

Reaching Out to America's Immigrants: Community Health Advisors and Health Communication

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Purpose: To describe clinical services and health communication needs for recent immigrants. **Methods:** A review of relevant health behavior and policy research published in the past 20 years was conducted. **Results:** Health coverage for primary care, prenatal and safety net services needs to be continued for all immigrants. Legislative bodies should repeal those aspects of welfare reform laws that diminish funding for health programs. English training provides efficient and effective access to

health care and health communication. Finally, health communication messages mediated by community health advisors constitute an effective alternative to mainstream health communication. **Conclusions:** Societies whose populations consist primarily of immigrants need to be better prepared to promote the health of this group.

Key words: community health advisors, communication/persuasion model, immigrant health

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The migration of human beings is as old as their presence on earth: with out migration, homo sapiens would by now have evolved into several different species.¹ Two percent (120 million) of the earth's population lived outside of its nation of birth in 1990,² and 8% of Americans are foreign born. The United States, Canada, and many other countries are almost entirely populated by immigrants and their descendants. Economically prostrated by World War II and unprepared for the implications of decolonialization, European nations now host millions of immigrants as well.

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Yet host societies are highly ambivalent about immigration and immigrants. The baby boom generation begins retiring in the first decade of the new millennium, but with their 1.6 children per family, boomers have not reproduced sufficiently for the nation to support this retirement without young immigrants. We demand cheap lettuce and, when needed, an endless supply of skilled labor, but fear diversity. This ambivalence in turn may contribute to negative health and social impacts on the immigrated population. Compounded by the disruption in the immigrants' lives as they move away from their land of origin, the process of immigration may prove an isolative experience and a fairly high-risk venture.

Health Services Issues

Definitions of immigrant. From a legal perspective, immigrants are people

who have been granted permanent or conditional residence as recognized by the law of the host nation.³ Undocumented immigrants are not viewed officially as immigrants by the government, even though their change of residence is relatively permanent. In the United States, more than 3 1/2 million people compose this latter category, one third of whom are Mexican.⁴

The specific category of immigration status, although somewhat arbitrarily determined, can prove extremely important to the immigrant who seeks health care. Permanent residents, refugees, asylees, and others in the documented category are entitled by law to Medicaid benefits, as are their spouses, children, and dependent parents, who may gain admission relatively easily. Individuals who enter the United States illegally or who enter the United States legally but violate their immigration status are entitled only to emergency labor and delivery services.⁵

Immigration to the United States: who shall we be? A major impetus for loosening immigration laws throughout American history has been the need for cheap labor to fuel economic success. Therefore, in relatively strong economic times the control of immigration from southern Europe, Mexico, and other nations with relatively lower standards of living has been somewhat lax, whereas recessionary pressures have been manifested through attempts to restrict or even reverse immigration. During the Great Depression, for instance, hundreds of thousands of Mexicans were forced to leave the United States through its "Repatriation Campaign." In the 1950s, more than one million Mexicans whose services were no longer deemed needed by growers and other employers were expelled from the United States. Although today's "Operation Gatekeeper," the building of a fortified fence at the San Diego-Tijuana border, and post-9/11 enforcement efforts have diminished the flow of undocumented immigration, economic realities more than federal policies govern the rate of immigration from Mexico and elsewhere. Policies that do exist virtually always punish the immigrant job seeker rather than the American job giver.

In 1986, Congress passed the Immigration Reform and Control Act (IRCA)

making employers for the first time subject to sanctions for hiring employees without proper authorization to work. The Immigration Act of 1990 set an annual limit on immigration at 750,000 per year.⁶ The controversial welfare-reforming Personal Responsibility and Work Opportunity Reconciliation Act of 1996 proposed drastic consequences for many legal immigrants as well as undocumented ones, barring noncitizens from eligibility for Medicaid, food stamps, and supplemental security income. Arguing that they should not be required to pick up the tab for a national policy largely in shambles, local and state governments may exaggerate their costs of immigration in an attempt to recover these costs and augment their budgets. Conversely, these same governments will understate some of the amount of tax revenues collected by immigrants. However, extending benefits to undocumented as well as documented immigrants ultimately will be less costly, no matter which level of government picks up these expenses.³

Central to the economic debate about immigration is the cost to taxpayers of providing services for immigrants. In Los Angeles County, for example, providing health care to immigrants costs about \$350 per person per year, which is not disproportionate in the context of this region's poor people in general.⁷ Yet many immigrants work at or below minimum wage levels for employers who not only pay no benefits, but also may expose them to health-damaging conditions. Thus, the public takes advantage of lower costs through the labor of these individuals, yet begrudges them the wherewithal to obtain minimal health care needs.

How immigration affects health. The majority of immigrants are poor, and many have endured significant hardships in their journey from their native to their adopted homes. Upon arrival these individuals are subjected to hazardous work responsibilities as a function of assuming jobs in low-paid, unskilled, and difficult employment areas. Agricultural and meat-packing industries, for instance, offer employment that portends a far greater chance of occupational injury than do jobs in the service sector or other blue-collar areas. In turn, neighborhoods (or even improvised shantytowns) spring up around these places of employment, as impoverished workers are unable to trans-

port themselves to distant homes. These neighborhoods may be physically, ethnically, or even linguistically isolated from the majority community, reducing the opportunities for the immigrants to benefit from and assimilate into society.⁸

Whereas immigration represents the physical face of relocation, acculturation symbolizes the social, psychological, and behavioral changes subsequent to that relocation. Substantial controversy exists as to whether immigration and acculturation represent protective factors or pose risks to the health and mental health of the immigrant. For example, Japanese immigrants and their offspring have been shown to have lower prevalence and mortality from stroke than matched counterparts in Japan. Compared to immigrants, Mexican Americans have a relatively high prevalence of obesity, diabetes, and gallbladder disease, and more poorly controlled hypertension.^{9,10} Vega et al¹¹ concluded that immigrants born in Mexico had higher degrees of psychological distress than did Mexicans. In any case, after adjusting for SES, Mexican immigrants appear to have lower mortality rates than whites or Mexican Americans, who are equivalent after such an adjustment.¹⁰

Clark and Hofsess⁸ conclude that, at least among Latinos, health disadvantages associated with immigration and acculturation have been demonstrated. However, Gordon¹² notes that these and similar data for other immigration groups may be misleading due to a variety of factors. Healthier individuals may be more likely than others to migrate. Immigrants may come from countries with less adequate screening practices, resulting in an undercount of the incidence and prevalence of diseases. Nevertheless, there does seem to be an overall physical and social environmental impact that diminishes the health of the immigrant and exposes him or her to a higher risk for cancer, mental illness, and many other disorders.

Health care for immigrants: economic and political issues. Immigrants receive substandard care because they are uninsured and/or do not utilize health services.¹³ With limited options, both preventive and curative health care becomes unaffordable for most immigrants. The medical or therapeutic resources available to an individual also influence health

beliefs and health behaviors. Social isolation, which may stem from a lack of transportation or financial resources; fear of being deported due to documentation status, or physical distance from the community may also result in underutilization of health care.¹⁴ This isolation reduces the likelihood that the family will seek formal health services or be receptive to health promotion efforts geared towards the surrounding society. As a whole, social isolation, poverty, and lack of health care coverage may encourage individuals to postpone professional treatment in the hope that the illness will resolve itself.¹⁵

Even when care to the immigrant is provided, it may be inadequate. Cultural and linguistic barriers may contribute to inadequate health care by limiting the ability of the provider to understand the patient and his or her symptoms, and result in an unacceptable course of treatment from the patient's perspective.⁶ Additionally, undocumented immigrants may receive less care than their illness would call for. In a study by Siddharthan and Ahern,¹⁷ for example, undocumented immigrants in a large Miami county hospital had a shorter length of stay than native born patients or permanent residents, even though their Case Mix Severity Index was higher. These results were possibly attributable to financial pressures on the hospital or fear of deportation among the aliens.

Health Communication and Behavior Change

Psychosocial issues. Even fully funded and accessible health care services for all immigrants would not solve their health needs. They still would have to be convinced to avail themselves of these services and concurrently engage in other health promotive behavior to optimize their health status. Health communication promoting proactive behavior change addresses the demand side of the health services issue while potentially creating a healthier population less in need of such services. Fundamental to understanding health-care seeking and health-promotive behaviors of the immigrant are appropriate theories of behavior change. When considering various psychosocial models of health-related behavior among immigrants, the ethnic context of their origin must be addressed. In

most cases, theories of behavior change are based on stable, middle-class society. Related measures and instruments are developed to assess essentially white Anglo, often middle-class norms,¹⁸ thereby limiting generalizability. When people emigrate from their native land, they bring with them the beliefs and values associated with their past. As their new status as immigrants becomes part of their consciousness and they go through the jolting contact with the dominant culture, they may either become disassociated from these beliefs and values or cling to them as a source of self-support and self-worth. This choice, either freely committed or determined for them, can be understood only within the broader sociocultural context.

Theories of health behavior change to a great degree and emphasize the role of the individual and his/her thought processes in the development and maintenance, or loss of adaptive health-related behaviors. However, Elder et al¹⁹ question the extent to which these theories apply to immigrants outside the dominant mainstream American culture, with its anonymity and isolation coincident with personal autonomy. First, the model of individuals as relatively autonomous beings who weigh potential personal outcomes, their "self"-efficacy, and their personal readiness to change, while at the same time choosing whether to listen to or ignore pressure from peers, may have little relevance to more traditional cultures. Immigrants often bring with them a strong sense of identification with and attachment of individuals to their families, both nuclear and extended. The design of health messages must acknowledge this attachment, which promotes loyalty, unity, reciprocity, and solidarity within the immigrant community.²⁰ Collective identity is another factor that must be calculated in the development of health communication targeting immigrants. The typical immigrant from a *gemeinschaft* society is someone who emphasizes the needs of the group or family over his or her own.²¹ These individuals may not be influenced by messages that target only the individual. For example, in a study of Latino immigrants by Apodaca et al,²² perceived family approval and support more than autonomous decision making influenced an individual's decision to participate in a heart-health promotion

program. Third, in *gemeinschaft* societies, the individual's approach to health and illness is often fatalistic.²³ Disease may be seen as a punishment for past sins and health as a gift from God.^{23,24} Because of this fatalistic orientation, Western-style modification of negative lifestyle behaviors through an appeal to personal autonomy is less likely to be successful.²⁵ The search for useful theories and models of behavior change applicable to immigrant populations is complicated by many factors. Immigrants vary dramatically in terms of socioeconomic and legal status, language and literacy, religion and family orientation, acculturation, and experience with the dominant culture. Western models emphasizing personal autonomy and other characteristics may not be generalizable, especially to the newly arrived immigrant. Functional models prescriptive of how to change behavior (rather than how to explain it) may be more useful, at least until theories can be developed that are more universally applicable. McGuire's²⁶ Communication persuasion model comprises one such functional approach.

The Communication/Persuasion Model. The communication/persuasion Model²⁶ considers how mass media and other forms of public communication change attitudes and behaviors. The effectiveness of a given communication effort will depend on various inputs and their characteristics, as well as the types of outputs in which one is interested. Communication-input variables applicable to immigrant communities will vary substantially from those appropriate for the majority population. Input variables include the *source* of message, the *message* itself, the *channel* by which it is sent, *receiver* characteristics, and *destination*. Sources variables focus on characteristics of the individual perceived as sending the message. Sources vary in terms of the numbers of people sending the message, their credibility, their physical attractiveness, and characteristics they have in common with the receiver. Messages themselves vary in their specific appeal (eg, negative vs positive appeal), the information they present, what is included and what is omitted in the message, how the messages are organized, and how frequently they are repeated. Channel factors were initially thought to vary primarily between print (eg, newspa-

per, pamphlets), and interpersonal electronic (radio and television) media. Receiver (ie, audience) factors present a mirror image of source factors. Again, these include the demographic characteristics of the people at whom the messages are aimed, as well as their capacity to understand and assimilate the information, their "personality," and their lifestyle. Finally, destination factors refer specifically to the target behaviors on which the communication is expected to impact.

More central to the present discussion are McGuire's²⁶ output factors. Output factors reflect the specific sequence of change the receiver of the communication is expected to go through, from the initial exposure to the communication to the long-term behavior change. Implicit in this sequence is the assumption that knowledge change is a prerequisite for attitude change, which, in turn is a necessary precondition for decision making and behavior change.

This section will present the articulation of McGuire's output variables with special characteristics of immigrant communities. Specific attention will be given to how (1) interpersonal communication via CHAs enhances attention and exposure, (2) comprehension of health messages is improved through their modification based on target audience literacy, (3) acculturation can influence attitude change, and (4) family-focused interventions optimize the potential for maintaining behavior change.

Promoting attention and awareness via community change agents. Optimal exposure and attention to health promotion messages requires selection of an appropriate and popular channel and delivery of messages at an appropriate time and place for the target audience to attend to the message. This entails a very careful process, as mistakes can be costly. Not only must the target audience be exposed to the message, but they also must attend to it. Health behavior communication is clearly at a disadvantage in competition with commercial marketing, as health messages by nature tend to be less glamorous and the behavior more complicated than the simple purchase of a consumer product. When immigrants compose the target audience, exposing them and getting them to attend to the communication are complicated even further.

To succeed, health communication efforts in immigrant communities must overcome financial, cultural, and even legal barriers. Health officials and providers may be ignored as message sources, perceived to be unaware of the patient's culture, or even perceived as siding with hostile law enforcement. Formal health promotion programs typically rely on broadcast and print channels not intended for non-English speaking or immigrant communities. Many of these barriers can be surmounted by the use of community health advisors (CHAs) who come from the communities they serve and yet are sufficiently acculturated to the host culture to be able to understand and appreciate certain health promotion and health care messages that need to be communicated to recent immigrants.

The CHA model^{27,28} is based on the assumption that within every community there are formal and informal social networks through which health information is exchanged and predisposing interpersonal environments are created. CHAs are indigenous lay health advisors who exist in all communities, and generally have attributes of leadership, compassion, and familiarity with the community. Interpersonal communication via CHAs addresses the weaknesses of impersonal mass media, the latter which may not result in sufficient exposure, attention, or comprehension.

CHAs are often called on to communicate on a face-to-face basis with those in their charge, increasing access to care²⁸ and reducing the likelihood of misunderstanding of treatment or health promotion communication, while increasing the acceptability of the communication. These CHAs in turn are accessible should patients need further follow-up regarding a specific issue or should they need to be referred for additional treatment (eg, after a high blood pressure screening shows high blood pressure in the individual). Through the CHA channel, information is provided about the importance of a medical intervention, how the medical care system operates, eligibility requirements for various health programs, and even how to fill out forms for participation. Community health advisors may be adept at translating the need to alter health practices that are culturally bound, such as eating habits. Community health advisors are also important in providing

logistical and other support, sometimes including transportation; providing directions; or even helping set up screenings in immigrant neighborhoods. A large number of projects, especially in Mexican-immigrant communities, have been successfully carried out using the CHA model.²⁷ Unfortunately, the interpersonal channel suffers by comparison with mass media in terms of the scale of the intervention effort. CHAs may be very effective, but require a lot of professional time for recruiting, training, and sustaining them in their efforts. High dropout rates, occasional errors in health messages, or eventual decay of skills acquired may all characterize a CHA led program. Such risks are especially prevalent if the program is a long-term one requiring extensive new recruiting and retraining efforts or if program designers have overly high expectations of CHAs.²⁸

An interesting solution to the public health challenge of using CHAs has been provided by the *A Su Salud* program in southwestern Texas.²⁹ CHAs working with *A Su Salud* are primarily trained to expose participants to a health promotion effort (eg, smoking cessation, lowering dietary fat) and gain initial attention by providing them with minimal information. The more technical details of the program are then offered via mass media channels. In this scenario, the CHAs recruit participants to join them in listening to a particular radio show or television program that will convey the information needed. After the program is over, the CHA then conducts a discussion group among the participants and follows up with each of them on their own homework assignments with respect to the risk-reduction behavior change. Through this type of effort, CHAs can spend more of their time recruiting an audience and less time training to become risk-factor experts. CHAs have a vested interest in the well-being of the group to which they belong and thus have a greater than average sense of community. They have the capacity to create awareness, disseminate health information, and support behavior change. The formal use of these change agents in American immigrant communities is growing.^{30,31} This type of approach is important to immigrant populations who are generally less acculturated and often do not benefit from mainstream health promotion efforts. Once trained,

the CHA provides a conduit for diffusion of information and a channel for empowerment through formal and informal education sessions.

Improving comprehension of health communication: the literacy issue. According to McGuire,²⁶ once exposure and attention to health communication are accomplished, the receiver must comprehend the fundamental aspects of the communication. The CHA can prove instrumental in this aspect as well, through bilateral interpersonal communication tailored to the abilities and characteristics of the audience. Yet mass media are still required, either to deliver the bulk of the message to the audience or complement that which it receives via the interpersonal channel. The print medium comprises a core element of mass media, though its effectiveness will be limited by the literacy of the target audience.

A major aspect of the problem of low literacy in the United States is the fact that most recent immigrants, especially from Latin America, know little or no English upon arrival in this country, limiting their ability to function in job training programs, the community, and the workplace. In addition to the economic risk in which low-English literacy places immigrants, health risks accrue to this population as well. For instance, current health instructional approaches and materials are typically designed for relatively educated individuals highly literate in English. Materials available in Spanish or other non-English languages are largely direct translations from English and are often not culturally or even linguistically appropriate. Further, they tend to be written at a high Spanish (or other language) readability level, making them inappropriate for low-level readers in their native languages.^{32,33} Such barriers apply not only to health education materials³⁴ but also to instructions that go along with medication prescriptions³³ and even condom use.³⁵ Illiteracy may negatively affect health through incorrect use of medication and inability to comply with medical directions or advice, high rates of accidents, and a lack of access to health information and services.^{36,37} Health messages that concurrently promote literacy may constitute the ideal approach to health communication for immigrants. In "Language for Health," Elder et al³⁸ wove heart health

and stress management information into English as a Second Language courses for recent immigrants from throughout the world. While these immigrants were learning English, they were also successful in reducing dietary fat and at least for a short period of time improving HDL, total cholesterol levels. Alumni left these classes with not only improved English but also improved health practices.

Promoting the acceptance of health communication: issues of culture and acculturation. Health communication messages aimed at immigrant or minority communities will often specify the audience's ethnicity in an attempt to render the communication more interesting, attractive, and acceptable to the audience. Even this seemingly obvious measure, however, may prove complicated. For example, individuals of Mexican origin may prefer to be called Mexican American, Latino, Hispanic, Chicano, or even Mexican, depending to a degree on their level of acculturation. Therefore, using "Mexican American" or other term to specify certain receiver characteristics, though understood by all, may yield less than optimal acceptance and may even be rejected by some groups. Thus, after exposure, attention, and comprehension are optimized, health communicators must ensure that messages are accepted and result in attitude change among all the segments of the target audience. Messages must be appropriate both to the culture and acculturation level of the audience.

Acculturation has been described as a process in which an individual's attitudes and behaviors shift from those of the culture of origin toward those of the dominant culture³⁹ or as the process by which individuals learn about and adapt to a new culture.⁴⁰ Changes that occur in attitudes, norms, and values of individuals exposed to a new culture are an important part of this process⁴¹ and may provide insight into the relationship between acculturation and health-related behaviors. Models of acculturation may be classified as linear, 2-dimensional, or multidimensional. Linear models imply that an individual moves along a continuum from unacculturated to assimilated, with "bicultural" being a phenomenon that occurs somewhere in the middle. In this model, the immigrant gradually loses linguistic abilities and cultural practices in

his or her native culture and becomes more and more a part of the dominant host culture.

The linear model and any health communication efforts that it informs can be criticized as being ethnocentric, implying that the immigrant gradually "overcomes the handicap" of being nonnative and separated from mainstream society. A 2-dimensional model of acculturation, in contrast, holds that a bicultural (contrasted to an assimilated) person is someone who is totally acculturated to the new culture yet who loses little if any of the skills and practices related to the previous one.^{42,43}

As research into the 2-dimensional model is fairly recent, little in the way of cross-immigrant group validation has occurred. It will prove interesting to see whether all categories stand the test of time. Although it is possible to envision marginalized immigrants and their offspring who have a firm link with neither their homeland nor with American society, it would be more difficult to imagine that many individuals of poor or average circumstances would be able to go through the jolting process of Americanization without losing some identification with the native culture. This especially would be the case for those from Asia or elsewhere, where geographic and linguistic challenges to maintaining this identification may be insurmountable. Indeed, assimilation may actually be occurring, but to native-born minority groups rather than to the culture as a whole. Acculturation to these minority groups may sustain desirable mechanisms of social and cultural support, yet at the same time extend the disadvantages suffered by these groups.⁴⁴

Acculturation has been assessed by a variety of self-report measures, generally including questions on length of time in the United States, age at time of entry, and language preference and use. Based on a review of the literature, Rogler et al⁴⁵ concluded that exposure to and mastery of the English language appears to be the most critical characteristic of acculturation. However, a sole focus on language as a proxy for acculturation may be inappropriate, particularly when one takes into account geographic location of the population to the country of origin (eg, US/Mexico border cities) and cultural congruity between the country of origin and the

receiving country. Simply offering health messages in the immigrants' native language will not ensure their acceptance.

Effecting behavior change and consolidation: a family focus. Effective health communication leads the target audience through behavior change once prerequisite perceptual and cognitive factors are addressed. For most immigrant groups, that behavior change will occur in the context of the family. Targeting interventions to the entire family acknowledges the tradition and self-definition of many immigrants.⁴⁶ However, the mother or female head of household often serves as the primary target of health education interventions. Although immigrant cultures are generally patriarchal in nature, the primary female often runs the household. This continues despite an increase in the proportion of women employed in the labor force. The primary female often carries the brunt of change within the family, taking the lead in bringing about behavior change among its members.⁴⁷

SUMMARY AND CONCLUSIONS

The health and welfare of immigrants will continue to present a major public health challenge. General policy recommendations, as well as specific strategies for improving health services and health communication for immigrants, are presented below.

1. The governmental role in health care for the immigrant—documented or undocumented—must not be abandoned. Federal officials have the responsibility for coordinating all efforts and cannot be allowed to balance their budgets by passing on the costs accruing to their decisions to state, county, and insurance agencies. Immigration is a national issue; abandonment of this responsibility not only sets the stage for state-by-state decisions that are at best uncoordinated (and at worst irrational), but also contributes to problems that will ultimately be more expensive to resolve.

2. As do most developed nations, our society should offer universal coverage for at least a minimum set of primary care, prenatal, and safety-net services.

3. Legislative bodies should repeal those aspects of welfare reform laws that diminish funding for preventive and primary care and food programs, especially where there is evidence of the effectiveness of such programs. These limitations penal-

ize immigrants and eventually result in more tax-supported medical interventions.²⁵

4. Educating immigrants in general may be an important avenue to promote their health.¹⁰ Training immigrants to be skilled speakers of English, and in other ways reducing socioeconomic disparities, should be expanded. English training will help reduce the tension between immigrant and native-born communities, provide more efficient and more effective access to health care and better health communication, and help the immigrant fulfill the "American dream." Providing immigrants with these skills may actually lead to higher levels of self-esteem and reduce acculturation-related stress.³⁸

5. Whether designed to promote health-services utilization or risk reducing behaviors, health communication efforts for immigrant communities need to be more effective. Messages that are mediated by community health advisors, considerate of literacy and cultural issues, and targeted toward families rather than individuals should help realize that goal. Yet a variety of challenges and issues face us if we are to make the CHA model a sustainable and effective public health force. First, affordable incentives need to be identified, such as work force preparation, college credit, publicity for the CHAs' efforts, or affordable financial compensation. Limiting their period of commitment and having realistic expectations of them²⁸ may reduce dropout rates. Feasibility and efficacy will dictate the identity of the CHAs, who may be coparticipants, neighbors, or paraprofessionals. Finally, research is needed to determine whether the CHA approach is indeed differentially effective compared to other methods of communication and, if so, whether it is also cost-effective. Should answers to these questions prove encouraging, CHAs may see an expansion of their roles, from face-to-face to electronic communication, from risk reduction to advocacy, and from immigrant to other communities.

Immigration represents one of the most important issues on the horizon, not only for public health but also for society in general. In the words of the great Mexican author Carlos Fuentes:⁴⁸ "North Africans in France, Turks in Germany; . . . Japanese, Koreans, Chinese and Latin Americans in the United States. Instantaneous communication and economic interde-

pendence has transformed the issue in a short period of time from one isolated to immigration alone to a universal reality, defining and omnipresent for the 21st Century." ■

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