and popular revolts against both the Japanese and the remnants of French colonial society.

First Indochina War

At the conclusion of the war in 1945, the Allied powers returned Vietnam to French control. The Viet Minh – a group led by Ho Chi Minh, attempted to declare independence after Japan's surrender, but chaos and conflict led to continued famine and their forces were pushed out of the cities. The Viet Minh fought a guerilla war against the French until the Chinese communists under Mao Zedong reached the Vietnamese border in the 1950s and began supplying heavier weapons and providing training. This led to a catastrophic defeat of elite French troops at the Battle of Dien Bien Phu in 1953 and, 1 year later, Vietnam was again divided – this time at the 17th parallel. In 1954, control of North Vietnam was given to the communist Viet Minh, and the South became the State of Vietnam, with a plan for unification elections to be held in 1956. At least 800,000 people – mostly Catholics – moved from North to South Vietnam, and 52,000 are believed to have moved from South to North. During this time, the People's Republic of China decreased its support for the Viet Minh, and North Vietnam became a close ally of the Soviet Union. The unification elections were not held because the American-supported South Vietnamese believed they would lose control of the country to the communist Viet Minh.

Second Indochina War

The 1954 division led to the Second Indochina War (referred to in the USA as the Vietnam War) from 1960 to 1975. It began with indirect American support in the 1960s and escalated to years of continuous bombing campaigns and massive commitments of troops and resources from the USA and its allies. In the face of massive public opposition and political lack of will, the USA signed the Paris peace accords and withdrew from Vietnam in 1973. Two years later, South Vietnam fell to the forces of the Communist north. By the end of the war, more than 3.1 million Vietnamese had been killed and 2.6 million injured. This marked the end of 116 years of foreign control of Vietnam and 30 years of continuous warfare since the end of World War II.

After the unification of Vietnam in 1975, more than one million Vietnamese who were considered to have collaborated with foreign enemies of the new Communist State were placed in "reeducation camps," and 165,000 of them are estimated to have died there. Reports state that one in three South Vietnamese families had a relative in a reeducation camp and that the average sentence was for 10 years under harsh physical and mental conditions. At least 34,641 survivors are known to have fled to the USA after their release with 128,068 of their family members.

Conflict returned 4 years later in 1979 when Vietnam (with Soviet support) invaded Cambodia to topple the Khmer Rouge, allies of the Peoples Republic of China. The Khmer Rouge were believed to have killed 21% of all Cambodians in a genocidal campaign. This led to an aborted Chinese invasion of northern Vietnam and the expulsion or fleeing of 450,000 ethnic Chinese refugees from Vietnam by boat or across the border to China. Between 1975 and 1995, more than three million people are thought to have fled Vietnam, Laos, and Cambodia, many as "boat people" who ended up across the world. Some estimates suggest that as many as 250,000 boat people died on their journey. The ones who survived did so in extremely harsh conditions, often languishing in refugee camps for years with the constant threat of return to the country they had fled.

Emigration, Refugees, and Exodus After the War

Almost 1.4 million refugees from Southeast Asia ended up in the USA after this period of war and conflict; 1.1 million of them are thought to have been Vietnamese, the majority living in California and Texas. More than 250,000 Vietnamese refugees are thought to have settled in Orange County, California alone. A significant percentage of Vietnamese refugees were fathered by some of the more than three million male American personnel stationed in Vietnam during the war. These children often experienced discrimination and abuse in Vietnam because of their illegitimate parenthood.

Even after 2000, one out of seven Vietnamese who went to the USA did so up to 25 years after the end of the war. Studies of the Vietnamese immigrant experience have suggested that assimilation in the USA has been difficult, although the majority have been naturalized as American citizens over the years. Two-thirds of all Vietnamese immigrants in the USA have limited English proficiency. Vietnamese men are less likely than other foreign-born residents to be employed. There are more than 150,000 Vietnamese in Canada, and their experience is reportedly similar to Vietnamese-Americans.

Australian-Vietnamese comprise 0.8% of the Australian population – 159,848 people in the 2006 Census. Ethnic Vietnamese also comprise the largest Asian population in Germany. The majority of them arrived in the 1960s or 1970s as refugees from the Second Indochina War, and many originally settled in the former German Democratic Republic (East Germany), where they were the largest immigrant group. Other Vietnamese immigrants, numbering in the tens of thousands for each country, settled in the eastern bloc nations of Europe and Russia. Norway accepted almost 20,000 Vietnamese as refugees after 1975.

In Cambodia, Vietnamese are thought to make up as much as 5% of the population, although no reliable data exist. Vietnamese immigrants in Cambodia have at times been subject to violence by the majority ethnic Khmer population; antagonism by the Khmer was one of the reasons given for the Vietnamese invasion of Cambodia in 1979. However, Vietnamese immigrants returned to Cambodia when that nation's market economy was opened after improved political stability in the 1990s.

French-Vietnamese have had communities in France since the late nineteenth century, concurrent with French colonization. Unlike the USA and other nations with large Vietnamese populations, the French-Vietnamese are characterized by high degrees of assimilation and strong identification with their adopted nation, especially in the second generation.

Following years of polarization between the Vietnamese government and many who fled during and after unification, relations with "Viet Kieu" or overseas Vietnamese have begun to improve as Vietnam tries to encourage the return of Vietnamese who can bring capital and expertise.

Labor Migrants

Prior to 1999, other than cross-border migration, only official state enterprises could send workers abroad. Since 1999, private enterprises have been allowed to do so. In 2002, there were approximately 46,000 Vietnamese workers overseas. The most common destinations are Malaysia, Taiwan, and Laos. The bulk of workers are domestic helpers, but others work in factories, low-skilled construction jobs, and the garment or the seafood and marine industries.

Human Trafficking

Human trafficking is a form of exploitation that involves controlling and transporting people through the use of force, deception, or coercion. It is reported to be the third most profitable criminal activity in the world after drug and gun smuggling and resulted in estimated worldwide profits of US$31 billion in 2008. Vietnam is a significant source for trafficking in persons. Women were trafficked primarily to Cambodia, Malaysia, China, Taiwan, and South Korea for sexual exploitation. Women were also trafficked to Hong Kong, Macau, Thailand, Indonesia, the UK, Eastern Europe, and the USA. At the same time, Vietnam imports trafficked Cambodian and Chinese women, who work in the local commercial sex industry.

The Cambodian sex industry appears to be heavily controlled and staffed by Vietnamese, with the workers being paid subsistence wages and subject to violence. The traffickers are reportedly organized crime syndicates, who obtain women referred by relatives, friends, intimate partners, and neighbors. In 2004, a report by Cambodian police estimated that more than 50,000 Vietnamese women were brought into Cambodian brothels. One-third are estimated by UNICEF to be under the age of 13 years. Young Vietnamese girls who are virgins are highly sought after by traffickers, as they are believed to be free from HIV or sexually transmitted diseases. Reports state that they are bought for as little as a "week of use" at a time and confined to a hotel or guesthouse room for the duration.

Trafficked women are at high risk of sexually transmitted diseases and often have their access to health care and diagnostic testing restricted by their employer. Healthcare workers who see victims of trafficking may not realize their patient's history or at best may mistakenly screen them only for domestic violence.

One female trafficking program of quasi-legal status seen in Vietnam consists of marriage agencies. Marriage services are illegal in Taiwan, but heavily patronized; in 2005, it was estimated that more than 118,000 Vietnamese women had been brought to Taiwan as brides. These women are particularly vulnerable to domestic violence, rape, and forced labor as they have little recourse or access to information or resources. Women sometimes arrive to find themselves in indentured servitude. According to reports from the United Nations High Commissioner on Refugees, at least 3,000 women had been left stateless by divorce or being disowned. This particularly impacts their health and their children's education as they may not be eligible for state services if they return to Vietnam. Marriage agencies are also used in South Korea, involving thousands of Vietnamese women and South Korean men from rural areas.

Vietnamese Culture and Communication

Like many Southeast Asian cultures, importance is given to the family over the individual. Elder family members are given significant weight in decision making, and families are expected to care for elders. The oldest male will often be given the role of speaking for the family, and this can be difficult for Western healthcare workers who may not understand why a female or younger patient is deferring or refusing to make a decision if the spokesperson is not present. Because there is a cultural tendency to avoid conflict with authority figures, Vietnamese families may appear to be passive when they do not respond to cognitive reasoning by doctors and nurses.

Vietnamese may expect immediate relief through the prescription of a medicine or a procedure. A failure to provide a medication or intervention may result in their seeking medical attention elsewhere. Accepted alternative forms of health care not only include traditionally Asian herbal medicines and interventions (e.g., acupuncture, cupping), but also access to Western medicines from nonphysician practitioners, including pharmacists and "injectionists." Providers should be aware of the risk of discontinuation of medicines after symptom relief and provide adequate counseling regarding potential risks should the full regimen not be completed or "leftover" medication shared with others. The treatment of asymptomatic chronic diseases – such as diabetes, hypertension, hypercholesterolemia, and HIV – can be challenging if not handled with due care to the patient's need for education about the nature of chronic disease and reinforcement of adherence. This should be offered in Vietnamese if the patient's English language ability is limited. In addition, some patients may believe that Western pharmaceutical dosing is too strong for them due to differences in physical size, and patients may choose to self-adjust doses.

Despite these independent belief patterns, Vietnamese society gives great respect for medical education and training. However, they may not be accustomed to seeing the importance of patients and doctors working together in a cooperative healthcare process. It may not be expected to have doctors probe extensively and perform a thorough review of symptoms, especially regarding sensitive health issues such as sexual and mental health. By the same token, extensive discussion and explanation of options or treatments in English can be difficult for primarily Vietnamese-speaking patients to follow.

Complex or prolonged illness will often be viewed as a combination of factors rather than the traditional reductionist thinking taught in Western allopathic medicine (e.g., Occam's razor). When diagnosed with an infection, Vietnamese patients may see a role for spiritual factors and a loss of balance in internal "humors" (hot and cold in particular). Thus, some patients may choose to "mix and match" modalities. The management of a specific condition may include seeking advice from a spiritual practitioners and herbal remedies in addition to filling a prescription. Healthcare providers should be aware of the potential for this addition of external healthcare approaches and the potential risk for drug interactions and poor response to prescribed treatment.

Pregnancy

There are a number of cultural traditions surrounding pregnancy and childbirth. Although the importance of prenatal care is well known, recent immigrants may not know it is freely available under health insurance options available in many high-income countries. Miscarriage is associated with eating too many humorally "hot" foods as well as intercourse during pregnancy or raising one's hands above the head. Post-partum women are considered vulnerable to a loss of body heat.

Mental Illness

PTSD and depression can be serious issues among Vietnamese immigrants, especially former military and civilians who survived the wars in Indochina. Life experiences with bombing campaigns, or living as boat people and/or in refugee camps where people were at risk of rape, predation, and violence can all contribute to long-term mental health issues. Immigrants to western countries may describe isolation, harassment (verbal, sexual, or physical), stigma, and loss of status.

It is commonly difficult for the Vietnamese to discuss mental illness, and practitioners should be alert for psychosomatic presentations of PTSD and depression when vague symptoms are reported that do not respond to commonly prescribed treatments. Investigations of vegetative functions like sleep, appetite, and motor activity may be more useful than traditional markers of mood and guilt.

While most clinicians strive to establish a good rapport, with Vietnamese patients, a strong alliance and validation of the patient as a partner in the provider–patient relationship is crucial before introducing the idea of psychiatric care or referral. This may take several visits and even then should be introduced slowly and sometimes indirectly. Local Vietnamese community support organizations can be invaluable in providing advice in many cases. In smaller communities, confidentiality can limit clinicians' ability to access them without prior patient approval.

Tuberculosis (TB)

Vietnam has reportedly exceeded WHO targets for addressing TB and is the only country of the 22 nations with the highest prevalence of TB to do so. As of 2007, it was reported to have a low incidence of multidrug-resistant TB, and current figures suggest a relatively low HIV prevalence rate of 0.5%. However, rates of TB detection are not decreasing, suggesting that there may be a new epidemic emerging among Vietnamese in Vietnam, particularly among young adults. It is not clear if this represents increasing HIV disease, internal migration, better detection, or increased spread of drug-resistant TB from China.

Ethnographic studies of TB in Vietnamese in Vietnam suggest that providers need to address a number of specific misconceptions, including (1) "everyone has TB", (2) the BCG vaccination leads to immunity to TB, and (3) the issue of blood loss and X-rays mentioned above.

Infections remain the most common cause of death in Vietnam. However, as the Vietnamese economy improves and people are living longer, patients are increasingly developing chronic diseases like diabetes and cardiovascular disease.

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Vigilante

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"Vigilante" is derived from the Spanish word for "watchman" or "guard." Merriam-Webster defines a vigilante as a member of a volunteer committee organized to suppress and punish crime summarily, as when the processes of law are viewed as inadequate, and more broadly as a self-appointed doer of justice. More simply, a vigilante is someone who illegally punishes for perceived offenses. Vigilantes may seek to enforce existing laws or they may have their own concept of right and wrong.

There are abundant examples of vigilantes in popular culture. Most of the time, they are portrayed as "good guys" rather than as criminals. Robin Hood was embraced by the common people because he "stole from the rich and gave to the poor." Zorro protected the people of his land from corrupted officials. Many of our comic book superheroes could be classified as vigilantes. Batman, The Punisher, and Daredevil became crime fighters because of violent losses in their pasts that the law was helpless to do anything about. Dexter Morgan, a fictional character created by Jeff Lindsay, is the serial killer who kills other serial killers.

Real-life vigilante groups have existed throughout history, each with their own agenda. Like the fictional examples above, some have been perceived as righteous and beneficial to society; others have been viewed in less positive light.

- In colonial America, the Regulator Movement was composed of private citizen volunteers who wanted to punish banditry.
- The Sea Shepherd Conservation Society has been fighting illegal fishing and whaling practices since 1977.
- The Bakassi Boys of Nigeria formed in 1998 to fight crime when police were ineffective.
- The Irish National Liberation Army punishes criminals who harm the working-class people of Ireland.
- The Davao Death Squad in the Philippines carries out extrajudicial punishment of criminals.

Some of the most active vigilante groups across history have been those opposed to illegal immigration. These vigilante groups promote Nativism which is the policy of supporting native-born citizens or established inhabitants over immigrants.

More people immigrate to the United States than to anywhere else in the world. They come in pursuit of the American dream. There are those that feel that resources and opportunities for Americans are being unjustly given to non-Americans. Extremist Nativists literally believe American ideals and traditions are being destroyed by illegal immigration. Accordingly, vigilante groups have sprung up to remove illegal immigrants from the USA and to prevent people from illegally crossing our borders.

As far back as the 1800s, there were vigilante groups in the United States with an interest in removing unwanted immigrants from the country. The San Francisco Committee of Vigilance was formed in 1851. Although the primary focus was on crime and government corruption, they also deported illegal immigrants. Interestingly, immigrants to the United States sometimes formed their own vigilante groups to combat those they felt were trying to oppress them and restrict their chances for success in a new land. The fabled Molly Maguires (1870s) was a secret group of

Irish immigrants formed in Northern Pennsylvania who used terror tactics to combat coal mine owners. There is historical debate as to whether or not this group actually existed in the US. Some evidence suggests that the Mollies were just as much the victims of vigilantes as they were victimizers.

The original Ku Klux Klan was formed after the American Civil War by Tennessee veterans of the Confederate army. The Klan used terrorism and murder as tools of oppression against minorities. Their goal was to restore White supremacy. Although Black Americans were their number one target, the Klan was also anti-Catholic, anti-Semitic, and anti-Communist. All the various versions and manifestations of the Klan over the years have taken an anti-immigration stance.

In modern times, regulating immigration across the United States-Mexican border has been a hot-button political issue for over a decade. There are several vigilante groups that have dedicated themselves to stopping illegal Mexican immigration including the American Border Patrol, Civil Homeland Defense, and Ranch Rescue. Some of these groups organize armed patrols of the border. To discuss one example in more depth, the Minuteman Project was founded by Jim Gilchrist in October 2004. This organization describes itself as a "citizens' Neighborhood Watch on our border." Gilchrist, a Vietnam veteran and Purple Heart recipient, has been a very controversial figure in the immigration debate. He said he founded the Minuteman Project because he was tired of law enforcement's failure to enforce existing immigration laws and prevent the "invasion" of our country by Mexican immigrants. The Minuteman website boasts that the organization is "operating within the law to support enforcement of the law."

The internet has endless links to and about organizations dedicated to discussing illegal immigration across the US–Mexican border. Some of these websites view the vigilante groups favorably and other links are highly critical of the methods used by the vigilantes to achieve their goals. The Border Action Network and the Southern Poverty Law Center are two organizations that have been vocal about abuses done by some citizen border patrol groups. Sadly, anti-immigration extremists have resorted to violence and even murder to achieve their goals. Illegal border crossings take place in isolated areas where violence against the immigrants is less likely to be witnessed. Individuals who survive the crossing are unaware of their rights. They rarely report abuses because they know they will be detained while the case is looked into. The motivation to return to Mexico and reattempt the crossing is greater than the motivation to seek justice for violent offenses.

Anti-immigration vigilante groups are not restricted to the United States. After the United States, Russia was second greatest immigration destination in the world in 2008. According to a 2/14/09 Newsweek article on "The Kremlin Vigilantes" by Owen Matthews and Anna Nemtsova, there were 7 million migrants, 2.8 million legal and about 4 million illegal immigrants to Russia in 2008. During preceding years of economic expansion, immigrants were accepted and found semi-skilled labor jobs. Now that the economy is suffering and unemployment is high, there is backlash against foreigners. Per this article, violence against foreigners has greatly increased and some of the hate crimes have been horrific. The Movement Against Illegal Immigration (DPNI) and the Youth Guard have indicated willingness to train vigilante groups to assist police in locating illegal immigrants. In February 2009, Italian Prime Minister Silvio Berlusconi legalized private, night-time unarmed citizen groups to patrol the streets and report suspicious individuals to police. This is part of the plan to crack down on illegal immigration. People who oppose this decree consider the citizen groups to be vigilantes.

In summary, vigilantes are citizen volunteers who take the law into their own hands. Across time, vigilantes have been viewed both positively and negatively depending on the historical context and the actions taken by the groups. Anti-immigration vigilante organizations can be found around the globe. In the United States, there are several vigilante groups dedicated to monitoring the US–Mexican border. When emotions and socioeconomic pressures are high, vigilante groups can resort to violence to achieve their goals. We must be mindful of human rights violations perpetrated against immigrants, both legal and illegal.

Related Topics

- ► Hispanics
- ► Human rights
- ► Mexico
- ► Undocumented

Suggested Readings

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Suggested Resources

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The Minuteman Project. http://www.minutemanproject.com/

Violence

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Introduction

Regardless of whether the crime is physical, property based, or drug-related, it negatively impacts communities, including immigrant communities, particularly with regard to mental health. Despite the overall decrease in crimes of large urban cities in the USA that also have large immigrant populations, crime continues to impact perceptions of safety and overall general well-being.

Crime and Health

Criminal acts provoke fear. Fear of crime can push people to relocate from an area if they are able to do so, increasing the social disparities within that area, especially in urban settings. Crime and the fear it engenders decrease quality of life. As quality of life decreases, community social relations can become strained and the residents can become increasingly stressed by the crime. Due to the strain on social relations over time, a community's economic status may also decline as the area is avoided or abandoned. Another reaction to crime or the fear of crime is feelings of helplessness. Positive associations with one's surroundings increase one's perceptions of safety. However, when people feel helpless, they often choose not to return to the neighborhood if they are able to leave. When the negative environmental aspects of a socially disempowered community dominate, it is difficult for individuals, both within and outside the community to feel welcomed and safe.

Immigrant Communities and Crime

Research findings are mixed regarding immigrants and crime, suggesting that the prevalence of victimization is similar between immigrants and US-born adults. For example, foreign-born populations in Chicago were disproportionately locating in the safest neighborhoods. On the other hand, a study that analyzed the impact of street crime on Boston's Chinatown, one of Boston, Massachusetts's immigrant communities, indicated high concentration of crime, including violent crime. The researchers concluded that the zoning of the Boston adult entertainment district next to Chinatown was the major source of crime.

Among school-aged Latino children, first-generation immigrant students were more likely to feel unsafe, while less likely to be a victim of school violence. Third- and second-generation students were more likely to be victimized. This is consistent with a broader literature showing worse health and educational outcomes with increased length of stay in the USA. In addition, native English-speaking Latino students were less likely to be victimized at school. It may be that socioeconomic income has more of an impact on victimization than generation. As the student's family income increased, their fear for safety decreased.

Other research suggests that the concentration of Latinos has no effect on the incidence of Latino homicide. The immigration of Latinos into the ethnic enclaves may decrease the incidence of robbery and may stabilize conditions for the population. Apparently, this finding does not hold in Black communities, where violence does not decline when Black populations become more concentrated. Adolescence and violence are often associated. However, immigrant concentration has been found to deter violence among adolescent youth.

Domestic violence is distinct from other forms of violent crime in that it is often underreported, and this may be particularly true for immigrant families. The immigration process and acclimation to a new host country is a stressful time in most families. US-based research involving Chinese immigrants suggests that the power relations among couples may change following immigration to the USA due to the male spouse's loss of income in relation to the wife's gain in income. As a result, the patriarchal societal structure to which some Chinese immigrants are accustomed may change, with a resulting loss of decision making power by the male. This shift in power relations has been found to be a leading predictor of domestic violence.

In some cultures where women may have financial dependence on their husband, they may be reluctant to report abuse due to lack of independent resources. Undocumented family members may be at higher risk of both abuse and inability or unwillingness to report the abuse due to fear of deportation. In addition, immigrant women may not have information about shelters that can assist them in leaving the abusive relationship. Language and economic barriers may also impede immigrant women's efforts to obtain information about the legal system within the host country and to avail themselves of legal procedures that may help to alleviate their abusive situations. US-based research has found that the prevalence of domestic violence is similar in immigrant and native communities, but the severity of violence and how each immigrant community addresses the violence varies. It is critical that resources be established within immigrant communities that addresses the need for housing, health, education, and employment, in addition to shelters for women of domestic violence.

Related Topics

- ► Border health
- ► Child abuse
- ► Childhood injuries
- ► Convention Against Torture
- ► Domestic violence
- ► Ethnic cleansing
- ► Eugenics
- ► Family violence
- ► Genocide
- ► Homicide
- ► Injuries
- ► Rape
- ► Slavery
- ► Terrorism
- ► Torture
- ► Trafficking

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Violence Against Women Act

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The Violence Against Women Act (VAWA) was signed by US President William Jefferson Clinton in 1994 and was reauthorized in 2000 and 2006. When it was passed, VAWA was considered by many advocates as first and the most comprehensive recognition of and response to domestic violence and sexual assault in US history. In general, the VAWA allocated funding to the states for training, prevention, and intervention services and created new criminal penalties for these crimes.

The Battered Immigrant Women's Protection Act was included in the 2000 reauthorization and provided additional legal remedies for immigrant or noncitizen battered victims. Today, three legal remedies exist for noncitizen immigrant victims of domestic violence: self-petition, cancellation of removal, and battered spouse or child waiver. The self-petition remedy allows noncitizen domestic violence victims, who were married to or recently divorced from a US citizen or legal permanent resident, to apply for legal permanent residence without the assistance of the abusive partner. To make these claims respondents must show a history of substantial physical or mental abuse in the context of an intimate relationship. Cancellation of removal is a remedy for noncitizens that are in or in threat of being placed in deportation proceedings. The Battered Spouse or Child Waiver is for victims who have a conditional "green card." This remedy allows for the conditional permanent residency requirement to be waived before the typical 2-year period. These legal remedies explicitly recognize the power and control dynamics experienced by noncitizen immigrant victims.

Noncitizen victims and their legal representatives are utilizing these remedies in federal immigration courts. Many of these cases are being handled by faculty and law students working in immigration clinics in schools of law, by nongovernmental organizations, and individual attorneys often on a pro bono basis. For example, American Gateways (formerly known as Political Asylum Project of Austin) in Austin, Texas, has a program to provide free and low cost legal services to immigrant battered victims. Many other organizations and individual attorneys throughout the USA also provide these vital legal services to noncitizen battered victims.

Immigration law is very complex, and therefore experts are often needed to provide clarification on substantive issues related to the claim. Experts may also offer the court an opinion on the credibility of a respondent and the consequences of deportation in VAWA cases. Experts are also often needed to educate the court on the prevalence, dynamics, and complexity of domestic violence, the effects of trauma and abuse on victims, the impact of deportation on the victim and children, and may need to discuss a lack of resources or dynamics of how domestic violence is viewed in the respondent's country of origin.

Related Topics

- ► Domestic violence
- ► Immigration status
- ► Intimate partner violence

Suggested Resources

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Visa

- ► Immigrant visa status
- ► Immigration status

Vision and Eye Care

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Blindness and visual impairment are one of the top five leading causes of disability in the USA. Representing a critical public health problem, these conditions have a major impact on society as well as on individual's quality of life. Having a history of eye disease – cataracts, diabetic retinopathy, macular degeneration, and glaucoma – has been associated with having a higher risk of visual impairment and blindness.

Because prevalence and progression of most of these eye diseases can be controlled with adequate and timely vision care, the importance of routine eye examinations cannot be overstated. National guidelines suggest a comprehensive dilated eye exam once a year for the general population over 40, and more often for those with a history of eye disease.

Latinos comprise the largest minority group in the USA and the fastest growing segment of the population. From a socioeconomic and biologic perspective, Latinos seem to be at a higher risk for visual impairment and blindness. Additionally, Latinos are overrepresented amongst immigrants with lower health care quality and thus too often do not receive the eye care they need. For example, Latinos comprise over 90% of hired farm workers in the USA. Of this subgroup, more than two thirds have never had an eye health care visit. Lower socioeconomic status and poor health literacy are examples of some of the factors that are present at a higher rate in immigrant subpopulations, and that are often associated with worse care. Most studies done on immigrant populations have focused on maternal and child health, depression, infectious diseases, tobacco and substance use, chronic diseases, and cancer. Vision and eye care have not been commonly studied. This is important because of the existing disparities that exist in relation to actual eye care. Especially concerning is the fact that there is a growing older population and that many eye diseases are treatable and preventable when diagnosed in their early stages. For example, those who are over 65 are at a higher risk of having other medical problems such as hypertension and diabetes mellitus that cause direct changes to the retina when poorly controlled. These conditions may result in subsequent vision impairment and other eye problems which elevate the risk of vision loss. The Los Angeles Latino Eye Study is the first and largest epidemiologic study of eye disease in the Latino population in the USA. Furthermore, it is the first investigation of its kind to evaluate the prevalence of blindness and visual impairment, as well as major eye diseases in the Latino population.

Eye Care Use in Latinos

Visual impairment and blindness may cause significant morbidity and mortality when not appropriately and timely treated. These conditions especially affect health and quality of life in older adults. Activities of daily living, psychological health, physical health and work-related activities are some examples of how visual impairment may affect subjects. Significant disparities among different segments of the population have been extensively reported. Latinos are one of these groups which are not receiving adequate eye care per recommendations of the American Academy of Ophthalmology. Data from the Los Angeles Latino Eye Study revealed that approximately 63% of the study participants had eye diseases which had not been previously detected. For example, more than 75% of the people with glaucoma in this study, a potentially blinding condition, had no history of the disease or treatment. In the case of age-related macular degeneration, the leading cause of visual impairment and blindness in the USA, only 21% of study participants with the disease had visited an eye care provider in the last 12 months, as recommended per guidelines. Lastly, Latinos have a high prevalence of diabetes mellitus. Diabetic retinopathy is an ocular disorder which is a frequent complication of diabetes. Sixty-five percent of those study participants with diabetes had not complied with vision care guidelines for people with this disease. Language differences, health education, having diabetes, and insurance coverage are primary risk factors for not getting appropriate and needed eye care in this population. Facilitating vision care access and thus providing timely detection and treatment of eye diseases would greatly decrease the burden of visual impairment and blindness in this population.

Visual Impairment and Blindness in Latinos

A person is visually impaired when daily activities are challenging even when wearing regular glasses, contact lenses, taking medicine, or having had surgery. There is no universally accepted definition of visual impairment. Even though many evaluations solely include a measurement of visual acuity, the definition of visual impairment includes a measurement of peripheral visual field as well. The three most commonly used definitions of visual impairment are:

1. Best-corrected visual acuity (VA) of 20/40 or worse in the better seeing eye (including 20/40). Visual impairment was categorized as mild (20/40–20/63),

moderate (20/80–20/160), or severe (20/200 or worse).

2. Best-corrected VA worse than 20/40 but better than 20/200 (not including 20/40 or 20/200).
3. Best-corrected VA worse than 20/63 but better than or equal to 20/400 (not including 20/63 but including 20/400). This definition has been used by the World Health Organization.

Data from the Los Angeles Latino Eye Study suggest that Latinos have a higher age-specific rate of visual impairment than other ethnic groups in the USA. The overall prevalence for visual impairment was 3.0% with a range that went from 0.9% for the younger subjects (40–49 years) to 27.8% for the older subjects (≥80 years). The overall prevalence of blindness was 0.4% with a range from 0.2% for those 40–49 years old, to 4.2% for those 80 or older. Higher rates were seen in older Latinos as well as in female Latinos. Commonly found risk indicators were lower socioeconomic status, unemployment, having lower levels of education, having a history of eye disease, and having diabetes. Those with higher levels of education (12 or more years) were less likely to be visually impaired. In comparison to other ethnic groups in the USA, this study confirmed Latinos having the highest age-specific rates of visual impairment of any racial/ethnic group in the USA. Specifically, Latinos seem to have higher prevalence of visual impairment and blindness than non-Hispanic Whites in the USA, and lower prevalence than African Americans only in the younger ages but higher rates in older individuals. Screening and early treatment would thus be helpful to decrease the burden of eye disease caused by visual impairment.

Lens Opacities

Lens opacities or cataracts, which are mostly related to aging, are a clouding of the lens in the eye which affects vision. Cataracts are the leading cause of visual impairment in the USA. As with most eye diseases, prevalence is more common after 40. However, even though people may have cataracts in their 40s and 50s, cataracts start affecting vision on those subjects who are 60 or older. There are three major types of age-related lens opacities categorized based on their location. Nuclear opacities occur in the central region of the lens; cortical occur in the region surrounding the central core; and posterior subcapsular opacities occur at the back of the lens. The Lens Opacities Classification System II (LOCS II) is a system based on photographic standards to classify the severity of cataracts. There are three definitions of lens opacities: "*All lens changes*" are defined with the presence of at least one gradable lens opacity according to the LOCS II; "*Any lens change*" is defined as any of the three types that is gradable in either eye; and "*Single and Mixed lens changes*" of opacities refers to the presence of one or more different types of opacities in one subject.

Data of the Los Angeles Latino Eye Study reveal that all types of lens opacities increase with age. Twenty percent of study participants had "*all lens changes*," 7.6% had cortical-only opacities, 3.5% had nuclear-only opacities, 0.4% had PSC-only opacities, and 5.9% had "*mixed-type opacities*." Latina women have a significantly higher rate of lens opacities than Latino men. As in the general population, the risk of cataracts increases with age, diseases like diabetes, exposure to sunlight, and personal behaviors such as smoking and alcohol intake. The study data also revealed significant visual impairment associated with lens opacities. This is important because cataracts are a treatable cause of vision loss; therefore the importance of timely vision care cannot be overestimated in the reduction of visual loss in Latinos.

Diabetic Retinopathy

Diabetic retinopathy is a leading cause of vision loss in the USA, the most common eye disease in people with diabetes. It is one of the complications of diabetes and the most common of those which affect the eye. It is caused by changes in the blood vessels of the retina. People with diabetes are at a significantly higher risk of losing their vision than those without the disease. When left untreated, diabetic retinopathy may cause severe vision loss or blindness. There are four stages of diabetic retinopathy: mild nonproliferative retinopathy, the earliest stage with small areas of swelling in the retina's blood vessels; moderate nonproliferative retinopathy some progression with some blocked blood vessels; severe nonproliferative retinopathy with more blocked blood vessels starting to leave some areas of the retina with no available blood; and proliferative retinopathy in which new blood vessels start appearing as the retina sends signals of undernourishment. These new blood vessels are abnormal and while they do not directly cause vision loss, they are fragile and can leak which consequently may cause severe vision loss or blindness.

There is an increased risk of diabetic retinopathy with longer duration of diabetes. Furthermore, Latinos have a high prevalence of type 2 diabetes mellitus and therefore are at a greater risk of developing diabetic retinopathy. Data from the Los Angeles Latino Eye Study revealed a threefold increase in risk of visual impairment in persons with diabetic retinopathy versus those without diabetes. Of those participants with diabetes mellitus, 46.9% had diabetic retinopathy. Data from this study also revealed that lower education, being uninsured, not having had a routine physical examination in the previous year, and having higher levels of glycosylated hemoglobin were risk indicators for increased noncompliance with recommended vision care. Even though comparisons of the prevalence of diabetic retinopathy among different groups are difficult because of different definitions and techniques used, data from this study suggest that Latinos may have higher rates of more severe diabetic retinopathy which affects vision, when compared to non-Hispanic Whites in the USA. Given that vision loss from diabetic retinopathy can be prevented with timely vision care, guidelines recommend that subjects with diabetes have a dilated eye examination at diagnosis and yearly thereafter.

Glaucoma

Glaucoma is the second leading cause of blindness worldwide. Glaucoma refers to the disease in which the pressure inside the eye increases damaging the eye's optic nerve. When left untreated, glaucoma may result in vision loss and blindness. However, vision loss can be avoided with early treatment. Any increase in ocular hypertension does not mean that the subject has glaucoma, but rather the subject is at an increased risk of developing glaucoma. Glaucoma is defined only after the optic nerve has been damaged. This damage can happen at different levels of high pressure for different individuals. Data from the Los Angeles Latino Eye Study revealed an overall prevalence of glaucoma of 4.74% and of ocular hypertension of 3.56%. Three risk factors were associated with glaucoma in the Latino population: age, family history, and diabetes mellitus. In fact, the oldest group of Latinos ($\geq$80) had a 20-fold higher risk than the youngest age group in the study (40–49 years) while siblings showed a higher risk for glaucoma than the parent–child relation. With regard to diabetes, study participants with the disease had a prevalence of glaucoma 40% higher than those without diabetes. With regard to demographic risk factors, study data showed a higher risk of glaucoma in males, unmarried status, and being unemployed. When comparing the result of this ethnic group with others in the USA, the rates of glaucoma were significantly higher than those of non-Hispanic Whites. Latinos also have a high prevalence of ocular hypertension when compared to other ethnic groups. Over 75% of study participants with glaucoma were previously undiagnosed. This rate is higher than most rates found in other population-based studies stressing the need for timely eye care services in this population.

Age-Related Macular Degeneration (AMD)

AMD, the leading cause of visual impairment and blindness in the USA, is a disease that affects the macula by blurring the central vision or the vision needed to see clearly straight ahead. It is associated with aging and gradually affects the sharpness impeding to see fine detail. There are two types of AMD: wet and dry. Wet AMD occurs when abnormal blood vessels start to grow under the macula and often leak blood or other fluids. Damage to the macula occurs producing fast loss of central vision. In the early stages of wet AMD straight lines start appearing as wavy. Dry AMD has three stages: Early AMD is when people start having drusen, yellow deposits under the retina which do not cause vision loss, but when they start to grow in number and size, the risk for AMD starts increasing; intermediate AMD has either many medium-sized or a few large drusen and some blurred spots may start appearing; advanced AMD occurs when people have a breakdown of light-sensitive cells in the central retina in addition to drusen. The blurred spot in the center starts growing. Data from the Los Angeles Latino Eye Study revealed an overall prevalence of early AMD of 9.7% (range from 6.2% to 29.7% in those younger subjects 40–49 years to those 80 or older), and overall prevalence of advanced AMD of 0.5% (ranging from 0% to 8.5% in those same age groups). Risk factors for

AMD found in this study are age, smoking, obesity, race, family history, and being female. Even though the risk of developing increases with age, Latinos appear to have comparable rates of AMD when compared with other ethnic groups. However, a considerably high percentage of AMD in Latinos is undiagnosed. Specifically 98% of AMD detected in the Los Angeles Latino Eye Study had not been previously diagnosed.

Eye Care in Latinos

When compared with other ethnic groups, Latinos in the USA have one of the highest rates of visual impairment. Visual impairment and blindness are associated with untreated eye disease. Latinos have a high prevalence of diabetes and therefore are at a greater risk of diabetic retinopathy. Latinos also have a high risk of cataracts and glaucoma. Many risk factors for undetected eye disease are present at a higher rate in this population. Some of these factors which are sociodemographic and modifiable are lower socioeconomic status, lower education status, lower acculturation, being uninsured, and never having had an eye examination. The American Academy of Ophthalmology recommends that Latinos who are a high-risk population group receive a comprehensive eye examination every 1–3 years between the ages of 40 and 54 years, every 1–2 years between the ages of 55 and 64 years, and every 6–12 months after the age of 64 years. Given the high rates of undiagnosed eye disease, blindness, and visual impairment, data suggests that this ethnic group is not receiving recommended vision care. Although visual impairment and blindness are largely preventable, they will continue to be an important health problem in aging Latinos, without increased use of eye care services.

Related Topics

- ► Blood glucose
- ► Diabetes mellitus
- ► Medicare

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Vitamins

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Vitamins are organic molecules that are crucial for normal function and growth. They are used by the body to create energy and build important biological compounds. Only a relatively small amount of vitamins are required to survive compared to carbohydrates, fats, and proteins. The word “vitamin” can also be used to refer to these nutritional compounds when found in food sources or to a pill or tablet supplement that contains one or more of the compounds.

When a person shows signs and symptoms of not consuming enough of a vitamin, it is considered a vitamin deficiency. The opposite situation, vitamin toxicity, occurs when a person shows signs and symptoms of having consumed too much of a particular vitamin.

The classic example of vitamin deficiency that occurs with immigration is Vitamin D deficiency where an individual migrates from a climate with more sun exposure to a climate with less. Factors such as skin color and lifestyle changes associated migration also compound the risk. Vitamin A is another vitamin that has been documented to be potentially deficient in immigrants. This is because there are different types of vitamin A and the foods that normally contain them may change in availability for the immigrants. Folate has been shown to benefit pregnant women and their newborns in developed countries such that taking extra folate in vitamin form is standard care during pregnancy. Despite the availability of vitamins, some women fail to take these vitamins because they are unaware of their benefits. In some cases the women choose to manage their prenatal care by the standards of the country from which they emigrated. Finally, it is important to recognize that the immigrants from some countries may have different beliefs regarding the practice of medicine than what is accepted by developed countries and the World Health Organization. For example, Ayurvedic medicine in India is a traditional model of medicine that offers a variety of treatments in the form of natural products and supplements, often called “vitamins” by those that use them. There have been cases reported of lead or mercury toxicity after taking these types of vitamins and furthermore some products are sold by frauds and do not contain what is advertised. The National Center for Complementary and Alternative Medicine is a US institute that studies the products of variant medical practices to assess scientifically whether they are effective or not and may be a useful resource for a practitioner that comes across an immigrant taking a foreign “vitamin.”

Health professionals often subdivide vitamins into two main categories, *fat-soluble* and *water-soluble*, based on the chemical properties of the vitamin (Table 1). This chemical difference is reflected in the way the human body digests, stores, utilizes, and excretes the vitamins. This important distinction has several clinical applications.

The fat-soluble vitamins are Vitamin A, D, E, and K. While each individual vitamin has its own specific properties, as a group there are several common traits. For fat-soluble vitamins, the body is only able to absorb these vitamins along with fat or oil. Therefore, when eating foods rich with fat-soluble vitamins, it is important to eat something that contains at least a small amount of fat in order to allow the body to transfer the vitamin from the digestive tract into the blood stream. For example, when eating a salad, it is important to use a dressing that contains some oil or fat in order for the body to make use of the fat-soluble vitamins that are in the vegetables. Furthermore, any problems in the digestion or absorption of fat, resulting from a number of medical conditions (e.g., celiac disease, Crohn’s disease, cystic fibrosis), can result in fat-soluble vitamin deficiency.

Once in the blood stream, fat-soluble vitamins are delivered to tissues by special molecules, called micelles, formed from chylomicrons and lipoproteins (a type of fatty protein). Fat-soluble vitamins are stored in fatty tissue and the liver. The body can maintain normal function for periods of time without the intake of these vitamins by using what is stored. However, if intake of the fat-soluble vitamins does not resume once the stores are depleted, it can lead to deficiency. Since fat-soluble vitamins are stored in this way and are not excreted as efficiently as water-soluble vitamins, high intake of these types of vitamins have a greater potential to lead to toxicity.

The water-soluble vitamins are each of the Vitamin B subtypes (Vitamin B1, B2, B3, B5, B6, B7, B9, and B12) and Vitamin C. Water-soluble vitamins are dissolved in water and are therefore sensitive to the way the foods containing them are processed and cooked. Steaming is the preferred method of preparing foods that contain water-soluble vitamins to ensure that these essential nutrients remain available for use by the body. Since food is not fully submerged in water during steaming, this process retains more water-soluble vitamins than boiling does.

Vitamins. Table 1 Key facts about specific vitamins

Vitamin	Also known as	Primary Functions	Potential Sources	Special Considerations
Fat-soluble vitamins				
A	Carotenoids Alpha-carotene Beta-carotene Beta-cryptoxanthin Retinol	Bone development Cell growth Healthy skin Immune system Reproduction Vision	Carotenoids: Broccoli; cantaloupe; carrots; mangoes; peaches; romaine lettuce; spinach; sweet potatoes. Retinol: eggs; fish; fish oil; fortified cereal, juice, and milk; liver.	*Carotenoids* are converted by the body into **Vitamin A**. **Retinol** is preformed **Vitamin A**. Most American diets consist of foods with high amounts of **retinol**, but diets from other parts of the world, especially from impoverished areas, rely primarily on **carotenoids** in fresh fruits and vegetables. It is possible to develop toxicity from consuming too much **retinol**, but not from **carotenoid**.
D		Regulates calcium absorption Bone formation Bone break down Maintains normal levels of calcium in the blood	Egg yolks; fatty fish; enriched milk and cereal; liver; sunlight. Sunlight exposure initiates a reaction in the body that produces Vitamin D.	The rates of **Vitamin D** deficiency are high in developing countries. Sunlight is the main way humans get enough **D**. Factors such as the use of sunscreen and length of time spent outside impact the ability of the body to utilize sunlight to create **D**. In climates that do not get much sunlight and during seasons when there is not much sun, it is important to get **D** from other sources. Aside from fortified products, dietary sources often do not supply adequate amounts of **D**. Lighter skinned people require less sunlight than darker skinned people to create the required amounts of **D**. Problems in bone structure and formation become apparent when an individual is **D** deficient. Rickets, osteoporosis, and osteomalacia are types of bone disease associated with **D** deficiency.
E	Tocopherol	Antioxidant Red blood cell production Helps the body to use Vitamin K	Almonds; asparagus; avocados; corn; nuts; olives; peanut butter; spinach; sunflower seeds; vegetable oils such as sunflower, corn, and soybean.	Smokers require higher levels of **Vitamin E**. Low fat diets are vulnerable to **E** deficiency because generally fats are a rich source. **Vitamin E** is susceptible to damage in processing, preparation and storage. Individuals taking blood thinners or other medications should check with their medical provider before taking **E** supplements.

Vitamins. Table 1 (continued)

Vitamin	Also known as	Primary Functions	Potential Sources	Special Considerations
K	Phylloquinone/ phytol Menaquinone Naphthoquinone	Blood clotting May help build and maintain strong bones	Bacteria that naturally live in the colon; broccoli; cauliflower; green beans; green leafy vegetables; some vegetable oils; soybeans.	Long-term use of antibiotics may kill the **Vitamin K** produced by the gastrointestinal tract. Blood thinners and other medications are affected by **K** intake.
Water-soluble vitamins				
B1	Thiamin Thiamin pyrophosphate (TPP)	Breakdown of food into energy Heart functioning Muscles Nervous System	Asparagus; brown rice; cereals; eggs; flour tortillas; kale; liver; oranges; pork; potatoes; whole grain bread; yeast. Absent from white rice and processed carbohydrates.	Beri beri and Wernicke-Korsakoff Syndrome are two important deficiencies that can occur when not enough **thiamin** is consumed. Alcoholism is associated with these deficiencies because it disrupts the body's ability to absorb **thiamin**. Some foods in developed countries are fortified with **thiamin**.
B2	Riboflavin	Breakdown of food into energy Healthy skin Red blood cell production Tissue repair	Asparagus; bananas; dairy products; eggs; fortified cereals; green beans; green leafy vegetables; kidney; liver; meat; nuts; okra; yeast.	**Vitamin B2** degrades when exposed to sunlight. Foods containing this vitamin should be stored in opaque containers. Milk is an important source of **B2**. In cultures that do not emphasize dairy in the diet, other sources must be identified to provide adequate levels.
B3	Niacin Nicotinic acid Nicotinamide	Breakdown of food into energy Digestive system Healthy nerves Healthy skin	Bread and enriched bread products; eggs; fish; meat; mushrooms; nuts; poultry. Can be created in the body from protein rich foods containing tryptophan (such as turkey).	Diets based heavily on corn or maize, are at risk for niacin deficiency. Pellagra, caused by a **Vitamin B3** deficiency, can be avoided if the corn is prepared in a way that releases the vitamin from the plant. Large doses can cause serious side effects such as liver damage, ulcers, and rashes. **Niacin** has been found to lower levels of LDL cholesterol and triglycerides and to raise levels of HDL cholesterol.
B5	Pantothenic acid Part of Coenzyme A	Breakdown of food into energy Growth	Broccoli; dairy; eggs; fish; legumes; meat; sweet potatoes; whole grain cereals; yeast. Made by intestinal bacteria.	It is rare to find a **Vitamin B5** deficiency. Occasionally it is seen in alcoholics and many times it is associated with other B vitamin deficiencies.

Vitamins. Table 1 (continued)

Vitamin	Also known as	Primary Functions	Potential Sources	Special Considerations
B6	Pyridoxal Pyridoxal phosphate (PLP) Pyridoxamine Pyridoxine	Breakdown of protein Healthy brain function Nerve function Production of antibodies Red blood cell production	Bananas; beans; cantaloupe; legumes; meat; nuts; oranges; papaya; whole grains.	Large doses can cause numbness and neurological disorders. Deficiencies can cause confusion, depression, irritability, and sores in the mouth and are often associated with alcoholism. Certain medications including isoniazid (given for tuberculosis) and theophylline (for asthma) reduce the amount of **Vitamin B6** available in the body.
B7	Biotin	Breakdown of food into energy Growth	Grains; egg yolk; kidney; liver. Made by intestinal bacteria.	Critical for the healthy development of a newborn. Deficiency can cause hair loss and scaly rashes. Consumption of raw egg whites can cause problems with the absorption of **Vitamin B7**.
B9	Folacin Folate Folic Acid Pteroylglutamic acid	Breakdown, use, and creation of protein Cell growth and division DNA production Red blood cell production	Beans; citrus fruits and juices; dark green leafy vegetables; fortified cereals and grains; legumes; liver; nuts; pork; poultry; shellfish; whole grains. Processing, preparation, and exposure to light readily destroy this vitamin.	Many food products are enriched with **folate** in developed countries. **Folate** is crucial for the health of a developing baby, especially during the first few weeks of pregnancy (when a woman may not even realize she is pregnant). Women who may become pregnant are advised to take supplemental **folic acid** to prevent birth defects.
B12	Cobalamin	Breakdown of fat Maintenance of the Central Nervous System Red blood cell production Replenishes various enzymes in the body	Dairy; eggs; fish; fortified grain products; meat; poultry; shellfish.	Can be stored in the body for future use. It can be stored in the liver for years. Requires special secretions in the stomach to be properly digested. Individuals who have had certain types of stomach or small intestine surgery must take **Vitamin B12** supplements. **B12** deficiency can cause anemia.
C	Ascorbate Ascorbic acid	Antioxidant Assists in the absorption of iron Collagen production Essential in healing of wounds Growth and repair of tissue Repair and maintenance of bones, cartilage, and teeth	Broccoli; cantaloupe; citrus fruits and juices; green peppers; leafy green vegetables; strawberries; sweet and white potatoes; tomatoes. Vitamin C is very sensitive to heat and light, and can be damaged during processing, cooking, or storage.	Severe **Vitamin C** deficiency is referred to as scurvy. Some signs of scurvy include anemia, bruises around hair follicles, fatigue, depression, and bleeding gums. Scurvy is usually seen in malnourished older adults. Areas of the world that do not have access to fruits and vegetables have higher levels of scurvy. Cigarette smokers require higher amounts of **C** than nonsmokers.

Once water-soluble vitamins enter the body, they are available for use by all cell types via the blood stream. With the exception of Vitamin B12, water-soluble vitamins are not stored for long periods of time by the body and are readily excreted in the urine. Therefore it is important to ensure that these types of vitamins are consumed daily. Many foods are fortified with these types of vitamins in the United States.

The World Health Organization and the Food and Agriculture Organization of the United Nations established the Codex Alimentarius Commission, which has created international standards and guidelines for food since 1963. Many developed nations have their own standards and guidelines that are utilized in lieu of the Codex Alimentarius. When considering the amount of vitamin an individual must consume per day to maintain good health, there are two different organizations that offer recommendations in the United States, The Food and Nutrition Board and The Food and Drug Administration.

The Food and Nutrition Board has conducted large population studies since 1943 to determine the amount of nutrients required for subgroups of individuals. These recommendations are called *Dietary Reference Intakes* (DRIs), and more specifically this umbrella term describes a set of values that includes Estimated Average Requirements (EARs), Recommended Dietary Allowances (RDAs), Adequate Intakes (AIs), Estimated Energy Requirements (EERs), and Tolerable Upper Levels (ULs). These values are specific for each nutrient and account for factors such as age, gender, and pregnancy status. Health professionals (e.g., nutritionists and dieticians) utilize these recommendations to make appropriate individualized plans for their patients.

The Food and Drug Administration (FDA) has its own set of recommendations that are called *Daily Values*. These values are an aggregate of Reference Dietary Intakes, which are used for vitamins and minerals, and Daily Reference Values, which are used for nutrients that do not have an established RDA. These values are used to convey the amount of nutrient in a food relative to the total amount of that nutrient that is recommended to be consumed daily. For vitamins this is reported on nutrition labels as a percentage.

Immigrants need to be aware of different labeling standards in their new country. Changes in the consumption of different vitamins due to the culinary culture of a new home country may cause health issues for some individuals. In addition to vitamin deficiencies caused by diet changes, individuals migrating from locations close to the equator to climates closer to the poles should be aware of a potential for Vitamin D deficiency due to the relatively lower levels of exposure to the sun. Most vitamin-related health issues in immigrants can be corrected by adjusting diet or adding vitamin supplements.

Related Topics

- ► Alternative and complementary medicine
- ► Dietary patterns
- ► Food
- ► Maternal dietary intake
- ► Nutrient intake
- ► Nutrition

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Vulnerable Populations

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Despite the widespread use of the term, there is no single definition of vulnerability and its conceptualization varies across discipline. The word itself derives from the Latin word *vulnerare*, meaning "to wound." The concept of vulnerability is applied to various populations in the context of health care in order to establish how health care resources are to be allocated and who is to be considered eligible for special benefits, and in the context of health research to identify those who must be afforded special protections in order to protect them from potential exploitation and abuse. Vulnerability in the context of health care may result from the delivery of health care services on the basis of color, class, caste, religion, age, ability to pay, or other characteristics of the population, rather than on the basis of need. As a result, these persons are at increased risk for morbidity and premature mortality.

In the context of health research, vulnerability may also result from illness, an inability to access needed care, cognitive challenges or limitations, societal marginalization and disempowerment, and/or reduced control over one's own environment and decision making. As a result, these persons may be at increased risk of exploitation and abuse in research. Kipnis developed a taxonomy that distinguishes between six types of vulnerability within the research context: cognitive, juridic, deferential, medical, allocational, and infrastructural.

In general, vulnerability results when a group lacks adequate power, prowess, intelligence, resources, strength, or other needed attributes to protect its own interests. Although vulnerability is generally conceived of as a characteristic that is fixed and immutable, this definition suggests that vulnerability of populations may change over time as groups gain or lose power or other resources necessary for their informed and voluntary decision making. The definition further suggests that membership in a population identified as vulnerable may shift over time. As an example, immigrants as a group might be considered to be vulnerable due to an inability to navigate the health care system of their new country, an inability to speak the language of the host country, difficulties in adjusting to their new environments, and the stress of migration. However, there is a significant difference between an individual who immigrated recently and one who immigrated as a young child 40 years previously. Accordingly, although groups may continue to be identified as vulnerable, the individuals within those groups may no longer be individually vulnerable. In the context of research, the researchers must achieve a balance between protecting the vulnerable group and recognizing and respecting the autonomy of each individual participant.

In contrast to the previous conceptualization of vulnerability, some scholars have suggested that vulnerability attaches to groups which, within a specific society, have been devalued on the basis of one or more characteristics, e.g., race, ethnicity, religion. In this case, the characteristic of the group is not immutable and the vulnerability of the group cannot change in the absence of a redistribution of power within that society.

In the context of research, the classification of populations as vulnerable varies depending upon the laws and regulations adopted with the particular country. International documents related to ethics in research and scholarly literature in the field of bioethics have characterized these populations as vulnerable: homeless persons, immigrants and refugees, mentally ill and disabled persons, chronically ill and disabled individuals, individuals who are suicidal or homicidal, families characterized by abuse, persons living with HIV/AIDS, mentally ill and disabled individuals, high-risk mothers and children, residents of rural areas, non-English speakers, individuals lacking access to health care, racial and ethnic minorities, economically disadvantaged persons, those who are educationally disadvantaged, soldiers, and students.

The concept of vulnerability is not without controversy. It is often noted in the literature that vulnerability is an inherent aspect or characteristic of human existence. DeBruin has argued that, in the context of research, groups should not be identified as vulnerable and that the focus should be placed on the concepts of special risk and empowerment. Kottow suggests that a distinction must be made between the concepts of vulnerability and susceptibility. He argues that vulnerability is encompassed within the principle of justice and requires the equal protection of all members of a society, whereas susceptibility refers to a state of destitution which must be specifically designated in order to trigger the application of palliative measures. Some scholars' writings have suggested that the categorization of populations as vulnerable subjects those persons to pity and that the use of the term is paternalistic and demeaning.

Related Topics

- ► Detention
- ► Disability
- ► Ethical issues in research with immigrants and refugees
- ► Ethical issues in the clinical context
- ► Immigration status
- ► Language barriers
- ► Refugee
- ► Research ethics
- ► Undocumented

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Waiver

► Communicable disease of public health significance

War-Affected Children

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Exposure to war has particularly pernicious and wide-ranging effects on children beyond the risks associated with actual physical injury or death. Armed conflict disrupts education; forces families to flee their homes; separates children from their parents and relatives; destroys health care systems; produces shortages of food and clean water; and puts children at risk of being coerced into child labor, prostitution, or soldiering. In short, war disrupts all of the familial and societal safety systems that allow this vulnerable group to mature into healthy, productive adults. In the Democratic Republic of the Congo in the first decade of the twenty-first century, for example, a series of mortality studies by the International Rescue Committee demonstrated that in war zones, indirect consequences of war such as starvation and disease may account for as much as 86% of fatalities due to war, with children being disproportionately affected.

Child protection in the climate of modern warfare is particularly difficult. Unlike wars of the past, which were largely between states, the wars of today are increasingly internal conflicts involving non-State actors such as drug cartels, Al Qaida, and national resistance movements, often with varying levels of support from States. Many of the traditional protections afforded by the Geneva Conventions, treaties and other instruments of international law, and peacekeeping forces are explicitly intended to apply conflicts between States rather than to conflicts involving non-State actors. While States are signatories to treaties and conventions on human rights, many non-State actors feel free to disregard such conventions, putting children at increased risk with fewer international resources to protect them. An even more concerning trend is that children and other civilians are increasingly targeted as victims in modern warfare.

In times of armed conflict, the loss of family and social protection for children occurs for a variety of reasons. Education may be disrupted for obvious reasons such as destruction of school buildings or unsafe roads between homes and schools, but also because of lack of availability of teachers, use of school buildings to house displaced persons, or a need for children to carry out the duties of adults who are fighting or have been killed. Additionally, schools have increasingly become targets of attacks, an offense designated as a grave human rights violation under humanitarian law.

Children and families may be displaced because conflict has limited access to some other necessity. For example, even if there is no active fighting in an area, destroyed irrigation systems or the recruitment of child soldiers may mean that abandoning the home becomes the only option for survival. Children and families may end up in refugee camps or temporary housing or they may become homeless. Children who become separated from relatives or who are orphaned are at especially high risk because they need to fend for themselves. Such children are particularly vulnerable to rape and ongoing victimization such as recruitment into child soldiering, slavery, unwanted marriage, or prostitution. Registration, child protection, and family tracing are key components of intervention programs designed to aid unaccompanied children.

Increasingly, children are also threatened by abduction in times of war as a way of terrorizing civilian

Sana Loue & Martha Sajatovic (eds.), *Encyclopedia of Immigrant Health*, DOI 10.1007/978-1-4419-5659-0,

populations. Such children may be abducted from homes, refugee camps, or schools and may be forced into slavery, nongovernmental armed forces, or trafficking for sexual purposes. Children who become soldiers generally witness and are forced to participate in murder, sexual assault, and torture, and girls often are forced to sexually service the males of the group. Drug problems are rampant. Once the children have participated in such activities, they fear they will not be accepted back into the community and fear for their lives at the hands of their fellow soldiers. Such children become deeply traumatized, and the process of rehabilitation is difficult. Rehabilitation programs are sponsored by a variety of international groups and consist of disarmament, demobilization/demilitarization, and rehabilitation and reintegration into the community (DDR). The goal of such programs is to assist former child soldiers to become accepted, productive members of their communities and to address problems that arise as a result of their participation in armed combat. Unfortunately, such programs are not always well-suited to the needs of girls, who often are not combatants, but are used as cooks or sexual slaves. Such girls and any children born to them need to be a focus of renewed effort in the implementation of these programs.

As terrorism has increased and children have been used in terrorist plots or as combatants, the arrest and detention of children in times of war is an increasing problem. Such children may be held in ways that violate international juvenile justice standards, and their detention may continue after hostilities have ceased. Additionally, children may be used to place or smuggle small arms or landmines, and children are disproportionately victims of landmines and unexploded ordnance for years after the cessation of hostilities.

Children subjected to the adversities of conflict are often affected for many years. Their physical and mental scars may impact them for life, and disrupted education decreases their future earning power and the potential to improve their standard of living. Although many children are never able to surmount such obstacles, a surprising number of children are resilient in the face of adversity. Protective factors that contribute to resilience include individual factors, such as strong social skills and the ability to find meaning in the situation through religion or a personal value system; family factors, such as the presence of a caring parent who protects and supports the child; social support from the community or peers; a caregiver who manages stress well; adequate child care and education systems to maintain a sense of normalcy; and cultural and political values emphasizing and funding the support of children and other vulnerable parties. When intervention programs support such factors, children have a greater chance of being resilient in the face of conflict.

Finally, there are a variety of international legal mechanisms to support children's rights and secure justice for children who have been caught in wars and other conflicts. The United Nations Convention on the Rights of the Child focuses on children's rights to safety, education, care from a parent or parent-substitute, health services, protection from abuse, and freedom from exploitation or unreasonable detention. There are also two Optional Protocols to the Convention that protect children from participation in armed conflict and trafficking/sexual slavery. The United Nations, regional organizations, individual States, and NGOs are all charged with ensuring these rights, and war crimes affecting children are under the jurisdiction of the International Criminal Court (ICC).

The nature of modern conflicts, documentation of the effects of war on children, and our understanding of factors that contribute to resilience all need to be considered in developing truly effective child protection programs for the children of the twenty-first century. Over the past few years, international humanitarian law has begun to be applied to non-State actors perpetrating war crimes against children. This is a promising trend and highlights the need for creative thinking and the development of new policies and programs better suited to modern types of conflict. New ways of addressing the protection of children in times of conflict are essential for the rebuilding of shattered societies.

Related Topics

- ► Adolescent health
- ► Family reunification
- ► International adoption
- ► Pediatrics
- ► Refugee youth

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Water

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Water is necessary for sustaining all life and, while abundant, is neither uniformly distributed nor universally pure. The importance of water to all life is demonstrated by the general concentration of living species in and around water sources. Indeed, physical health (and economic health) of a community is intrinsically connected to the availability of water resources. The prosperity of agricultural enterprise, animal husbandry and many industrial ventures depend directly on water availability, while water quality and associated hygiene practices to a large extent determine the physical health of community inhabitants.

The lack of water distribution is one of several factors resulting in the widespread existence of "subsistence farming" in sub-Saharan Africa and many other parts of the world. The lack of adequate water for farming frequently results in inadequate nutrition or imbalances in the nutrients, vitamins, and minerals in the diets of immigrants adversely impacting their health.

Water Distribution and Quality

The hydrological cycle represents the pattern by which water recycles through the environment. Heat from the sun evaporates water from ocean, lakes, and plant life; evaporation is effective in separation of virtually all contaminants and is a primary mechanism for water purification. Additionally, UV light from sunshine destroys the DNA of many bacteria and viruses. Condensation of airborne moisture in the form of rain or snow is the primary source of both surface water and groundwater available to all biological entities. Surface water primarily occurs in the form of streams, rivers, and lakes, while groundwater (literally water penetrating the earth) travels through the soil to aquifers (i.e., underground beds or layers of permeable rock, sediment, or soil that contains or conducts water). Typically, groundwater enters lakes and rivers through underground springs. Surface water and groundwater generally commingle as water returns to the oceans.

The purity of raw water is largely impacted by the conditions encountered during the path it takes on journeys from the clouds to the user. Condensate from the air will contact particulates, aerosols, and other airborne contaminants, scrub them from the air, and incorporate them into the rain or snow and thus into surface water. During transit, surface water also typically contacts and incorporates numerous surface-dwelling bacteria and viruses from fecal matter of humans and animals, as well as contaminants from farming and industry. By contrast, groundwater traveling within the aquifers, which typically have fine sand and gravel layers, is highly filtered during the low velocity flow (commonly ~15 m/day) of the water through the media. As such, groundwater rarely contains evidence of biological pathogens; however, it frequently contains dissolved salts of the subsurface inorganic materials it contacts. In most instances, the levels of these salts encountered is harmless or even helpful for ingestion; certain other dissolved salts can be hazardous to adults for longer term ingestion (e.g., As, Cd, and Pb) or even short term to infants (e.g., NO3 and Pb). Untreated groundwater (from wells) is typically safer for consumption than untreated surface water because the latter can be contaminated with biological pathogens which can generate severe short-term illnesses.

Waterborne Pathogens Affecting Severe Illness

The impact of water quality on public health has been and continues to be a primary focus of the World Health Organization, WHO, which publishes guidelines for potable water uses. Unfortunately, not all sovereign States provide or enforce regulations based on these guidelines. The WHO water quality guidelines available online provide the most comprehensive current information on water quality.

Microbes such as pathogenic bacteria, viruses, and parasites are the most common and widespread health risk to drinking water. These microbes enter the water either through contact with airborne biological contaminants or more commonly through contact with biological wastes within the soil. The later typically comes from uncontrolled or unsanitary disposal of human or animal wastes. The ability of these pathogens to replicate within the human body makes them a major source of severe infectious diseases. The variety of pathogenic microbes is extensive and the WHO has recommended stringent test procedures and zero tolerance for an indicator microbe (*E. coli* bacteria – ubiquitous in infectious waste products). Rather than identifying a specific bacteria or virus, these tests provide an indication that harmful pathogens are present.

The WHO also publishes guidelines on the maximum desirable chemical contaminant levels (for both inorganic and organic chemicals) in potable water. Most inorganic contaminants in water are harmless or even needed for good health, while others are deemed toxic to the body for long-term exposure (i.e., As, Cd, and Pb). Nitrates (NO_3) in drinking water can be harmful or fatal to infants. More recently, the WHO has undertaken study and development of guidelines for >50 organic chemicals including contaminants in water from human/animal discharge of endocrine disrupters (from pharmaceuticals) as well as byproducts of water disinfection operations (i.e., Trihalomethane (THMs) from reaction of chlorine or other halogen compounds used in water treatment with organic substances in the water). Guidelines also exist for radionuclide content in drinking water.

Since immigrants from rural Third World villages can have a long history of consuming water contaminated with waterborne pathogens, they are frequently observed to have stomach problems (including stomachaches and severe bloating), chronic diarrhea, intestinal worms, or other health problems including river blindness as well as residual issues from these contaminants.

Even in medium-sized to large cities where water treatment infrastructure exists many of the facilities are incapable of providing pathogen-free potable water to the citizenry and the existence of many illnesses or death from waterborne pathogens have been observed. Two colleagues from different major cities privately shared their experiences with the personal loss of loved ones who succumbed to waterborne illnesses. In each case, a breakdown in the water system maintenance was cited as the probable cause of the incursion of the pathogens. In spite of attempts to minimize waterborne diseases, immigrants always have the possibility of presenting such illnesses regardless of the areas from which they hale.

Waterborne Diseases

The majority of waterborne illnesses are caused by contamination of the drinking water supply by bacteria, parasites, protozoa, and viruses. The leading symptom of illness is diarrhea amounting to four billion cases annually and resulting in over 2.2 million deaths with bacterial infection (e.g., Campylobacteria). Dehydration and other illness complications are the major causes of death. Typhoid (17 million cases annually) and cholera (140,000 cases annually) are also major waterborne bacterial infections. Waterborne parasites annually infect >1.5 billion individuals and account for 300,000 deaths, primarily from schistosomiasis. Discussions of specific waterborne infections as well as statistics are available at the World Health Organization (WHO) web site.

Water Quality Impact by Age

Studies have shown that the highest incidence of death from waterborne diseases occurs in children between the ages of 1 and 5. Prior to age of 1 year, most children in rural villages are breast-fed and the infant is generally not exposed to waterborne pathogens. By age 1, the infant's immune system has begun development but is ill-equipped to deal with the bacterial or viral contaminants in the water available to many poor villagers. When adequate precautions are taken, such as boiling, filtering, or chlorinating of the water, the infant will be able to attain 5 years with a minimum of disease complications from ingesting the impure water. By age 5, the child's immune system is usually more robust and able to deal with many waterborne pathogens.

Urbanization of Population

Immigration (or the movement of people to a nonnative region) has generally consisted of the uprooting of individuals or families from poor, rural villages or farms where the workers and families exist through subsistence farming or work as day laborers for small local farms. The lure of greater prosperity draws the rural poor to the larger towns and cities where they believe they have opportunities to improve their lifestyle. Cities have become centers where vast numbers of people compete for the most basic elements of life: for a room within reach of employment with an affordable rent, or vacant land on which a shelter can be erected without fear of eviction; for places in schools; for medical treatment; for access to clean drinking water; for a place on a bus or train; and for a corner on a pavement or square to sell some goods – quite apart from the enormous competition for jobs. Usually, governments have the power and resources to increase the supply and reduce the cost of these. Often, a family member leaving a rural village will find that the costs of urban living outstrip the wages provided by the position. In the best cases, they will be able to save a small sum of money to send back to their family and slowly bring other family members into the urban community.

Impact of Water Sources on Health Considerations

Numerous rural villages (and even cities) will be settled along the same stream or other water source. The impact of fecal waste entering the stream from a source upstream of the population center is obvious and can be disastrous unless the village inhabitants take precautions either in common (e.g., to hand-dig a river well or provide for filtration) or individually by treating their water (e.g., boiling or chlorinating).

In small villages, when water is suspected of being "bad" (i.e., contaminated with pathogens), local people will either boil the water (if firewood is available) or treat the water with household bleach. Alternatively, they may switch to drinking fresh fruit juices or carbonated soft drinks such as colas because they know the bottlers utilize purified water for beverage preparation. Unfortunately, purified bottled water is sometimes more costly than soft drinks. The acids and high sugar content of many soft drinks may be a major cause of tooth decay and associated poor dental health of immigrants. Recently one dentist had to extract 271 teeth over a period of 10 days from residents in one rural village because of inadequate dental health.

Ingestion of low doses of arsenic over long periods (~years) has been determined to be one source of lung and bladder cancers. Similarly, the ingestion of lead by infants and young children is well known to negatively impact the development of mental capacity. These and other heavy metal contaminants are occasionally present in drinking water (especially from groundwater sources) both in the USA and worldwide. In many areas, rural villages rely entirely on hand-dug or shallow-drilled wells for their potable water. Subsurface incursion of heavy metal salts into an aquifer from heavy metals ore mining or volcanic activity can result in excessive concentrations in the drinking water thereby yielding increased occurrences of associated illnesses within immigrant populations.

While many chemical elements in drinking water are harmless or beneficial, others such as fluoride can be beneficial at low concentrations (0.5–1 ppm desirable for preventing tooth decay) and detrimental at high concentration (leading to fluoridosis and bone decay). Unfortunately, most rural villages have no ability to monitor fluoride content in their drinking water. Water from some shallow drilled wells in east Africa have shown excessive levels of fluoride and instances of fluoridosis have been observed in older residents.

Impact of Loss of Disease Immunity

A common concern of health professionals working in rural village settings is that once individuals have access to potable water, it is possible over time to lose their immunity to waterborne contaminants resulting in increased potential for illness when they travel to areas outside their normal grounds. It is unclear to governmental officials how to best address this situation, since in many regions it is not practical from a cost perspective to provide purified water for all rural inhabitants.

Urban Versus Rural Water Quality Issues

Because of the public awareness of the importance of waterborne illnesses on the public health and economic growth, urban centers typically have provided (through tax revenues) for water purification and waste treatment on a larger scale. This means that residents generally have better access to water of improved quality; however, even in the most modern cities it is not unusual to have outbreaks of disease due to inadequate water treatment. Worldwide, significant epidemics occur in major cities when treatment facilities are inadequately designed to remove or destroy waterborne pathogens. The WHO has assisted governmental agencies worldwide to institute regulations pertaining to water quality and numerous water districts labor to improve water quality to achieve regulatory compliance. In many instances, implementation of ultrafiltration, UV light disinfection, and/or reverse osmosis technologies are being coupled with sedimentation, filtration, and chlorination to achieve improved protection of citizenry against waterborne illnesses. Currently, even with such controls water quality is a major issue because to date it has not been practical to provide clean potable water to all because of financial constraints. In cities, where access to information about current water quality is more available, residents can take action to purify their water by boiling; in rural areas, the information is not available and appropriate actions are often lacking. Use of the above technologies in rural settings is being jointly attempted by both governmental and nongovernmental (NGO) agencies. Frequently the availability of electrical power to implement some of these technologies is the limiting factor in achieving potable water of adequate purity.

Need for Development

While there is continuing need to develop cheaper, more effective water treatment technologies, it must be emphasized that – even if the water available to residents is free of pathogens and contaminants – if the individual does not properly handle that water, pathogens can easily be reintroduced into the purified water. Reintroduction occurs through the use of improperly sanitized transport vessels, through inadequate washing of hands and improper cleansing/rinsing of drinking vessels. Studies conducted by aid workers and epidemiologists have confirmed a need to train all citizens about the importance of hand washing and proper cleansing of transport and drinking vessels as a part of general hygiene practices.

Related Topics

- ► Communicable disease of public health significance
- ► Disease prevention
- ► Intestinal parasites
- ► Occupational and environmental health
- ► Pesticides
- ► Sanitation

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Water Pipe

► Narghile

Weight Control

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Obesity is a medical issue most pressing in contemporary time. The problem has evolved from a public health issue to a global epidemic. The obesity problem is not new. Hippocrates recognized it as a factor jeopardizing individuals' health status. He commented that it is injurious to anyone to get more food than can be supported when no exercise is scheduled to compensate the excess. Today, there are increased risk factors associated with obesity, including: high cholesterol, an inactive lifestyle, osteoarthritis, sleep apnea and respiratory problems, cancers, heart disease, stroke, and diabetes. Hippocrates felt the medical condition a Western disease.

The World Health Organization estimates that currently there are approximately 300 million obese adults worldwide, with 115 million of these living in developing countries. Increasing obesity in the overall population has been linked to urbanization and its effect on reducing physical activity and increasing consumption of energy dense diets. It is predicted that in developing countries, there will be a dramatic shift in causes of mortality from nutrition-related chronic diseases. The last decades reported important population migration from underdeveloped to developed countries. The liberty and access to food, combined with the low price of food, put under medical attention new challenges related to weight. The issues are complex relative to weight and immigrants. Frequently, they emigrate from a situation in which there is a history of food scarcity, and their migration takes them to a locale in which usually there is more than adequate access to food. Subsequently, new medical cases are charging the host medical system. As they collaborate with the patient to establish a weight-loss intervention, health providers are admonished to consider cultural factors distinctive to the population being served and the barriers that patients articulate.

Cultural Factors

A variety of cultural factors come to bear on the weight loss process. One obstacle is that obesity is desirable in some developing societies. The perception of ideal body size varies with culture, ethnicity, educational level, and socioeconomic group and can influence the development of obesity. In Western societies, thinness is associated with self-control, elegance, youthfulness, and attractiveness. In those societies, women of higher socioeconomic groups are less likely to be obese. In some developing countries, however, the situation appears to be the opposite. Some researchers have posited that in certain developing countries – where resources are scarce – obesity is admired, seen as sexually desirable, and a symbol of social success and wealth.

Others' Body Size

Recent research suggests that the body size of those around individuals may serve to shape their social perception of what is healthy and appropriate in terms of weight and body size. The U.S. Department of Health and Human Services reports that data suggest that despite an increase in the prevalence of overweight and obesity in recent decades, overweight people have become less likely to perceive themselves as overweight. In turn, this may exacerbate the obesity epidemic by inhibiting individuals' motivation to maintain a healthy body weight or to initiative the process of losing excess weight.

In a recent study of a predominantly European American (EA) population, it was found that individuals were more likely to gain weight over three decades if their same-sex friends were obese. Other studies among children and adults support the tenet that peers can affect physical activity levels and caloric intake of individuals. It holds, therefore, that peers can potentially influence weight status.

Cultural Perceptions of Children's Body Weight

The prevalence of obesity has increased markedly in US children and adolescents in the past 30 years.

Obesity-related diseases formerly seen exclusively in the adult population are being recognized increasingly in obese adolescents and even younger children. Childhood obesity is increasing in all ethnic and racial groups; however, its prevalence is higher in non-White populations.

The reasons for the differences in prevalence of childhood obesity among groups are complex; they likely involve interplay between variables, including: genetics, physiology, culture, socioeconomic status (SES), environment, and others not fully recognized. Researchers contend that understanding the influence of these variables on the patterns of eating and physical activity will be critical to developing public policies and effective clinical interventions to prevent and treat childhood obesity.

Cultural Barriers to Weight Loss

Recent research has shed light on the various cultural barriers to weight loss that immigrants may likely experience in the new host country, especially those immigrants who are coming from significantly less-developed countries. Immigrants report receiving mixed messages when determining their appropriate weight. They indicate that their desire to lose weight to be healthy – influenced by professional advice and personal experience – often is in conflict with the idea that being overweight is healthy – influenced by the culture of family and/or country of birth. Immigrants describe discordance when adapting to the mainstream, leading to the loss of healthy traditional habits. Participants in recent studies have expressed their desire for culturally appropriate nutrition education and reassurance regarding healthy dieting from health care providers. Other emerging themes include the importance of interactions with peers during education and a positive response to group education.

Related Topics

- ► Body mass index
- ► Body shape
- ► Child development
- ► Food insecurity
- ► Health literacy
- ► Health perception
- ► Health status
- ► Percent body fat

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Suggested Resources

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For information on the National Institutes of Health. http://www.nih.gov/about/FAQ.htm#copyright

For information on the U.S. Department of Health and Human Services. http://www.hhs.gov/

West Africa

► Africa

White Supremacy

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White supremacy, in general terms, describes the belief that Caucasians are superior to other races and/or ethnicities. The term can also be used to describe a political ideology wherein it is believed the Caucasian race should dominate political and social matters. White supremacists believe those who are White are superior intellectually, morally, and ethically. The belief system typically prohibits interracial relationships, believing the White race should be kept "pure." Adolf Hitler's Third Reich and Apartheid are commonly cited as examples of white supremacy. White supremacists' beliefs are not limited by geography, but can be found in most countries that have a large White population. For example, white supremacy groups exist in North America, Europe, Australia, South Africa, the Russian Federation, and parts of Latin America.

White supremacy believers target individuals and groups of other races, for example, peoples of African and Asian descent. Native groups, such as Native Americans and Aborigines, have also historically been targets of white supremacists. However, white supremacy groups do not all agree on the definition of "white." Many white supremacists do not consider people of Jewish or Muslim descent, to be Caucasian. Thus, many white supremacists are anti-Semitic and groups such as the Klu Klux Klan, Aryan Nations, The Order, and the White Patriot Party adhere to an anti-Semitic ideology. Muslims are another group of peoples who are seen as inferior by many white supremacists.

White supremacy groups can be religiously and/or politically motivated. Religious white supremacist groups include Christian Identity, Aryan Nations, The White Order of Thule, and the Creativity Movement (formally known as World Church of the Creator). Groups such as National Alliance, the American Nazi Party, and the National Socialist White People's Party are more politically motivated. Some white supremacy groups are neither religiously nor politically motivated. The Klu Klux Klan, for example, follows the general supremacist ideology, but is not usually motivated by religion or politics. Racist skinheads and neo-Nazi groups are also well known types of white supremacists.

White supremacy has been on the rise in recent years. For example, in England and Wales, there were 54,286 racist incidents between 2003 and 2004. This number increased 7% to 57,902 between 2004 and 2005. According to the Southern Poverty Law Center, there were 926 hate groups active in the United States in 2008. This was up more than 4% from the 888 groups in 2007, and a 50% increase from 2000. Additionally, of the 7,780 hate crimes reported in the United States in 2008, 51.3% were racially motivated. This was an increase from 2007, where, of the 7,621 hate crimes, 50.8% were racially motivated. The majority of the racially motivated crimes were caused by an anti-Black bias. The Organization for Security and Co-operation in Europe (OSCE) reported 195 persons were charged with crimes motivated by racial or similar hatred in the Czech Republic. Included in the report were the following statistics: 463 racist crimes and 3,048 crimes with xenophobic motives were reported by Germany; 2,902 prosecuted racist crimes were reported by France; and 4,224 racist and xenophobic crimes were reported by Sweden. The increase in white supremacy beliefs and white supremacy groups can be attributed to multiple factors. Downturns in various economies and terrorist attacks have turned some toward such groups. In the United States, the election of Barack Obama as President and immigration debates served as recruiting tools for white supremacy groups. The popularity of the internet and social networking sites, however, may have been the largest contributor to the growth of white supremacy.

The internet has allowed white supremacy groups to flourish as they no longer have to rely on word of mouth or printed propaganda to spread their message. Instead, they are able to establish websites and chat forums that can be visited freely by anyone with access to the internet. The groups now have access to a potential audience that numbers in the millions and exceeds borders. White supremacists can now communicate with others in different states, territories, and countries. Propaganda has been posted by these groups, often under misleading tags or titles to increase viewership, on YouTube and MySpace Video. Finally, blogs and social networking sites, such as Facebook, Twitter, and MySpace, provide white supremacists with the ability to find and communicate with other like-minded individuals. Thus, the internet and social networking sites have provided white supremacists with tools that allow them to easily spread their message, recruit, and reinforce their beliefs. Moreover, the anonymity of the internet permits people to search for information or like-minded individuals without any social stigma. Similarly, the internet encourages such individuals to express and share white supremacy-based thoughts, ideas, and propaganda without this stigma. For example, many websites, including Yahoo and online newspapers, permit readers to post comments about the posted article. White supremacists have taken advantage of this to post racial and anti-Semitic comments. Additionally, the anonymity of the internet and the ability to reach across borders makes prosecuting hate crimes, such as credible racial/ethnic threats, difficult.

Many countries have laws that prohibit discrimination, hate crimes, and hate speech. However, countries that protect free speech tend to have varying approaches toward hate speech. In the United States, hate speech is protected by the First Amendment unless it incites imminent lawless action or qualifies as fighting words, obscenity, defamation, or true threats. Internationally, there are also measures in place to prevent such behavior. The International Covenant on Civil and Political Rights and the International Convention on the Elimination of All Forms of Racial Discrimination require its members to refrain from discrimination based on race, ethnicity, or national origin.

White supremacy crosses geographic and cultural barriers. Some white supremacists merely believe in keeping the Caucasian race, however they define it, pure. Other white supremacists encourage, or participate, in violence against non-Caucasians. While white supremacists seem to differ on the details of their doctrines, they share one common belief: the Caucasian race, as they define it, is superior to all others.

Related Topics

- ► Ethnocentrism
- ► Nativism
- ► Racism
- ► Vigilante
- ► Violence

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Women

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Being a woman in the immigrant context signals many of the same concerns that being a woman does generally. Immigrant women, depending on location, are simultaneously granted benefits unavailable to men and ignored or denied care provided to citizens and their male counterparts in institutional settings. Geographically speaking, there is a stark contrast between the benefits and disadvantages of being a woman while searching for opportunity or struggling to survive. The following discusses the ways in which female immigrants use gender to capitalize on rights in receiving countries that they are not afforded elsewhere while also considering the many burdens women face in obtaining care.

Recently, some of Central Europe's more generous welfare states, particularly France and Denmark, have faced economic problems which they attribute to a large influx of immigrants from Russia, Hungary, Bosnia, Iran, Lebanon, and North Africa. Each state essentially claims that its welfare system, which categorically provides equivalent health care to all individuals living within its borders (subject to certain limitations), is overly burdened by immigrants who have not yet invested sufficiently in the system. For instance, France provides vast protections to all mothers and children. The program, aptly named Protection Maternelle et Infantile ("PMI"), provides all pregnant women with a team of private-practice pediatricians, nurses, midwives, psychologists, social workers, and with financial incentives to make and keep appointments. The program's success is alleged to have led to, at least indirectly, a large influx of North African and Southeast Asian immigrants in Montmarte. This influx has significantly burdened the system to the extent that an entire building in the district has been given over to care for immigrant pre- and postnatal care.

Denmark, with its guest worker program, has experienced problems similar to those of France. The country estimates that 10–15 billion Kroner annually go to serve the welfare needs of immigrants. While Denmark's annual budget nears 500 billion Kroner, the cost associated with immigrant care has recently led Denmark to offer each immigrant 11,000 Kroner to resettle in their country of origin. While potentially a cost-saving mechanism for Denmark, this offer overlooks female immigrants who relocate to Denmark for the specific purpose of accessing quality medical care.

With a significant portion of female populations emigrating in search of work, one cannot forget the elderly populations that immigrants are leaving behind. Given that women still tend to be primary caregivers to elderly family members in much of the world, seniors are adversely affected when women leave their native countries to find work. As a result, many older women are left alone with little or no family or support. While there are positive instances when female immigrants achieve success at a high enough rate to send financial support home, it is increasingly the case that many elderly women face spending their last years alone in institutional settings.

Much like the unanticipated effects that increased support for women's healthcare has seen in the universal health setting, governments with large exoduses of women may experience an economic drain on the welfare system as a result of increased spending on elder care. In the event governments are not able to sustain adequate elder care for soon-to-be orphaned seniors, the quality of elder care may decrease and/or citizens remaining behind may be asked to contribute more into the welfare system. Unfortunately, while the first scenario is undesirable from a human rights standpoint, the latter scenario implicates a political tax which is a significant point of contention in general and even more so for individuals residing in countries and regions struggling financially – likely the same areas experiencing migration in the first place.

At the other end of the spectrum, the United States plays host to certain feminist ideals that are particularly hard on immigrant women in both the physical and mental health arena. Consequently, in an attempt to meet these standards that require women to excel both in the workplace and in the home, an overwhelming number of immigrant women in the US fail to take proactive health care measures. Though perhaps initially less devastating economically, women here forego preventive screenings, potentially resulting in increased health care costs when they seek emergency care. Examples of neglected screenings include: gynecological exams, pap smears, breast exams, birth control, menopause consultations, and nutritional health. The reasons for forgoing services vary widely, but can be attributed with some particularity to language barriers, power differentials between men and women, and prescribed gender roles for women to care for their families. Women's health is, however, important and in immigrant communities where women's needs are often subordinate to men's sexual desires and children's healthcare needs. But unfortunately, a failure to obtain appropriate care can seriously impair a women's well-being.

Not only do female immigrants deal with undue burdens regarding their own health, but also because women also tend to take care of the health needs of their families, female immigrants must often face large health systems that are foreign to their knowledge base and that often require an in-depth understanding of corporate entities. Because most access to health care at this point involves hospital-based care by a majority of male physicians and administrators, female immigrants seeking care for themselves or on behalf of their families must understand where to seek care, what appropriate care is, how to linguistically and culturally translate their concerns to professionals, and how to deal with opposite sex doctors who hold more power than they and with whom they may not be able to speak directly due to religious or cultural concerns that prohibit opposite sex interactions with unrelated individuals. Other social, economic, and political factors may also affect how female immigrants view and deal with health systems.

As young immigrant women attempt to identify with their new culture and begin to realize their own sexual identity, many may face struggles. Instead of developing an integrated self, young female immigrants are at risk of developing "split identities," requiring them to balance religion and family culture with the values and attitudes of the host culture. While this balance is not easy for any young woman living in today's modern society, young immigrant women may be at a particular disadvantage in cultures that condone attempts to police their bodies.

Policing women's bodies is one way that some immigrant men rationalize their superiority over the dominant host culture that in every other respect seems to degrade their existence and exert power over them. Men who adhere to this belief set reason that because they are able to control their women and their women's actions, they are morally superior to the host culture. Accordingly, they may believe that the host culture's ability to control the immigrant's life means nothing, the reason being that immigrant men would not choose to be part of that system, even if afforded the opportunity, with kept women. Policing women's bodies in immigrant communities runs a second important risk, namely, that immigrant community leaders deny the prevalence of domestic abuse in their communities. Leaders, most often men, implicitly condone violence by their silence or excuse the act as an acceptable coping mechanism for men who are dealing with hardships of the immigrant experience.

Lesbian immigrants often identify both with lesbian groups in their new culture and women from immigrant culture. Because many immigrant cultures are unfamiliar with lesbianism, the immigrant culture (immigrant women included) may tend to condemn lesbianism as an evil imposed upon immigrants by the host culture, rather than as a legitimate identity and a universal concept. Condemnation by one's immigrant community and female counterparts can impose difficult psychological burdens on lesbian immigrants seeking acceptance. Unfortunately, acceptance of lesbian immigrants within the new host cultures is still lacking, thus making acculturation in these circles particularly difficult.

As an example, although US immigration laws now allow LGBT individuals to seek refuge from persecution due to sexual orientation, some nonprofit organizations that provide assistance to refugees may deny their services to lesbians or provide them with suboptimal services. Lesbian refugees may be housed in the most dangerous neighborhoods without jobs, in conditions that are essentially similar to those they fled. While public discussion on this focuses mainly on gay males, it is not to say that females do not encounter similar problems.

Like lesbian immigrants, women from cultures where female genital cutting (FGC, also known in Western countries as female genital mutilation) is culturally acceptable, trafficked women and women in medical need of or desiring an abortion raise special concerns within the context of policing the female body. While these topics typically gain more exposure in the public discourse, they too are plagued with the same problems inherent in a male-dominated ordering of society. Both topics involve women subjugated to law where they must conform to someone else's idea of what should be done to their body – either cut or forced to become a mother.

FGC, a practice that ranges from minimally invasive cutting to full clitoridectomies, is sometimes likened to male circumcision. The cutting process, which occurs primarily in parts of Eastern and Western Africa, the Arabian Peninsula, and several Western countries, is much riskier than circumcision in the amount of blood expelled and the stress the procedure places on the vulva. Indirect risks resulting from inadequate conditions include: sepsis from unclean or improperly cleaned tools, septicemia from bacteria that reaches the bloodstream, urinary tract and pelvic infections, infertility, and fetal distress. FGC warrants consideration in a discussion of policing female immigrant bodies because the practice appears to be spreading by way of immigration to countries not typically associated with the practice and because the practice is thought to minimize female sexuality.

There are several arguments in support of FGC as a cultural virtue. These arguments include the notion that FGC is one of few acts that can ensure a woman economic stability and religious duty mandates such sacrifice. The first argument in support of FGC promotes the idea that cutting off particular vaginal folds evidences virginity and thus, the woman's purity. The second argument is weaker given that some Muslim communities tend to promote this idea despite its confirmed pre-Islamic origins.

The most reasonable explanation coincides with the quest for control in the battle of the sexes. FGC as a cultural phenomenon thus appears to be explained by the notion that women are sexually dangerous and must be transformed, or excised, in order for men to maintain social order, virtue, and morality. This explanation is consistent with the desire to control women and limit their sexual and social empowerment.

Abortion laws and the trafficking of women immigrants into various wealthy countries, much like FGC and reduced roles for lesbian immigrants, reinforce a patriarchal version of society in which men are permitted to dominate based on the ability to control both access to sex and in many instances, the product of sex. Abortion, like FGC, if done improperly can result in devastating health repercussions. Much of the world still does not condone abortion on request. The few countries permitting requests for abortion include: Tunisia; South Africa; Cape Verde; the Democratic People's Republic of Korea; Japan; Mongolia; Kazakhstan; Kyrgyzstan; Tajikistan; Turkmenistan; Uzbekistan; Cambodia; Armenia; Azerbaijan; Bahrain; Georgia; Syrian Arab Republic; the majority of Eastern Europe less Poland; the majority of Northern Europe less Finland, Iceland, and Ireland; the majority of Southern Europe less Greece, Malta, Portugal, and San Marino; the majority of Western Europe less Liechtenstein, Luxembourg, and Monaco; Guyana; Canada; the United States; and Australia. All in all, about 67% of more developed countries permit abortion on request versus a mere 15% of less developed countries. While more countries permit a woman to obtain an abortion for births resulting from rape or incest, statistics indicate that much of the world is still uncomfortable terminating a pregnancy. Here too, more developed countries permit termination at a greater rate than less developed countries for pregnancies following the perpetration of a criminal act, rape, or incest, 84% versus 37%. These statistics indicate that greater education and economic resources help accommodate a woman's choice and more importantly, her well-being. Unfortunately, the circumstances under which women most reasonably could not be expected to care for the health and well-being of another individual's life are the exact circumstances which legally often require a woman to do so. The impact of abortion laws often causes women to travel from their native country to countries where abortion is not criminalized. Alternatively, many women harm themselves as a way to circumvent the need for an abortion with the same results. Both these situations may adversely impact a mother's health and well-being; this issue must be addressed by legislatures to prevent future harm to women forced to immigrate in order to obtain an abortion and those forced to do so in countries where health care is inaccessible to those of little or no means.

In recent years, human trafficking has increased exponentially. The increase can be attributed to several factors. Government attempts to control trafficking are often ineffective due to the numerous channels of trafficking, the numbers of women who are trafficked, and the diverse destinations to which the women are transported. Additionally, the trafficked women often have inadequate language skills to enforce their rights.

The pattern behind trafficking indicates that men often poach women from many countries in the southern hemisphere and send them to wealthier countries in the northern, and primarily western, hemispheres. Women from Albania, Belarus, Bulgaria, China, Lithuania, Nigeria, the Republic of Moldova, Romania, the Russian Federation, Thailand, and the Ukraine are particularly susceptible to becoming victims of trafficking. Countries receiving a significant number of trafficked women include Australia, Belgium, Canada, Germany, Greece, Israel, Italy, Japan, the Netherlands, Thailand, Turkey, and the United States. Traffickers recruit women in origin countries by and through both direct and indirect means before transporting women to their final destination countries.

Indirect recruitment may occur when women are nearly forced into the sex worker industry because of desertion by their families or partners or because they are enticed into work under entirely false pretenses. Not infrequently, women marry military men on tour in their respective countries and follow their partners only to find their marriage dissolving when they arrive in the new country. After dissolution, some women may turn to the sex industry because they do not have the requisite language or technical skills to find work. Some women answer want ads for manual labor, sweatshop jobs, or are enticed away from their country of origin by the allure of a proper education, only to find themselves in situations in which they are sexually enslaved. In some instances, women are oppressed, economically depressed, born into poverty, and in some instances, born into brothels and raised in the sex industry; for some women in such circumstances, it may seem that moving to another country to continue the same way of life they have ever known is reasonable.

Regardless of how women arrive in new countries and become part of the sex industry, enforcement and criminalizing trafficking is problematic. In the United States, Los Angeles, California, and Southern Texas have both recently developed task forces to help quell the demand for sex workers. Unfortunately, the industry earns some 9.5 billion dollars a year; given the number of women who are present without resident or citizen papers and the number of workers who are unaware of their rights and without proper language skills it is difficult to regulate. Aside from enforcement, there is another challenge inherent to trafficking; many women believe that as bad as being part of the sex industry is or seems, it may be better than the conditions they faced previously in their countries of origin.

Though the state of women's care, specifically immigrant women's care, appears bleak, several coalitions have made enormous efforts to safeguard women. Organizations of note include: the United Nations Development Fund for Women ("UNIFEM"), UNICEF, and the United Nations High Commission for Refugees ("UNHCR"). UNIFEM works and raises funds primarily for internally displaced women through the world food program which helps strengthen women's economic security and empower women living in post-conflict regions or in trauma post-conflict.

Related Topics

- ► Access to care
- ► Assimilation
- ► Asylum
- ► Breast cancer
- ► Breast cancer screening
- ► Child health care access
- ► Emergency services
- ► Family planning
- ► Female sex workers
- ► Health care utilization
- ► Health insurance
- ► Reproductive health
- ► Sexually transmitted diseases
- ► Trafficking
- ► Trafficking Victims Protection Act

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World Health Organization

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In 1919, which marked the end of World War I, the League of Nations was created in order to promote peace and security in the world in the aftermath of war. The League of Nations established the Health Organization in Geneva to prevent and control disease around the world.

In 1945, the League of Nations became the United Nations and in 1948, the Health Organization became the World Health Organization (WHO). The WHO is regarded as the world's leading health organization. Its objective is "the attainment by all peoples of the highest possible standard of health." It is an international health cooperative that monitors the state of the world's health and systematically attempts to improve the health status of individual countries and of the world collectively. Disease prevention and control, promotion of good health, interventions in disease outbreaks, initiatives to eliminate diseases through immunizations and development of treatment and prevention standards are contributions made by the WHO to international public health.

The WHO views the world as a series of open national societies, rather than as a collection of relatively closed communities. This latter view would impede the ability to address the problem of global inequities. Poor countries or poor people within countries suffer from multiple deprivations that lead to high levels of ill health; ill health maintains poverty. Consequently, the poor are often caught in the cycle of poverty and ill health.

Absolute poverty is still spreading in many parts of the world and disparities of health and wealth are growing between and within countries. Over one billion people are without the benefits of modern medical science. One out of every five persons in the world has no access to safe drinking water. Infectious diseases alone account for 13 million deaths a year, most of them in developing countries. Seventy percent of the poor are women; in the world's poorest country, an expectant mother's chances of dying in childbirth is 500 times greater than women in the richest country.

Many health leaders from Third World countries have pleaded for a world federation, a "new international economic order," as the only possible basis for creating conditions conducive to more equitable world health. In 1994, the budget of the United Nations Development Program was slightly greater than that of the United Nations High Commissioner for Refugees. This means that the general response tends to be as reactive as it is proactive. Moreover, the 10 developing countries with well over two-thirds of the world's "poorest of the poor" receive only one-third of foreign aid; it is these countries that are home to the greatest numbers of internally displaced persons. Increasing numbers of impoverished people are pressing ever harder on overloaded environments. If foreign aid budgets were closely directed proactively to impoverished people in the countries and regions concerned, they could help to relieve the problem while it is still becoming a problem and before it becomes entrenched.

The WHO has 193 Member States that appoint delegations to the World Health Assembly, the decision-making body. Member States and donors finance the WHO. The WHO also has collaborations with NGOs, the pharmaceutical industry and foundations such as the Bill and Melinda Gates and Rockefeller Foundations. These voluntary contributions from national and local governments, foundations and NGOs, UN organizations and the private sector have now exceeded estimated contributions from the 193 member nations.

In 1979, a global commission confirmed the worldwide eradication of smallpox in which the cost of worldwide vaccination had been close to $1 billion dollars annually. The last identified and treated cases were in East Africa, and the decade-long campaign came to $300 million. This accomplishment reinforced the idea that investment in health yields economic benefit and humanitarian relief. This represents the first conquest of a deadly disease and the WHO's greatest achievement of disease eradication through human effort. Today, the WHO addresses communicable diseases, noncommunicable diseases, mental health, family and community health, sustainable development and health environments, health technology and pharmaceuticals, and policy development.

Related Topics

► Disasters
► Displaced populations
► Infectious diseases
► Refugee

Suggested Resources

World Health Organization website: http://www.who.org

X

Xenophobia

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Xenophobia encompasses negative attitudes and behaviors to exclude and vilify others pertaining to a particular ethnic or national group. Xenophobia is expressed as a defensive act by persons in groups that perceive a threat to their dominance. There is evidence that perceived disease threat predicts xenophobic attitudes. Negative consequences stemming from xenophobia include related acts of violence and bullying, a formation of negative ethnic identity in children, inhibited acculturation processes, and a general discord between ethnic and national groups. Xenophobia reflects structural violence or how history and political economy perpetuate social inequalities.

As a concept xenophobia is closely linked to stigma and discrimination. Stigma, a negative set of beliefs based on group belonging, is socially constructed through interactions but most often measured through perceived discrimination at the individual level. Growing more prominent in European countries, xenophobia is disproportionately directed at unauthorized migrants than legal or refugee migrants. Xenophobia contributes to the health burdens shouldered by immigrant populations around the globe, shaping experiences inside and external to the health system.

Health Consequences of Xenophobia

Violence motivated by xenophobia results in deaths, injuries, disabilities, trauma, and displaced persons. Violence against foreigners can cause movement of persons to displaced persons camps lacking infrastructure. Displaced persons are exposed to increased health risks due to unhygienic living conditions, poor clinical services, food insecurity, unsafe water sources, and greater exposure to infectious diseases. Further, bullying related to xenophobia places immigrants at greater risk for injury and harm.

Xenophobia determines the types of employment available to migrants. Often jobs open to migrants include hazardous working conditions and low pay. Workplace experiences may be shaped by xenophobia-related discrimination. Labor intensive jobs conducted without basic employment rights or entitlements to sick leave, health care, or convalescence time generate work-related accidents. Job insecurity and the discrimination perceived within the work sphere may cause stress and anxiety. By relation, loss of concentration places immigrant laborers at further risk of injury and peril to their health.

The prolonged stress of xenophobia leads to a physiological state of fear or hyper arousal. This state leads to increased allostatic load, a bodily stress response, which places migrants at greater risk for chronic illness. Perceived discrimination has been associated with increased incidence of chronic illness. Reports of discrimination have been linked to high blood pressure, respiratory problems, somatic complaints, negative self-rated health, and chronic health conditions.

Xenophobia-related discrimination has been associated with poor mental health. Anxieties related to experiencing xenophobia caused an increased need for mental health services. Among migrant groups such services have often been unavailable due to eligibility constraints based in legal status.

Health Care Seeking

Xenophobia provides an overarching context to the health care seeking activities of migrants. Contexts of xenophobia may compound rights-based limits on immigrant health care access such as lack of health care insurance or work-related limits on sick leave. Fear-based experiences of xenophobia may lead to

Sana Loue & Martha Sajatovic (eds.), *Encyclopedia of Immigrant Health*, DOI 10.1007/978-1-4419-5659-0,

avoidance of or delayed health care seeking. Migrants have avoided seeking health care services for a range of issues from prenatal care during pregnancy, broken bones, and abscesses. Aside from avoidance, delayed health care seeking results from xenophobia. Migrants delay prenatal and perinatal service seeking which likely leads to higher rates of perinatal mortality observed in many migrant groups. Migrants delay seeking health care for job-related injuries. The delay in seeking health care ensures that such injuries develop into longer term chronic problems.

Xenophobia shapes national legislation and thus influences health care access. Further, concern over limited health care resources can exacerbate xenophobia. In the United States, the federal welfare reform act of 1996, titled Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA), foreclosed eligibility for Medicaid to most legally authorized immigrants for the first 5 years of residence. The law required that state governments providing benefits to undocumented affirm migrants' eligibility. Intended to save costs, the legislation inadvertently created categories of eligibility within migrant groups, thereby increasing xenophobia toward illegal immigrants.

In certain contexts, health care staff are obligated by law to denounce undocumented migrants seeking health care services. Providing adequate care is further compromised by an inability to adequately supply medications to clinics serving migrants. Immigrants experience frustratingly longer wait times. Immigrants are more likely to report discrimination of health care compared with US-born counterpart populations.

Xenophobia shapes immigrant health risks, outcomes, behaviors, and health care seeking. By generating violence, xenophobia places persons of particular national or ethnic identity at greater risk of injury, disability, and death. Discriminatory experiences in the workplace may generate poor health outcomes. Xenophobia results in avoidance and delayed health care seeking, thus intensifying and worsening conditions. Fears of deportation and legal obligations for health care providers to report unauthorized immigrants result from contexts of xenophobia. Stress and anxiety related to xenophobia generate mental health needs which may be stigmatized in certain immigrant groups. Availability of mental health services is often limited to authorized immigrants. Health care services within contexts of xenophobia may be characterized by discrimination, long wait times, and poor supplies of medication. As protective factors against harms of xenophobia, immigrant groups may organize to claim their rights, receive social and economic support from nongovernmental organizations, labor unions, or other institutions.

Related Topics

- ▶ Discrimination
- ▶ Ethnicity
- ▶ Immigrant visa status
- ▶ Immigration processes and health in the U.S.: A brief history
- ▶ Labor migration
- ▶ Occupational and environmental health
- ▶ Stigma
- ▶ Undocumented
- ▶ Violence

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Y

Yoga

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Yoga is an ancient system for healing. The meaning of the word yoga may be defined as “yoking” or “bringing together.” Yoga, in its essence, is a union of the mind, body, and spirit. There is no aspect of life for which yoga does not have some benefit. The recent expansion in yoga speaks to the benefits in reduction of stress. The physical aspects help to bring movement to the body, oxygenating the musculature, and bringing balance to the habitual movements we do during our day. Spending time examining the internal landscape of the thoughts and emotions through meditation allows resiliency in the ability to adjust to everyday stressors. Pranayama or controlled breath exercises are a way to access control of the nervous system. All come together to give us the ability to adjust and course correct our life path for health, well-being, and resiliency.

The classic text and instructions regarding yoga come from the ancient writings of an Indian sage or wise man named Pantanjali. These writings are 200 short verses or sutras and date from an estimated time between 5000 B.C. and 300 A.D. They were passed down to students by song and are still taught this way in classic yoga schools. They have no religious binding and are nondenominational in nature. The sutras are a collection of guidelines and practices on which the structure of yoga is based.

The practice of yoga brings to each person certain benefits. As each person is different, variations on results occur in the practice of yoga. The commonly reported benefits of yoga may be summarized in three experiences: (1) an increase in a sense of well being and calmness; (2) less reactivity to stress and change; and (3) an increase in overall health, flexibility, and strength.

Any person of any age, ability, and level of health or fitness can do yoga. It is important to have an awareness of what your body can and cannot do safely when doing yoga. A good teacher should be able to help adapt the various practices of yoga to fit individual abilities, limitations, and past injuries. Always remember that yoga is a practice and a process, not a goal. Be gentle with yourself and allow time for observation and learning as you progress through your practice. One instructor used to say that movement of one telephone page at a time is enough. Just like a number of telephone pages added together result in a book of significant weight and volume, small advances achieved in yoga practice over time result in real progress from where one begins. As a last precaution, consult with your health care provider before starting any new physical activity.

Yoga is a physical, mental, and spiritual practice. The three most commonly discussed practices of yoga are postures (asana) to exercise and move the body, breath work (pranayama), which focuses on the energy of the body through the use of the breath, and meditation, which allows connection with one’s spiritual nature. The focus and relative balance of yoga practice rests in the needs of the yoga practitioner. Gary Kraftsow, director of the American Viniyoga Institute, recommends adapting the focus of practice depending on one’s age, physical and genetic characteristics. For people under 30 years of age, postures or more physical activity-based yoga would be most beneficial and should formulate the bulk of the practice. Between the ages of 30 and 70, a more balanced approach is the goal; therefore, the time is more evenly divided between asana, pranayama, and meditation. Meditation should predominate for people over 70 years of age with some gentle stretching and breath work.

In medical terms, no one has discovered exactly why yoga works. Yoga has long been known to help induce a sense of relaxation and peacefulness. By

Sana Loue & Martha Sajatovic (eds.), *Encyclopedia of Immigrant Health*, DOI 10.1007/978-1-4419-5659-0,

stretching and strengthening the body in a structured manner with the support of specific patterns of breath, we infuse the muscles, organs, and tissues with oxygen carrying blood. This gentle contraction and relaxation assists the body in cleansing the tissues of toxins and reducing the stress on the body. By focusing inwardly during movement, breath work, and meditation, there is a sense of peace. We know medically that the hormone cortisol is increased in the body during periods of stress. More and more research is pointing to cortisol as an important factor in acceleration of aging, worsening of depression and anxiety, disturbances in sleep, effects on the cardiovascular system, as well as feelings of well-being. If yoga helps induce relaxation, perhaps one of the mechanisms of its benefit may be an effect on cortisol and other stress-related changes in neurotransmitters, hormones, and neuropeptides. More research needs to be done to help delineate the effects of the practice of yoga in a physiologically measurable way.

More and more, people are turning to yoga as a complimentary treatment in combination with standard treatments to improve overall quality of life. There are many types of yoga practiced in the United States. The different types are generally named for the teacher who developed the type of yoga or the area of India from which the particular practice originated. Types of yoga that are known for their ability to adapt to the needs of special populations include Viniyoga, Phoenix Rising Yoga Therapy, Hatha Yoga, and Iyenger Yoga. Find an instructor with whom you can discuss your concerns, special issues, and goals for your yoga practice. The best teacher is one who teaches in a way that you understand and who works with the individual to achieve optimum health through a comprehensive, safe, and consistent practice. It is critical that the instructor and the student cocreate an environment which is safe and conducive to learning.

There are many places in which to learn more about yoga. Always remember yoga is a practice, and not a practice which should be perfect. May your practice bring you joy and health as it unfolds for you in the quest for improving your quality of life.

Related Topics

- ► India
- ► Stress

Suggested Readings

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Suggested Resources

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Yoga Alliance, Certified Yoga Teachers. http://www.yogaalliance.org/

Youth

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Immigrant youth, defined as children having at least one foreign-born parent, make up over 20% of the youth in the USA today. The majority of immigrant youth live in California, Florida, Illinois, New Jersey, and New York. However, immigrant populations are growing rapidly in other southern and western states, including Georgia, Tennessee, Oregon, and Colorado. Approximately 80% of immigrant youth have been born in the USA and are US citizens. Almost two-thirds of these youth have one or more parents who are not citizens. This lack of legal status can limit access to health care and school services, which in turn can affect physical and mental growth and development.

Immigrant youth, like any youth, are diverse, and it is difficult to generalize their overall development.

However, certain developmental and psychosocial issues are common across the population. For all teenagers, adolescence is a time of physical and intellectual maturation as children progress toward adulthood. The expected physical progression includes linear growth, weight gain, and the development of secondary sexual characteristics associated with puberty, such as breasts and menstrual periods in girls and facial hair and genital growth in boys. Physical development occurs earlier or later depending on nutritional status, overall health, and ethnic background. Children whose nutritional status has been compromised (by starvation or inadequate food supplies) or who have poor general health (because of chronic illness or undiagnosed medical issues) will enter puberty later, and girls will get their first periods later. Teenagers are usually self-conscious about pubertal development initially, but they do become more comfortable with the changes in the bodies of themselves and others. Adolescent sexuality also emerges during puberty; teenagers have sexual thoughts and feelings and may begin experimentation with the eventual developmental goal of forming stable relationships.

Depending on cultural beliefs or country of origin, normal developmental milestones – a first crush or a first date – may be met with anger or with limited communication between teenagers and parents even when topics presented at school are encouraged to be discussed at home. Some parents are not aware of the sexual culture in the USA to which youth are exposed in the media, society, or even at school and may, therefore be unable to anticipate or address questions about emerging adult sexuality.

As youth become adults, they must develop independence. Their initial attempts at autonomy can be characterized by loneliness and perceived moodiness. Teenagers try to dissociate themselves from their families, and parents may be concerned as teenagers spend more time away from home. Peer groups appear to take precedence over family as adolescents look to friends to help with self-image and behavioral codes. However, individual friendships eventually become more important than the large group, and family values can contribute to the adolescent identity and to the adults they will become. Along with developing independence, adolescents are also trying to define their identity – to explain, "Who am I?" Additional experimentation in this area is common as adolescents try out different roles and use their growing creativity and intellectual ability in defining a sense of self. Cognitively, adolescents are initially capable of primarily concrete thought and are unable to perceive the long-range consequences of their decisions. As their brains develop, they establish abstract thought processes and become more focused on the future. In some instances, the adolescent's declaration of independence may not be welcomed by parents unfamiliar with this type of psychosocial growth.

While this is the expected progression of youth development in the USA, the process varies within the USA and other countries as well as among the immigrant population. Perhaps most importantly, in the USA and other similar countries, adolescence is a long process, with much time given for youth to make their way through all the stages and tasks of development. Adolescence has been extended in part due to educational opportunities; many teenagers remain financially dependent on their parents into their early 20s as they complete their education. In other countries, youth may be faced with the responsibilities of adulthood more quickly. Parents of immigrant youth may not themselves have progressed through many of the stages described above and, during the acculturation process, can be confused by their teenager's actions. Immigrant parents may also have different views of adolescent experimentation; adolescent free time may be limited by higher parental expectations regarding school and work. High importance is not placed on adolescent social networking.

Adjustment issues among immigrant youth are common, and many of the stressors associated with immigration can contribute to these issues. Immigration itself is a disruptive and stressful event; immigrant youth must manage the loss of not only family and friends but of a common language and customs. While studies of migrant youth have found both higher and lower levels of mental health problems, many studies have found that immigrant youth are at high risk for mood disorders. Immigrant youth often have anxiety or depression, and they may demonstrate difficulty concentrating and sleeping. Immigrant youth at highest risk appear to be those without parents, those with learning or physical disabilities, those who have limited education or limited functioning, and those who have been separated from other family members for a long time. These adolescents may come from areas that do not have adequate mental health services, and their families may not use the mental health services available in the USA. Parents may not recognize sadness and withdrawal as warning signs, or there may be stigma or cultural barriers associated with seeking help. Even those who seek mental health services often have difficulty with access to care due to insurance, legal status, transportation problems, language issues, and long waiting times to see a provider.

Trauma also contributes to mental health problems and to adjustment issues. Posttraumatic stress disorder (PTSD) is common in the refugee population. Immigrant youth may have left their countries of origin as a result of war or natural disaster. Exposure to trauma at any age can place an adolescent at risk, particularly when adding the stress of resettlement. Refugees arrive in the USA with little cultural orientation – sometimes as little as 12 h of preparation; ongoing mental health issues can be exacerbated by both the trauma and quick resettlement. Poverty is an additional stressor. Immigrant youth have high rates of poverty – over a third of immigrant families have difficulty affording food. Poverty is associated with lack of access to medical care and with medical and mental health problems.

Despite these problems, immigrant families do have many strengths. They are more likely than their US counterparts to have two parents in the home along with an extended family. There is often a strong community of immigrants from the same country of origin. The community tends to place a high value on education, respect for family and elders, and tradition. Immigrant families are also generally healthy. The "immigrant paradox" demonstrates that, for example, Hispanic immigrants are healthier than US-born Hispanics despite higher poverty rates, less access to healthcare, and lower education levels.

While immigrant families do have strengths, they continue to face challenges. As adolescents begin to adjust to life in a new country, the expected parent–adolescent conflict is often amplified. School provides a means of acculturation for immigrant youth that their parents do not have. Adolescents, in their desire to "fit in," are more motivated to adapt to and to adopt new customs, enhancing their separation from parents. Immigrant youth learn English more quickly and may take on a more adult role as they become family translator and advocate. This role-reversal places adolescents in the parent role and causes tensions within families. Teenagers feel that their parents are unable to help them; they may be embarrassed by non-English speaking parents who have not adapted to American culture. Immigrant youth struggle to balance living in their old and new worlds. That struggle results in further withdrawal from the family and a perception by parents that their children are too "Americanized."

Some adolescent immigrants have been physically separated from their parents for a period of time. Either the parents arrived first or the children were sent ahead to stay with family. The disruption of family combined with loss of social and cultural norms can result in a sense of loss of control for both the adolescent and the parent. Adolescents and parents may have difficulty adjusting to the new role of parent as head of the household and to new family constructions. Immigrant parents may also have different expectations than US-born parents, and this may also contribute to family conflict. Adolescent immigrants may be expected to earn money or to act as babysitters. Immigrant youth whose parents are relying on them for support may feel uncomfortable in their adult roles and may "act out."

Part of "acting out" is the adolescent's attempt to form or participate in a peer group. Immigrant adolescents must develop friendships and rebuild the social networks they left behind in their countries of origin. Depending on the community in which they live, they may find other immigrant adolescents of similar background, or they may struggle with feelings of alienation and "otherness." Immigrant youth may be segregated in school racially, ethnically, and linguistically. There may be discrimination – real or perceived – that complicates the development of a cohesive sense of self. Some studies have demonstrated that immigrant youth are more likely to experience peer pressure to engage in risky behaviors such as substance use and sexual activities. Other studies show that immigrant youth are less inclined to use substances than their US-born counterparts.

Despite the many challenges, immigrant youth in the USA do well. The USA is, in many ways, a nation of immigrants. As immigrant youth adapt to American culture, they and their parents may also bring change to that culture. Immigrant youth who are able to maintain a sense of their own heritage identity while they take on new cultural values and customs have more positive psychosocial outcomes. Immigrant youth who can balance multiple cultures and identities can successfully integrate into and participate in the larger society.

Related Topics

- ► Acculturation
- ► Adolescent health
- ► Family
- ► Secondary education

Suggested Readings

Ellis, B. H., Lincoln, A. K., MacDonald, H. Z., & Cabral, H. J. (2008). Mental health of Somali adolescent refugees: The role of trauma, stress, and perceived discrimination. *Journal of Consulting and Clinical Psychology, 76*(2), 184–193.

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Suggested Resources

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Youth Antisocial Behavior

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It is quite common for the typical adolescent to on occasion engage in delinquent behavior. The vast majority of teens who commit delinquent behaviors or engage in acts of violence will stop such activities as they approach adulthood. However, there is a small minority of teens whose illegal conduct persists into adulthood. The task of identifying the teens who are at a higher risk for continued illegal behavior into adulthood is a daunting one, and is one that is frequently asked of mental-health professionals who work with children and adolescents. This is a very difficult and challenging endeavor, and working with youths and their families who have immigrated to the United States can significantly add to that challenge.

There are many factors that lead to juvenile delinquency; this entry focuses on environmental influences. While these factors make youths from low-income families vulnerable to developing antisocial behaviors, children of immigrant parents are at even greater risk. The following provides an overview of this process.

Low interest in school or chronic academic failure is a significant risk factor for the development of antisocial behavior. For the immigrant youth, poor command of the host country's language can lead to significant academic problems if the school is not able to accommodate him or her. The youth may have a learning disorder that is not identified as such and may be dismissed as merely a "cultural learning barrier." The same can be said if the youth possesses an intelligence quotient (IQ) that is well below average. This may result in the youth becoming frustrated and eventually becoming disenfranchised. This may lead to the youth engaging in truancy or discontinuing his/her education.

Economic factors also play an important role in the development of delinquent behavior. Parents of immigrant children who have a limited education or poor command of the English language are likely to find employment in low-paying jobs. This may require the parents to work multiple jobs in order to meet all financial obligations, which in turn requires them to be away from their home the majority of the time. This situation can lead to an inability to provide adequate supervision. Youths who have become disenchanted with school will have little difficulty when it comes to being truant from school. With no parent available to make sure he/she goes to school, skipping school becomes an attractive alternative to going to class and not understanding the lessons being taught or being anxious about having to read aloud when he/she is not capable of doing so.

Adolescence is a period of time in which a youth is very susceptible to peer influence and desperately wants to fit in with a peer group. If the youth feels that he/she is subject to chronic ridicule, for example, not having funds to participate in activities with peers, this may lead to his/her engaging in stealing these items or finding ways to obtain money to pay for them. One of the easiest ways for youths from low-income households to make a lot of money quickly is selling drugs.

Limited economic opportunities for the parents of these youths makes affordable housing difficult and thus the family is likely to live in an urban area that tends to have higher criminal activity. This provides the youth an easy pathway to obtain drugs and learning how to sell them. Access to weapons is much easier and street gangs are much more prevalent.

It is easy to see how a youth who perceives himself/herself as an academic failure with no hopes of going to college and who looks at his/her parents' struggle to make ends meet can be seduced by a lifestyle of quick money with little effort and no discernable skills. It is also easy to see that associating with other delinquents affords him/her not only a peer group who accepts him/her, but also a peer group that offers even more opportunity to engage more diverse delinquent acts.

A frequently overlooked factor in the development of delinquent behavior is the difficulty accessing mental-health services. Funding for mental-health services is severely lacking, and gaining access to a child psychiatrist is often difficult, much less a child psychiatrist with experience or language capacity to work with diverse immigrant populations. It is not uncommon for there to be a 3-month wait for medication services. If a youth has, for example, attention deficit/hyperactivity disorder that requires appropriate medication, obtaining treatment may prove difficult. Also, individual therapy for issues such as depression or anxiety, or group counseling for problems such as anger management or social skills training may be difficult to obtain.

Family counseling is often the treatment of choice for youths involved in violent acts or chronic delinquency. However, transportation can be a challenge for low-income families. Further, it is often not possible for the parents of these youths to take time from their jobs to attend appointments that will require them to miss work on a consistent basis, yet another barrier to treatment. Families may also not recognize or accept their child has mental-health needs because of cultural differences in classifying such behaviors or due to the stigma associated with mental illness. Thus, immigrant youths' mental-health needs can often go unmet.

The factors in this article illustrate how societal challenges a youth of immigrant status faces can place the youth on a path toward chronic delinquency and violent behavior. For youths who face these challenges, they face multiple hurdles that can be hard to overcome without help. Immigrant families may find the most success in accessing the services and assistance they may require by contacting local social service agencies that specialize in their particular culture. These agencies are typically run by persons who have emigrated from the same nation as the families requesting help, and can provide valuable information as to how best to access these services and can even provide case management services to the neediest families.

Related Topics

- ▶ Limited English proficiency
- ▶ Mental health
- ▶ Refugee youth
- ▶ Stigma
- ▶ Violence
- ▶ Youth

Suggested Readings

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Z

Zionism

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Zionism, a term derived from Zion, a biblical word for Jerusalem, is based on the ancient nationalist attachment of the Jewish people to *Eretz Yisrael* (Land of Israel). As an ideology, Zionism holds that the Jewish people are a nation and should gather together in a single homeland. The first use of the term is attributed to Nathan Birnbaum, Austrian journalist and founder of the first Zionist student association in Vienna. Birnbaum coined the term in response to growing anti-Semitism directed at Jews in the late nineteenth century. Zionism was formally introduced as a nationalist movement by Theodor Herzl in 1897 at the first meeting of the Zionist Congress. Within the framework of a political organization, Zionists developed a plan to extend nationalist sentiment throughout the world's Jewish population and promote Jewish development in Palestine.

The emergence of Zionism in the late nineteenth century can be understood only in the broader context of European and Jewish history. Since ancient times, Jews were exiled from Israel. The majority of the Jewish population came to reside in the Diaspora of Europe, North Africa, and the Middle East and faced discrimination and persecution for centuries. For example, in 1516 the state of Venice decreed that Jews would only be allowed to reside in a walled area adjacent to the city called the Ghetto, a trend quickly adopted by other European countries. Ghettos were overcrowded, highly taxed, and provided a convenient target for *pogroms* (mobs).

With the French Revolution and advent of the Enlightenment in the eighteenth century, the Jewish people began to gain hope that humanity was moving toward a new tolerance and liberalism. At the French National Assembly in 1789, Clermont Tonnerre demanded that Jews as individuals be denied no rights, and emancipation spread rapidly throughout Europe. Despite emancipation, anti-Semitism grew and European Jews began to see that mere cultural assimilation was insufficient for achieving equal status as nationals in host countries.

Proto-Zionist groups began to form in the 1860s and the political movement was formally established by Theodor Herzl, a Viennese journalist and author of *Der Judenstaat* (The State of the Jews), in which he argued that the best way to avoid anti-Semitism in Europe was to create an independent Jewish state. Herzl united 200 delegates from around the world, representing every aspect of Jewish religion, cultural philosophy and thought, at the first meeting of the Zionist Congress in 1897 in Basel, Switzerland. At the Congress, Herzl was elected president, the Zionist Organization was established, and a declaration of Zionism's goals were outlined in the Basel Program.

The Balfour Declaration of 1917, stating Britain would facilitate the establishment of a national home for Jews, marks the second major turning point in the political Zionist movement. However, the Declaration also confronted Palestinian Arabs with the danger of losing their country. Zionists paid little attention to the first stirrings of the Arab National movement and few envisioned the possibility of a clash of national interests, which would sow the seeds of the Israeli-Arab conflict that continues today.

Between the first and second world wars, conflict arose within the Zionist Organization. Ahad Ha-Am, one of the foremost pre-state Zionist thinkers and founder of Cultural Zionism, began to speak out and disengage from the political movement. Ha-Am and followers of Cultural Zionism believed only the Messiah could reestablish Jewish rule in Israel and

Sana Loue & Martha Sajatovic (eds.), *Encyclopedia of Immigrant Health*, DOI 10.1007/978-1-4419-5659-0,

emphasized a need for revolution in Jewish thought, rather than winning political support to achieve a Jewish state. With the advent of World War II and the Holocaust, a new faction of Revisionist Zionists, led by Vladimir Jabotinski, called for the creation of a Jewish army to defend the establishment of a Jewish majority in Palestine. The Political Zionist majority, in particular Labor Zionists, who believed that a Jewish state could only be created through the efforts of the Jewish working class settling in Palestine, rejected the ideology and tactics of the Revisionists as fascist. However, by 1946 Revisionist Zionists had rejoined the Zionist Organization, which would later be called the World Zionist Organization in 1960.

In 1947, the United Nations voted in favor of the partition of Palestine, proposing the creation of a Jewish state, an Arab state, and a United Nations-administered Jerusalem. Partition was accepted by Zionist leaders but rejected by Arab leaders, leading to civil war. The State of Israel declared independence in 1948, which marked the fulfillment of one of Zionism's main goals. After 1948, Zionism evolved into a movement dedicated to immigration for as many Jews as possible, land purchase for continued settlement, and political and economic support for Israel.

In summary, Zionism is based on historical ties and religious traditions linking the Jewish People to the Land of Israel. It encompasses several aspects and competing factions, but is most commonly thought of as the nationalist political movement that supported the reestablishment of a homeland for the Jewish people. Today about one-third of the world's Jewish population resides in Israel.

Related Topics

- ► Emigration
- ► Ethnic enclave
- ► Judaism

Suggested Readings

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Laqueur, W. (1972). *A history of Zionism*. United States: Holt, Rinehart & Winston.

Rotenstreich, N. (2007). *Zionism: Past and present*. New York: State University of New York Press.

Suggested Resources

Academic guide to Jewish history: Major print and internet scholarly resources. Compiled by University of Toronto Libraries. http://link.library.utoronto.ca/jewishhistory/index.cfm

Israel Ministry of Foreign Affairs. http://www.mfa.gov.il/mfa/history/modern%20history/centenary%20of%20zionism/