

INFORMATION TO USERS

This reproduction was made from a copy of a document sent to us for microfilming. While the most advanced technology has been used to photograph and reproduce this document, the quality of the reproduction is heavily dependent upon the quality of the material submitted.

The following explanation of techniques is provided to help clarify markings or notations which may appear on this reproduction.

1. The sign or "target" for pages apparently lacking from the document photographed is "Missing Page(s)". If it was possible to obtain the missing page(s) or section, they are spliced into the film along with adjacent pages. This may have necessitated cutting through an image and duplicating adjacent pages to assure complete continuity.
2. When an image on the film is obliterated with a round black mark, it is an indication of either blurred copy because of movement during exposure, duplicate copy, or copyrighted materials that should not have been filmed. For blurred pages, a good image of the page can be found in the adjacent frame. If copyrighted materials were deleted, a target note will appear listing the pages in the adjacent frame.
3. When a map, drawing or chart, etc., is part of the material being photographed, a definite method of "sectioning" the material has been followed. It is customary to begin filming at the upper left hand corner of a large sheet and to continue from left to right in equal sections with small overlaps. If necessary, sectioning is continued again—beginning below the first row and continuing on until complete.
4. For illustrations that cannot be satisfactorily reproduced by xerographic means, photographic prints can be purchased at additional cost and inserted into your xerographic copy. These prints are available upon request from the Dissertations Customer Services Department.
5. Some pages in any document may have indistinct print. In all cases the best available copy has been filmed.

**University
Microfilms
International**
300 N. Zeeb Road
Ann Arbor, MI 48106

8501156

Mason, Marco Antonio

THE DEVELOPMENT OF A FRAMEWORK FOR HEALTH CARE ADVOCACY
ON BEHALF OF CARIBBEAN IMMIGRANTS

City University of New York

D.S.W. 1984

University
Microfilms
International 300 N. Zeeb Road, Ann Arbor, MI 48106

Copyright 1984

by

Mason, Marco Antonio

All Rights Reserved

PLEASE NOTE:

In all cases this material has been filmed in the best possible way from the available copy. Problems encountered with this document have been identified here with a check mark .

1. Glossy photographs or pages _____
2. Colored illustrations, paper or print: _____
3. Photographs with dark background
4. Illustrations are poor copy _____
5. Pages with black marks, not original copy _____
6. Print shows through as there is text on both sides of page _____
7. Indistinct, broken or small print on several pages
8. Print exceeds margin requirements _____
9. Tightly bound copy with print lost in spine _____
10. Computer printout pages with indistinct print _____
11. Page(s) _____ lacking when material received, and not available from school or author.
12. Page(s) _____ seem to be missing in numbering only as text follows.
13. Two pages numbered _____. Text follows.
14. Curling and wrinkled pages _____
15. Other Dissertation contains pages with print at a slant, filmed as received.

University
Microfilms
International

THE DEVELOPMENT OF A FRAMEWORK FOR HEALTH CARE ADVOCACY

ON BEHALF OF

CARIBBEAN IMMIGRANTS

BY

MARCO ANTONIO MASON

A dissertation submitted to the Graduate Faculty
in Social Welfare in partial fulfillment of the
requirements for the degree of Doctor of Social
Welfare, The City University of New York.

1984

°
COPYRIGHT BY
MARCO A. MASON
1984

This manuscript has been read and accepted for the Graduate Faculty in Social Welfare in satisfaction of the dissertation requirement for the degree of Doctor of Social Welfare.

7/12/84
date

Living Weissman
Chairman of Examining Committee

7/12/84
date

Paula E. Chen
Executive Officer

Dr. Simon Slavin, Hunter College

Dr. Mildred Mailick, Hunter College
C.U.N.Y.

Dr. Aubrey Bonnett, Off. Aca. Aff.
Supervisory Committee

Preface

New York City is one of the most cosmopolitan cities in the world, composed of diverse ethnic groups from a variety of countries. Much of its rich cosmopolitan flavor is due to immigration. The post 1965 wave of Caribbean immigration to this traditional city of immigrants made a dramatic impact by Caribbeanizing this city's socio-cultural fabric. This phenomenon has serious implications for the city's economic, social, political and health systems, which in turn, presents a serious challenge to policy makers, service providers, and the general public, to devise effective programs for addressing these issues.

This report addresses the health issues revolving around the phenomenon of Caribbean immigration calling specific attention to the health context, impact and implications of Caribbean immigration to New York City. It examines the health needs, barriers to the provision of health care service, and the intervening variables that influence how health care services are utilized by this population. It seeks to develop a framework for health care advocacy on behalf of Caribbean immigrants and to explore alternative health care services delivery methods to respond to the needs of this community, which

in turn can serve as a model for other immigrant communities. It examines the sociomedical context of immigration, an area that tends to be neglected by researchers, health providers and policymakers.

The project is a serious effort to present an inter-disciplinary convergence (drawing on management science, health science, social science and social work advocacy) in addressing the problem. Conceived as a doctoral project, it has relevance for a diverse and wide-ranging readership, particularly health providers and policy makers. In addition, it should interest those concerned with the impact of immigration on the city's health delivery system and the corresponding impact of these dynamics on the immigrants themselves.

This project attempts to provide an understanding of the cultural dynamics and the health situation of Caribbean immigrants in New York City. It is hoped that the framework established can serve as useful model for meeting the health needs of this population.

This report is organized as follows: Chapter I presents the conceptual framework in which the project is anchored; Chapter II examines the health context, impact and implications of Caribbean immigration to New York City. Particular attention is given to cultural and socially conditioned health perceptions, data

collection, and research opportunities in this area. Chapter III is a report of a pilot study on Caribbean undocumented immigrants in New York City conducted over a two year period. This study established the framework for achieving the goals of this project; Chapter IV presents the project's design and methodology. The project's planning and modality of implementation is discussed in Chapter V. Finally, Chapter VI presents the summary and conclusions.

ACKNOWLEDGEMENTS

To my friend, Betty Staton-Payne, belongs the credit for whatever clarity and consistency this report may have. She took painstaking time out from her busy schedule to read the draft carefully several times. Her critical eye for cliché, non-sequitor, grandiloquence, and her firm demand for logic in argument and presentation have benefitted every page. She dedicatedly assisted with criticisms and encouragement throughout the long months of formulation and implementation. The project owes a great deal to her assistance and so do I.

A very special thanks to Dr. Irving Weisman, my thesis advisor for his reassurance, wise guidance, and consistent support; never losing patience with me even through the extended duration of the development and implementation of the project. To Dr. Aubrey W. Bonnett, my gratitude for his dedicated assistance, guidance and support. To Dr. Mildred Mailick who gave valuable time and experience, my thanks.

Denise Hylton typed innumerable drafts, survived my abominable calligraphy with patient sufferance. She deserves my ardent appreciation.

Finally, I am appreciative of the enthusiastic support I have received from friends and colleagues.

This dissertation is specially dedicated to my parents, my sisters and my daughters, Addis and Nadya.

TABLE OF CONTENTS

	<u>Page</u>
PREFACE	iv
ACKNOWLEDGMENTS.....	vii
LIST OF TABLES	xi
LIST OF ILLUSTRATIONS.....	xii
DEFINITION OF TERMS.....	xiii
CHAPTER	
I. THE CONCEPTUAL FRAMEWORK.....	1
. Notes	16
II. PROBLEM STATEMENT: THE HEALTH CONTEXT, IMPACT AND IMPLICATION OF CARIBBEAN IMMIGRATION TO NEW YORK CITY	
. Contextual Overview.....	20
. The New York City Caribbean Community: A Profile.....	26
. Health Context.....	31
. Impact on Cultural Differences and Social Conditioning in the Pattern of Health Services Utilization.....	38
. Folk Medical Knowledge, Beliefs and Practices.....	39
. Adjustment Pressures.....	51
. Mental Health.....	54
. Notes.....	59

CHAPTER	<u>PAGE</u>
III. BACKGROUND: THE PILOT STUDY ON UNDOCUMENTED CARIBBEAN IMMIGRANTS IN NEW YORK CITY	
. Introduction.....	75
. Methodology.....	76
. Community Resource Committee.....	79
. Technical Committee.....	79
. Data Collection.....	80
. Analysis.....	83
. Findings.....	89
. Recommendations.....	89
. Discussion.....	90
. Notes.....	92
IV. METHODOLOGY	
. Design Rationale.....	96
. Resources Identification and Data Retrieval Process.....	98
. Community Field Study.....	100
. Notes.....	106
V. MODALITY OF IMPLEMENTATION	
. Introduction.....	108
. Goals and Objectives.....	109
. Project Planning.....	111
. Project Management.....	114
. Structural Arrangements.....	125

	<u>Page</u>
. Summary of Panel Discussions.....	132
. Conference Evaluation: Report of Findings.....	139
. Post Conference Activities.....	144
. Notes.....	152
VI. SUMMARY AND CONCLUSION.....	156
. Notes.....	172
 APPENDIXES	
. Health and Caribbean Immigrants in New York City: Context, Impact and Implimentations (Conference Program).....	174
. Profile of Caribbean Women's Health Association Inc.	185
 BIBLIOGRAPHY.....	 188

LIST OF TABLES

<u>TABLE</u>	<u>PAGE</u>
1. Five Countries with Highest level of Immigration to the United States by Decade, 1821 to 1978.....	23
2. Immigrants Admitted to the United States from Jamaica, Haiti, Barbados, Trinidad and Tobago; 1957-61; 1967-71; 1972-76.....	26
3. Immigrants Admitted from Jamaica and Haiti to the United States, and to New York City; 1965 and 1976.....	27

LIST OF ILLUSTRATIONS

<u>CHART</u>	<u>PAGE</u>
1. Map of Circum-Caribbean Region.....	24
2. Map of Patterns of Residential Spatial Distribution and Clustering of Caribbean Communities in New York City....	30
3. Causal Scheme of Poor Health Among Migrants.....	37
4. Project's Workbreakdown Structure.....	113
5. Project's Work Flow.....	114
6. Interdependence of Management Functions.....	115
7. Sample of Conceptual Model For Developing Strategic Plans For Project Implementation...	117
8. Sample of Conference Evaluation Summary Sheet.....	140

DEFINITION OF TERMS

ALIEN. An alien is defined, under the Immigration and Nationality Act, as any person in the United States who is not a citizen or national of this country. The term alien is further divided into the following major categories: immigrant, non-immigrant, refugee and undocumented immigrant.

IMMIGRANT. An alien lawfully admitted who is not a citizen or national of this country and who has been admitted with the expectation that such an individual will reside permanently in the United States. The Immigration and Naturalization Service's (INS) definition of immigrant is as follows: "Any alien residing in the United States or in its territories with a legal, permanent residence visa, including, but not limited to refugee." This definition excludes non-immigrants, undocumented aliens and United States Nationals such as Panamanians born in the Canal Zone and American Samoans, who are not citizens.

NON-IMMIGRANTS. An alien lawfully admitted for a temporary period of time, such as a student and a temporary worker.

REFUGEE. An alien paroled into the United States as a conditional entrant who is fleeing racial, religious or political persecution from any Communist or Communist-dominated country.

ILLEGAL ALIENS. A "pejorative" term used to describe persons of foreign nationality who have entered the United States unlawfully; or who, after legal entry, have violated the terms of their admission, generally by overstaying and/or accepting unauthorized employment. The term is synonymous to undocumented immigrants.

UNDOCUMENTED IMMIGRANTS. More general term used to describe persons of foreign nationality who have entered the United States without proof of proper legal status or proper legal documents.

WEST INDIANS. People from the island chain extending in an eastward arc between southeastern United States and the northern shore of South America, separating the Caribbean sea from the Atlantic Ocean and including Bermuda and the Bahamas, the greater and lesser Antilles. This term is usually used to describe people from the English speaking Caribbean Islands. Note that West Indians are found on mainland territories in Central and South America, e.g., Belize, Costa Rica, Panama and

Guyana. Also note that the Caribbean communitites in New York City includes natives from Haiti, the Netherlands and French Antilles.

CARIBBEAN. A more general term used to describe people from the circum-Caribbean region, i.e., island in, or territories on the shores of the Caribbean Sea. The term West Indian and Caribbean are used interchangeably.

HEALTH CARE. Care received from in-patient, out-patient city and voluntary medical institutions. The term also refers to care received from private physicians in the community.

HEALTH. State of complete physical, mental and social well-being and not merely the absence of disease or infirmity. The social functioning extends the concept of health to include the quantity and quality of social contacts and social resources. Thus, in a model of health status containing social variables, a change in social support as an outcome of migration process, by definition, indicates a change in personal health status.

FOLK MEDICAL SYSTEM. Any health system at variance with western scientific medicine; any health system at vari-

ance with codified, formal, and literate medical tradition; any system of health practice at variance with the official health practice of the community or nation; It is characterized by a high degree of shared knowledge between public and practitioner.

FOLK ILLNESS. Refers to concepts of cause, etiology, manifestation and labeling of disease itself.

FOLK MEDICINE. Used as a blanket term for all folk practices and beliefs, related to health.

CHAPTER I

CONCEPTUAL FRAMEWORK

The Caribbean communities within the United States constitute one of the fastest growing populations in America today due to immigration.⁽¹⁾ Caribbean immigration increased substantially with the enactment of the 1965 Immigration Law. However, the economic importance of the cirum-Caribbean region to the United States, and that region's strategic significance to hemispheric and international relations has only recently been in the forefront of the mass media in this country. Consequently, priority attention is presently being focused on this region by the goverernment in Washington.⁽²⁾ These developments are of particular significance to those interested in or involved with Caribbean-American communities in the United States, as well as in the Caribbean region itself. Notwithstanding the current increased interest in the Caribbean, there is a dearth of research and literature related to Caribbean immigration to the United States.⁽³⁾

Caribbean immigration to the United States pre-

sents a unique opportunity for studying a host of migration related problems. Among these are the health consequences of: migration, culture change, cultural and social conditioned perceptions of health and illness, and adjustment pressures due to the migration experience. The high level of socio-cultural uniformity within the Caribbean community in New York City, and the fact that its members are largely found within the confines of an identifiable geographic area makes this population a viable group for comprehensive socio-medical studies.⁽⁴⁾

Socio-cultural perceptions of health and illness influence both the provision of health care services and its utilization. These socio-cultural factors tend to be outside of the realms of contemporary medical technology but have a definite impact on the health status of the individual.⁽⁵⁾ In this context, epidemiological research clearly demonstrates the relationship between certain behavioral variables and morbidity and mortality.⁽⁶⁾ Accordingly, "Individual and social reactions to illness do not exist apart from each other and a full understanding of the implications of illness must consider both the idiosyncracies of the individual and the social milieu in which he lives."⁽⁷⁾ Therefore, the

concepts of health, disease and illness can be explained beyond the somatic process in social and behavioral terms. Health services organizations are basically social organizations; hence, the patterns of health services provisions, its utilization, and the way society deals with health related problems are issues of socio-medical concerns.⁽⁸⁾

There is a misconceived view that the study of immigration is within the province of the social sciences, but outside of the purview of the medical field. However, the immigration process, in and of itself, fosters a host of health related problems.⁽⁹⁾

Accordingly, the magnitude of problems revolving around immigrants' health issues require that any study of these issues employ an interdisciplinary approach. Such an approach would draw from many areas including medical sociology and cultural anthropology and apply them to the health field. To increase its effectiveness, such a study should collaborate with related areas such as psychosomatic medicine, public health, medical psychology and social epidemiology. In discussing the need for a multidisciplinary approach in the analysis of migration it was stated that:

"Public health officers should be more knowledgeable about migration, even though it is a subject that does not appear to fall 'prima vista' into the

medical field. ...The analysis of migration phenomena has usually been the province of geographers, demographers, or economists, but it is apparent that only a multidisciplinary approach to include the perspectives of public health specialists and epidemiologists will facilitate the full comprehension of the various socio-medical effects of population movements."⁽¹⁰⁾

Immigration is also a social welfare issue and, as such, social workers should be included in the multidisciplinary approach to respond to immigration issues. In this context the Institute on Social Welfare Consequences of Migration and Residential Movements, sponsored by the National Association of Social Workers, Council on Social Work Research⁽¹¹⁾ made some critical observations on the issues revolving around migration. Among the points highlighted were the following:

The reception accorded to newcomers is important for understanding migration and its effects; and the existence of kinship and friendship networks help to direct migration streams.

There is a relationship of migration and the planning for health services.

The immigrant community or ghetto can be viewed in terms of being both an aid and a barrier to the social, political and economic adjustment of migrants.

Migration, historically, has influenced the life condition and culture of Black people in the United States.

Migration can be viewed as a process of stages, each stage has its psychological reactions to the migration episode.⁽¹²⁾

The issues and constraints impacting on the provision and utilization of health services to immigrants are complex. Consistent with the complexities involved, the perspectives highlighted by the Council on Social Work and Research clearly indicate that there is a need for a multidisciplinary approach to effectively address the various aspects of delivering health care and social services.

The frame of reference of the interdisciplinary approach of this work is derived from the theoretical and empirical findings of medical sociology, folk and modern medical systems analysis, migration theory, community organizing and the applied aspects of management and organizational theories. It highlights some of the significant issues in examining both folk medical and modern systems, which are basic to understanding the patterns of health care utilization by Caribbean immigrants. In this context, the following approaches are the basis of examining folk healing systems:⁽¹³⁾

The Symbolic: Examining the effects of religious belief and practices on health and health care services. Healing has its origin in religious belief of which symbolic and ritualistic representation of good and evil constitute significant factors.

The Technical: Includes the use of remedies and therapeutic procedures, such as baths, herbs, diets, and hygienic practices for preventative and

medical care. It is agreed that "Therapeutic trust persists over the ages as the magic in the practice of medicine."⁽¹⁴⁾

Theories of Disease and Illness: Theories about disease causation are grounded in logical efforts to determine the mission of man and his relationship to the environment.⁽¹⁵⁾ As such, the religious, philosophical, magical and scientific representations by society are used by folk healers to devise theories that can explain the mysteries of illness, the miracle of recoveries and the occultism of death.⁽¹⁶⁾ These theories explain the causes and classification of diseases or illness. Diseases are classified as due to natural causes, related to human actions and resulting from supernatural forces.⁽¹⁷⁾ More specific framework of the causes of diseases and illnesses are as follows:
(18)

- a) Sorcery: Due to manipulations by persons possessing magical and supernatural powers, based on imitative sorcery, for example Voodoo dolls; or contagious sorcery whereby the sorcerer induces illness through personal items of the subject.
- b) Breach of Taboo: Disease resulting from the punishment of the Gods for violating religious or social norms.
- c) Disease-Object-Intrusion: Disease due to the presence of a noxious foreign substance in the body.
- d) Spirit Intrusion: Disease that is the result of the presence of evil spirits or demons within the body.
- e) Soul Loss: Illness due to the loss of one's soul leaving the body.

The Social Organization of the Healing Role:

This includes studying the healer/patient relationship, the role of the healer as a solo practitioner, the adaptive functions of the healer in changing societies and the dynamics of the healing role in diversified settings, i.e., in economically developing rural settings as well as in industrialized urban settings.

"If the healer has a theory of disease causation he will also have technical and symbolic facets to his healing approaches."⁽¹⁹⁾ The frame of reference for examining the patterns of health care services utilization include the following approaches:⁽²⁰⁾

The Economic Approach: Based on examining such factors as the cost and modes of payments for services.

The Geographic Approach: Assessing such variables as distance, boundaries of catchment areas, and accessibility.

The Socio-Psychological Approach: Includes exploring such concepts as motivation to use services and perception of health, illnesses, and service delivery system.

The Socio-Demographic Approach: Assessing the impact of such variables as sex, age, level of education, socio-economic status and ethnicity.

The Organization and Service Delivery System Approach: Examining barriers within the organization and service delivery system that impact usage patterns.

The Socio-Cultural Approach: Examining the influences, socialization processes, and socio-cultural conditioned behavior patterns such as life-styles, social networking systems, ethnic identification, traditions, cultural heritage, cultural proclivities and belief systems.

In addition to examining patterns of service utilization, it is also useful to understand the migration experience. It is worth noting that the Caribbean immigrant population also include health services providers. For example, the critical shortage of

nurses in the United States served as a magnetic "pull" factor to attract Caribbean nurses to this country. The increased Caribbean population in New York City, served as another "pull" factor, yielding greater demands for the services of the traditional folk health healers. Accordingly, the migration frame of references include theories such as "push-pull."⁽²¹⁾

"Push-pull" theories suggest that internal socio-economic factors give impetus to primary population movements within developing countries from their rural interior to their urban sectors, and that similar socio-economic forces (e.g., unemployment, inflation, etc.) tend to foster secondary population movement, this time, to the exterior. This theory further suggest that immigration from these developing countries, particularly those in the circum-Caribbean region, to the industrial centers of the United States is because of geographic proximity, changes in the United States immigration policies, and the perceived and/or real magnetic economic incentives which tend to attract or pull the immigrants to the seemingly relative upwardly mobile alternative available in the United States. It is further argued that this "push-pull" phenomena results in destabilizing consequences for both the sending and host countries. This tends to foster among other consequences critical human resources depletion, e.g., "brain drain"

for the sending countries, while presenting a wide range of serious social, cultural, legal, foreign policy, economic and health challenges to the host country.⁽²²⁾

A planned outcome of this project was the development and institutionalization of an organizational advocacy structure to respond to the health care needs of Caribbean immigrants in New York City. The development of this group was grounded on social action as a strategy to foster social changes within the City's health care system as an approach to make this system culturally compatible and responsive to the health care needs of the Caribbean population in this city.

There is no one law of social change. Social change is explained among others by equilibrium, conflict and evolutionary theories.⁽²³⁾ An understanding and application of such concepts as power, social movements, crisis, conflict, resistance to change and legitimacy are basic to fostering social change.⁽²⁴⁾ It is argued that "social action directs itself to changes within social systems rather than changes of the social systems themselves."⁽²⁵⁾ It is further observed that: "Changes within the system refers to change that does not alter the system's basic structure...change of the system is any change that alters the system's basic

structure."⁽²⁶⁾ Change through social action is deliberate, systematic, purposeful and strategically planned towards achieving desired goals. Accordingly, social action strategy can serve as an effective approach to launch a social movement.

In this context, a social movement model with a social action strategy was the approach used to develop and institutionalize the advocacy structure (i.e., an advisory board of directors) charged with developing approaches to respond to the health care needs of the Caribbean immigrant population in New York City. Social movements are socially shared demands for changes in some aspects of the social order.⁽²⁷⁾ Further, social movements are based on the assumption that collective action can be more effective than isolated activities of individuals.⁽²⁸⁾ In this sense this type of movement will offer the Advisory Board members of the advocacy group, a framework to achieve the following: (a) develop leadership, (b) develop a common cause, (c) develop the group structure, (d) crystalize the issues, (e) propose approaches to achieve the common goals and (f) promote a sense of solidarity, and/or forum to collectively demand changes.⁽²⁹⁾

However, changes usually tend to be preceded by crisis, since they imply interruptions of the system's

modus operandi.⁽³⁰⁾ The changes proposed in this project are based on differences of beliefs, goals, values, interests and perceptions, all of which tend to inevitably lead to conflict. It is argued that "conflict is essentially an interactional process between parties who are interdependent." However, also note that "conflict acts as a stimulus for the establishment of new rules and norms."⁽³¹⁾ Notwithstanding, "whenever social action pursues a course of significant social change, resistance to change will be encountered and must be contended with."⁽³²⁾ Consequently, "social systems tend to resist innovations which interfere with their basic needs of pattern maintenance and tension-management, adaptation, goal attainment and integration."⁽³³⁾ In order to neutralize this predictable resistance it requires sensitive power deployment. These operations also requires establishing and maintaining credibility and legitimacy within the community on whose behalf the change is sought as well as with the changed targets. In this context:

"The innovator makes enemies of all those who prospered under the old order, and only lukewarm support is forthcoming from those who would prosper under the new. Their support is lukewarm partly from fear of their adversaries, who have the existing laws on their side, and partly because men are generally incredulous, never really trusting new things unless they have tested them by experience. In consequence, whenever those who oppose the changes can do so, they attack vigorously,

So both the innovator and his friends are endangered together." (34)

The adjustment and mental health aspect of immigration is rooted in the argument that the immigration process also tend to result in serious adjustment problems, particularly for undocumented immigrants who tend to be afflicted with insecurities, anxiety and persecution phobias. (35) Another proposition is that the Caribbean American community serves as a coping mechanism which facilitates the immigrant's adjustment process by providing ethnic identification and cultural solidarity. (36)

Empirical frames of references includes directing a two year Research project on Caribbean undocumented immigrants in New York City, coupled with more than fifteen years of professional experiences in immigrant advocacy work and conducting health-related field study tours throughout the Caribbean region. Both of the described theoretical and empirical frames of references serve as underpinnings to examine the health context, impact and implications of Caribbean immigration to New York City; and to organize and institutionalize an advocacy structure to respond to the health care needs of this Caribbean immigrant population.

All of the frames of references presented

contributes to a better understanding of the health issues impacting Caribbean immigrants. However, the socio-cultural approach is the most useful model towards developing and providing culturally compatible health care services to immigrants. Accordingly, in this work a broad area of interest revolves around the socio-cultural variables that influence Caribbean immigrants' perception of health and illness and their socially conditioned patterns of using health care services.⁽³⁷⁾ This work also examines some of the cultural barriers that result in inadequate delivery of health care services;⁽³⁸⁾ and offers a framework to develop a health care delivery model to respond to the health needs of the Caribbean community in New York City.⁽³⁹⁾ This project presents a useful paradigm for social workers, health providers, community organizers, policy makers, academicians, social scientists and those concerned with trans-cultural influences in the delivery of health care services. It is grounded in the theory that the phenomena of immigration impacts the health status of immigrants and has implications for health service providers as well.

Caribbean immigration to New York City entails disruption of the socio-cultural beliefs and the patterns of health care services provision and utilization to which these immigrants are accustomed. These immi-

grants come from developing Caribbean nations. The level of technology in those nations cannot, in most instances, be compared to the technological sophistication of the medical practices and facilities in this city. The provision of health care services and the attitude by the users of those services in Caribbean nations is compatible with conditioned cultural practices of the population.

The Caribbean is an economically developing area where modern medical technology and facilities are relatively limited. Additionally, folk medical beliefs are strong and folk health practices are an available, convenient source of cure. Caribbean folk medical systems, as well as healing systems in other non-industrial societies around the world, play a significant role in providing needed medical care. These folk systems also serve as vehicles in promoting cultural and ethnic solidarity.⁽⁴⁰⁾ Thus, to effectively provide health care services to this population will require relating the Caribbean folk medical system to the technological American health care system.⁽⁴¹⁾ Accordingly, this work is concerned with the folk medical and other such socio-cultural dynamics that influence the perceptions and patterns of utilization of health care services of this immigrant population as well as the socio-cultural dynamics that influence those who deliver health care ser-

vices to this population. An understanding of these dynamics is basic to improving the delivery of health care services to immigrants. Such an understanding could foster collaborative working relationships between community, immigration, health, international and social service organizations. Such collaborative relations and interdisciplinary approaches in addressing immigrant's health issues are areas requiring further development.

Because there is no formal structure designed to specifically address this problem, there is a need to develop such a structure. There exists no data which adequately address this problem of health care services to Caribbean immigrants. A report on "Immigrants Without Care" said this about the problem:

"The extent to which immigrants use medical care is important for a number of reasons. Migrants probably represent a unique epidemiological subgroup whose health status can be expected for a variety of reasons to differ from that of non-migrants and of the host population. Environmental change, altered social and psychological circumstances, shifts in exposure to transmissible diseases, and the dietary changes are some of the specific variations in social, physical, and biological environments which, for the migrant, may be reflected in physical and psychosomatic illness and need of medical care. Yet there has been, in the United States, at least, little emphasis on the immigrant in recent work on medical care and health services.⁽⁴²⁾

To study the socio-cultural variables that effect the patterns of provision and utilization of health care

services to and by Caribbean immigrants in New York City would foster a framework for improvement in the relationships between the Caribbean community and the city's medical system. This relationship is crucial both in terms of Caribbean immigrants as new consumers of health care services and in terms of developing programs to meet their needs.

NOTES

CHAPTER I

1. This growth history and patterns are demonstrated by tables 2-3, infra, pp. 22 and 23.
2. The Reagan Administration's Caribbean Basin Initiative programs and the current United States military intervention in El Salvador and Grenada highlights the significance of the region to the United States.
3. Comitas, Lambros, Caribbean 1900-1965: A Tropical Bibliography. Seattle: University of Washington Press, 1968. See Bibliography for current works.
4. The cultural uniformity of the NYC Caribbean population is the result of their common background of colonial experience. The geographics of residential patterns in New York City are demonstrated by the map in Table 4. These patterns illustrate the viability for conducting comprehensive studies.
5. The socio-cultural perceptions of Caribbean immigrants are anchored in mysticism, superstition, folklore, and other non-medical forces which, nonetheless, influence the individual's health practices and beliefs.
6. Mary McDill Saxton, "Behavioral Epidemiology," in Behavioral Medicine: Theory and Practice, (ed.) by Ovide F. Pomerleau and John Paul Brady, (The William & Wilkins Co., Baltimore, 1979), pg. 3.
7. Stanley King, "Social Psychological Factors in Illness," in Handbook of Medical Sociology, (ed.) by Howard E. Freeman, et.al., (Prentice-Hall, Inc., Englewood Cliffs, N.J., 1963) pg. 119.
8. George Rosen, "The Evolution of Social Medicine," in Behavioral Medicine: Theory and Practice, (ed.) by Ovide F. Pomerleau and John Paul Brady, (The William & Wilkins Co., Baltimore, 1979) pg. 51.
9. Table 5, "Casual Scheme of Poor Health Among Migrants", infra, Chapter two, illustrates the health situation of many immigrants in this country.

10. Boris Velimirovic, Special Feature: "Forgotten People-Health of the Migrants", Bulletin of Pan American Health Organization, 13(1), 1979, pg. 68.
11. Report of the Research Institute on the Social Welfare Consequences of Migration and Residential Movements, San Juan, Puerto Rico, November 2-5, 1969.
12. Ibid.
13. Andrew C. Twaddle and Richard M. Hessler, Sociology of Health, the C.V. Mosby Co., St. Louis, 1977, pp. 140-42.
14. Albert P. Anderson, "Therapeutic Trust: The Magic in Medicine," Medicine and Man, Vol. 3, No. 2, 1978, pp. 119-125.
15. E.H. Ackerknecht, "Problems in Primitive Medicine," Bulletin of the History of Medicine, 1942, 14:503-521.
16. Twaddle, pg. 142.
17. See: W.H. Rivers, Medicine, Magic and Religion, Harcourt Brace and Co. Inc., N.Y. 1924.
-F.E. Clements, "Primitive concepts of Diseases", Publications in American Archeology and Ethnology, 1939, 32: 186-252.
18. See: Rivers (1924) Clements (1939).
19. Ibid, pg. 140.
20. See: -John B. McKinlay, "Some Approaches and Problems in the Study of the Use of Services: An Overview," Journal of Health and Social Behavior, June 1972, 13:150-152.

-Ann Templeton Brownlee, Community, Culture and Care: A Cross Cultural Guide for Health Workers, The C.V. Mosby Co., St. Louis, 1978.
21. Saskia Sassen - Koob Exporting Capital and Importing Labor: The Role of Caribbean Immigration to New York City, occasional Paper No. 28, New York Research Programs in Inter-American Affairs, New York University, December, 1981.

22. Ibid.
23. Caughlin, Bernard J. and Khindaka, S.K., Social Change and Social Actions, Journal of Sociology and Social Welfare Vol. III, No. 3, January 1976 pp. 322-331.
24. Ibid
25. Ibid
26. Ibid
27. Ibid
28. Ibid
28. Ibid
29. Ibid
30. Ibid
31. Ibid
32. Ibid
33. Ibid
34. Niccolo Machivelli, The Prince (Translated with Introduction by George Bull Baltimore, MD: Penguin Books) 1961.
35. Pfister - Amende Maria, "The Symptomatology, Treatment and Programs in Mentally Ill Refugees to Repatriate in Switzerland" in Flight and Resettlement, H.B. Murphy (ed.) UNESCO: Paris, 1955
36. McLaughlin, Megan, West Indian Immigrants: Their Social Networking and Ethnic Identification (Doctoral Dissertation), Columbia Uiversity, 1981.
37. For an indepth discussion of this issue, see Chapter two, infra, on the "Health Context, Impact and Implication of Caribbean immigration to New York City."
38. Ibid

39. Samples of the instruments designed and developed for use in gathering the information to assess the health status of Caribbean immigrants in New York City is contained in the appendix. This information would form the bases for implementing a service delivery model. Chapter five, infra, on Modality of Implementation, discusses the process involved in accomplishing this goal.
40. A.I. Ojibwa Hallowel, "World View and Disease in Man's Image" in Medicine and Anthropology, Iago Galsdston (ed.) International University Press, N.Y., 1963, pp. 258-315.
41. See: Koss, Joan D., The Therapist Spiritual Training Project in Puerto Rico: An Experiment to Relate the Tradition Healing System to the Public Health System, Social Science and Medicine, Vol. 146, No. 4, Nov. 1980, pp. 255-266.
42. Lois Montiero, "Immigrants Without Care." Society. Sept./Oct. 1977. pp. 38-42.

CHAPTER II

PROBLEM STATEMENT:

THE HEALTH CONTEXT, IMPACT AND IMPLICATIONS OF CARIBBEAN IMMIGRATION TO NEW YORK CITY

CONTEXTUAL OVERVIEW:

The post-1965 increase of Caribbean⁽¹⁾ immigration to New York City impacts on the city's socio-cultural fabric which emphasizes the need for innovative approaches to understand this phenomena.⁽²⁾ For example, this new immigration wave tends to have implications for the City's service delivery systems, particularly its health system.⁽³⁾ Thus, there is a need for better understanding of the health perceptions and realities which are crucial to the provision of health services to Caribbean immigrants in New York City.

There can be no appreciation of American history without an understanding of American immigration.⁽⁴⁾ American immigration policies are among the most extensive and most complex the world has known.⁽⁵⁾ Hence, a reason for increasing public pressure for immigration reform.⁽⁶⁾

The Immigration and Nationality Act of 1965, described as the "most comprehensive rehauling of immigra-

tion laws for the country since the basic 1924 law,"⁽⁷⁾ and changes in international conditions, such as the gaining of independence by former Caribbean colonial territories were largely responsible for the wave of Caribbean immigration.⁽⁸⁾ Prior to 1965, the immigration policies favored admission of immigrants from Northern and Western European countries. This favoritism or quota concept originated in the Immigration Acts of 1921 and 1924, that "created a national origin quota system which by design allowed for immigration along lines which would basically retain established ethnic proportions within the country's population and favored the highest representations from countries which provided the United States with its earliest European settlers."⁽⁹⁾ The quota system concept, originally based on racial theories, was affirmed in the 1952 McCarran-Walter Act. "...The McCarran-Walter Act justified retention of quotas on the basis of assimilability, that is, the assumed easier integration of persons from countries with historical, and cultural ties to the United States."⁽¹⁰⁾

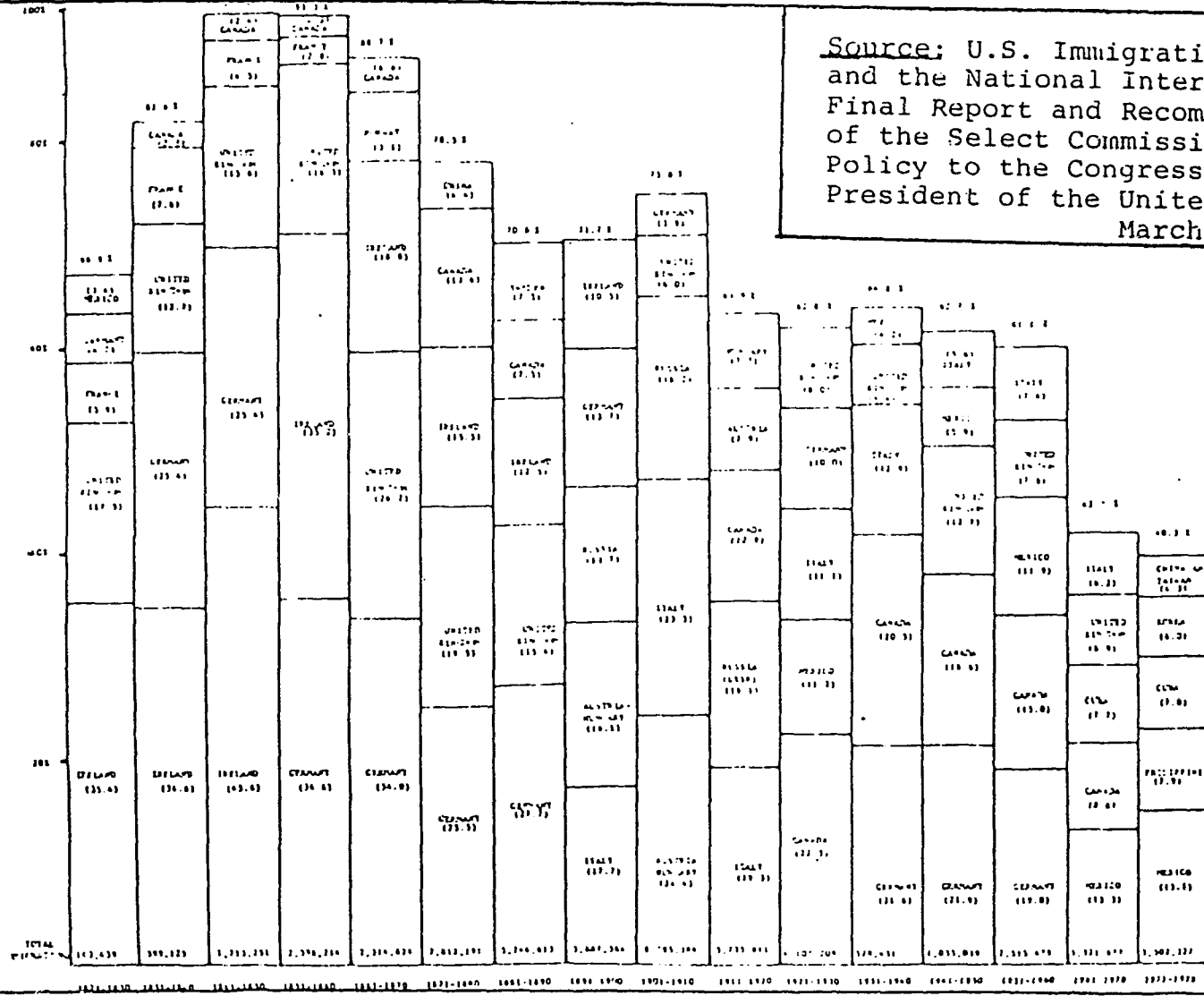
The 1965 Act resulted in major revision in the immigration policies of the United States. The 1965 Act is summarized as follows:

"More specifically, the 1965 Act replaced the single nation quota system by one based on hemispheric ceilings. It abolished restrictions against Asian and Pacific peoples while imposing a limit on the Western hemisphere. It instituted a first-come, first serve system of admission within a set of preferences and it freed close relatives of United States citizens from the numerical ceiling of 170,000 immigrants, with a limit of 22,000 persons per independent country. The Western Hemisphere was assigned a ceiling of 120,000 persons per annum without quotas for independent nations." (11)

Under the new preference system created by the 1965 Act, there was a major shift in the countries of origin of immigrants entering the United States. (See Table 1) Most European immigrants under the new system were primarily from Southern and Eastern countries instead of the former Northern and Western countries. Asian immigration soared. In the Western Hemisphere the proportion of immigrants from South America decreased while those from the Caribbean increased.⁽¹²⁾ This post-1965 Caribbean immigration wave marked yet another dynamic chapter in the history of this nation and city of immigrants.⁽¹³⁾

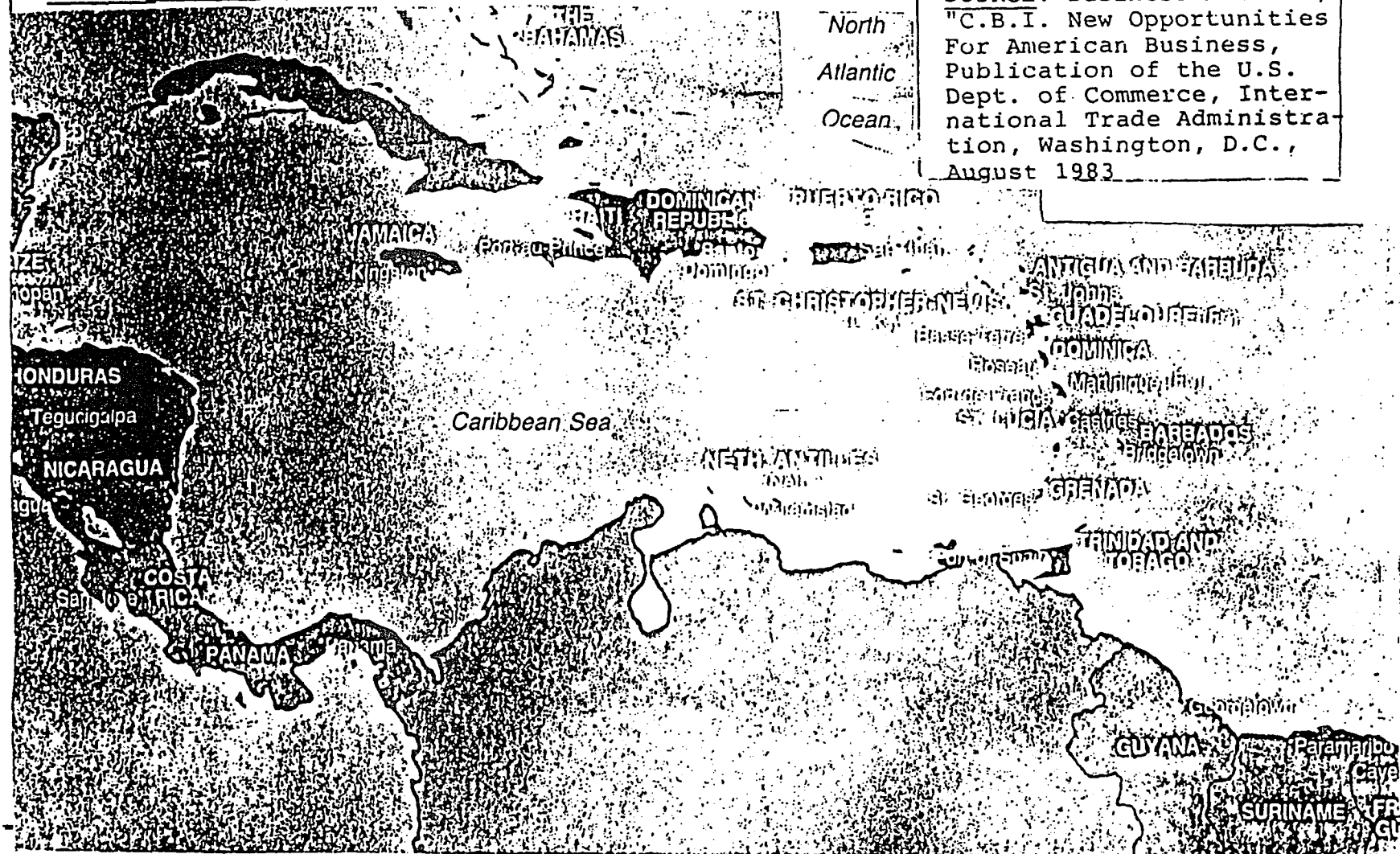
The circum-Caribbean area consists of the island chain and mainland territories which extend in the eastward arch between southeastern United States and the northern shore in South America. (See Chart 1, Map of Caribbean Basin countries) They separate the Caribbean sea from the Atlantic Ocean and include the Bahamas, and

TABLE 1 - THE FIVE COUNTRIES WITH HIGHEST LEVELS OF IMMIGRATION TO THE U.S. BY DECADE, 1821-1978



Source: U.S. Immigration Policy, and the National Interest, the Final Report and Recommendations of the Select Commission on Refugee Policy to the Congress and the President of the United States, March, 1981

CHART 1 - CARIBBEAN BASIN COUNTRIES



SOURCE: Business America, "C.B.I. New Opportunities For American Business, Publication of the U.S. Dept. of Commerce, International Trade Administration, Washington, D.C., August 1983

the greater and lesser Antilles.⁽¹⁴⁾ Caribbean countries have a long tradition of outward migration. For example, reports indicate that "historically, movements from West Indian colonies to the colonialist country have been significant. During the 1950's there was a large transfer of population from the Commonwealth Caribbean (Barbados, Jamaica, Trinidad-Tobago, and Guyana) to the United Kingdom.⁽¹⁵⁾ The 1961 Census of Great Britain recorded 174,000 persons from the West Indies and by 1971 there were 308,400."⁽¹⁶⁾

Although there was Caribbean migration on a transnational level with substantial numbers of Caribbeans migrating to the United Kingdom, it was the change in United States immigration policies in 1965 that was responsible for the dramatic increase in Caribbean immigration to the United States.⁽¹⁷⁾ For example, during the ten year period from 1967-1976 more than 180,000 Caribbean immigrants were admitted to the United States from Jamaica and Haiti, whereas only 23,000 were admitted during the ten year period from 1957-1966.⁽¹⁸⁾ Table 2 shows this increase for Haiti and Jamaica and also gives data for the available periods for Trinidad and Tobago, Barbados, and other West Indian areas.

TABLE 2

Immigrants Admitted to U.S.A. from
Jamaica, Haiti, Barbados, Trinidad-Tobago
1957-61; 1962-66; 1967-71; 1972-76
(in thousands)

COUNTRY	1957-62	1962-66	1967-71	1972-76
Jamaica	6.8	9.8	74.5	55.9
Haiti	3.7	12.7	31.3	25.1
*Trinidad-Tobago	-	2.5	28.7	31.0
*Barbados	-	2.1	8.5	7.9
*Other W.I.	-	13.7	22.2	21.1

SOURCE: U.S. Immigration and Naturalization, Annual Reports *Data for period 1957-1961 was not available. However, data for other periods was included to show dramatic increase in post-1965 immigration for these areas.

THE NEW YORK CITY CARIBBEAN COMMUNITY: A PROFILE

Consistent with its "Golden Gate" tradition "New York remains the leading target and ENTREPOT (Port of Entry) for Caribbean peoples to the United States...There is no other metropolitan area in which one would find a greater number of West Indians of any country and so many groups of West Indians from various countries congregating in such large numbers as in the New York metropolitan areas."⁽¹⁹⁾ Table 3 below for 1965

and 1976 illustrates that, of the number of Caribbean immigrants admitted to the United States from Jamaica and Haiti, the vast majority migrate to New York City.

TABLE 3

Immigrants Admitted from Jamaica and Haiti
to the U.S. and to N.Y.C., 1965 and 1976

	1965		
	U.S. (thousands)	N.Y.C. (thousands)	to N.Y.C. %
Jamaicans	16,503	11,302	68.5%
Haitians	3,801	2,824	74.3%
	1976		
	U.S. (thousands)	N.Y.C. (thousands)	to N.Y.C. %
Jamaicans	9,026	4,812	53.3%
Haitians	5,410	3,858	66.3%

SOURCE: U.S. Department of Justice, I.N.S. Annual Report 1966-1976.

The Caribbean community in New York City is a multi-national, multi-lingual, multi-ethnic group representing a cross-section of countries from the circum-Caribbean area.⁽²⁰⁾ The population therein, basically originated from English speaking nations

area, including both insular and non-insular countries. Also included in the New York City Caribbean community are Haitians who speak Haitian Creole and some French, Panamanians and Costa Ricans whose native language is Spanish, but who are first, second and third generation West Indian descent. This post-1965 immigrant population is basically educated and skilled.(21)

There are common cultural factors that foster a sense of solidarity and provide a feeling of identity among Caribbean groups.(22) However, although this Caribbean-American population identifies with the larger group as West Indians, differences in their historical, traditional, political, social, economic and national developments resulted in sub-cultural differences.(23) In this context,

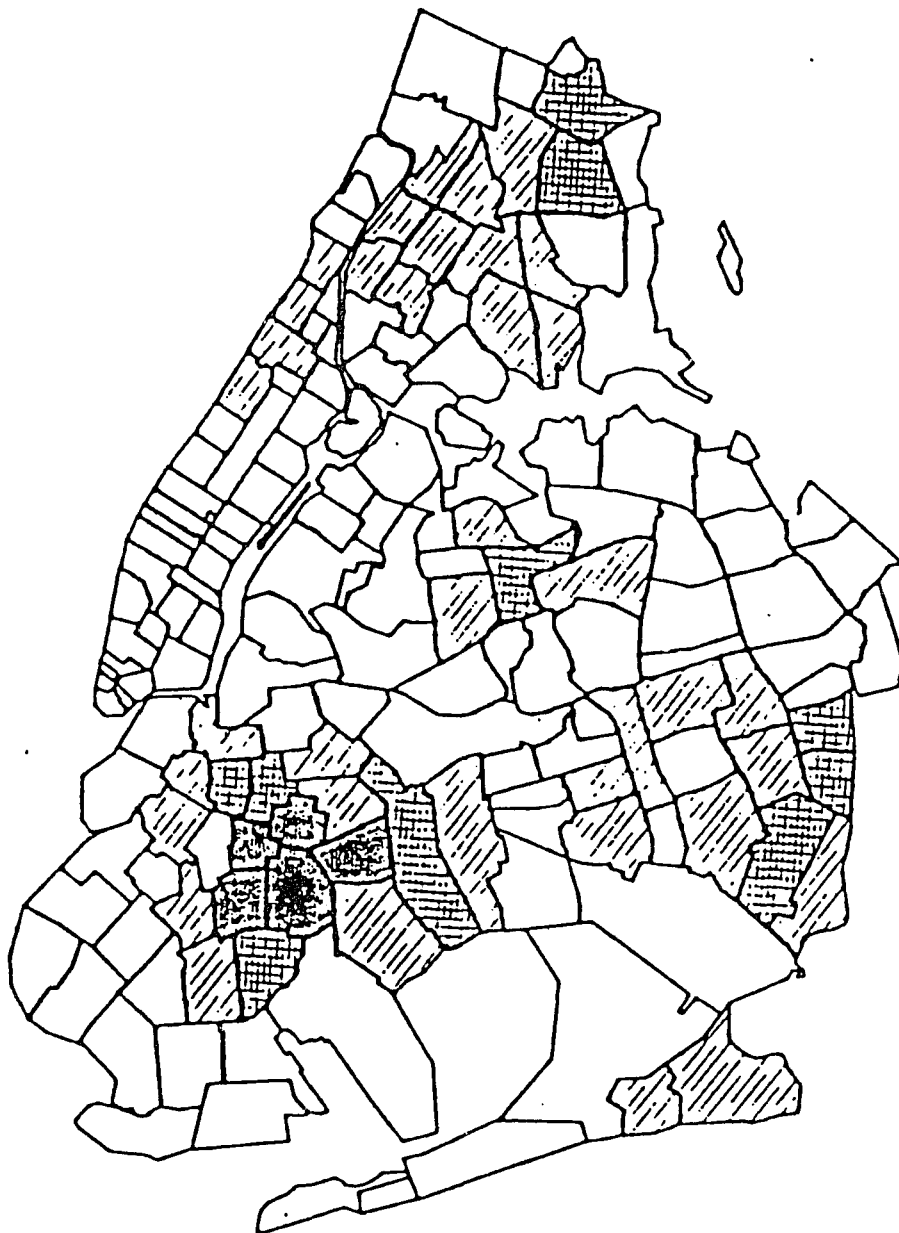
"Although there may be subethnic enclaves, as well as states or regional differences among them, in general the new immigrants (even the illegal) tend to be part of a larger ethnic class ghetto of which the members attend many of the same institutions and share many of the same limited resources and acute problems...While there can be no doubt that poverty, linguistic limitations, and illegality may suppress the degree of community or nature of community politics in which new immigrants may engage, their relative invisibility should not lead us to believe that as a sub-grouping they do not have distinctive features and, therefore problems and proclivities, or that these differences do not have consequences on the cities, communities and sub-societies and classes of which they are part..."(24)

The high degree of socio-cultural uniformity shared by this population is due, in part, to the fact that they come from small, tropical, developing countries with legacies of colonialism and protectorates of the Monroe Doctrine.⁽²⁵⁾ In New York City the majority reside within defined geographic boundaries, such as the Crown Heights and East Flatbush sections of Brooklyn and the Cambria Heights section of Queens. (See Chart 2: Map of Patterns of Residential Spatial Distribution Clusters of Caribbean Population in New York City) Some were born in the United States; others are naturalized American citizens; some think of themselves as West Indians, while others maintain nationality allegiance to their native countries. The following is an observation about the New York Caribbean population:

"There are signs that New York functions as a site of significant cultural and political contacts in which there occurs a coalescence structural reformation, and fusion of Caribbean peoples of various persuasion, cultures, classes and sub-regions who were apart, antagonistic, and even ignorant of each other at home. A Pan-Caribbean spirit is emerging in New York City... The emergence of even broader cross-identification can be observed in the celebration of the West Indian Carnival...It is this urban Caribbean overseas community which may eventually be intervening in behalf of impacting on certain lines of radical restructuring and reorientation on the Caribbean region itself."⁽²⁶⁾

Current demographic data clearly indicates that the Caribbean community is a defined constituency in New

CHART 2
MAP OF PATTERNS OF SPATIAL DISTRIBUTION RESIDENTIAL
CLUSTERS OF NEW YORK CITY'S CARIBBEAN POPULATION



No. of PERSONS	<div style="display: inline-block; width: 20px; height: 10px; border: 1px solid black; background-color: white; margin-right: 5px;"></div> 0000 - 0399	<div style="display: inline-block; width: 20px; height: 10px; border: 1px solid black; background: repeating-linear-gradient(45deg, transparent, transparent 2px, black 2px, black 4px); margin-right: 5px;"></div> 1500 - 2999	<div style="display: inline-block; width: 20px; height: 10px; border: 1px solid black; background: repeating-linear-gradient(-45deg, transparent, transparent 2px, black 2px, black 4px); margin-right: 5px;"></div> 0400 - 1499	<div style="display: inline-block; width: 20px; height: 10px; border: 1px solid black; background: repeating-linear-gradient(45deg, transparent, transparent 2px, black 2px, black 4px); background: repeating-linear-gradient(-45deg, transparent, transparent 2px, black 2px, black 4px); margin-right: 5px;"></div> 3000 - OVER
-------------------	--	---	--	--

SOURCE: 1980 IMMIGRATION AND NATURALIZATION SERVICES
 FILE BASED ON REGISTERED WEST INDIAN ALIENS (from:
 Netherland Antilles, Barbados, Jamaica, Trinidad, St.
 Lucia, St. Vincent, Haiti, Antigua, St. Kitts, Grenada
PREPARED BY: Information Systems Division, New York
 City Department of City Planning

York City.⁽²⁷⁾ This population as a group is bent on establishing a firm political base in New York City.⁽²⁸⁾ Moreover, their presence has contributed to making Brooklyn the largest Black Community in the City and the country, thereby shifting the traditional black power base from Harlem to Brooklyn.⁽³⁰⁾ Notwithstanding, the Caribbean community is viewed as a marginal segment of the New York City population and its needs are ignored. In this context, one of the most crucial needs to be addressed is health care.⁽³¹⁾

HEALTH CONTEXT

Most Caribbean immigrants enter the United States on a visa. Thus, prior to their departure from their country of origin, they are required to undergo a medical examination in order to qualify for the issuance of a visa by the U.S. Consulate.⁽³²⁾

Immigrants are usually prohibited from immigrating to the U.S. if they are afflicted with a contagious disease, or any disease which may become dangerous to the American public. Moreover, an immigrant will be excluded from entering the U.S. if he/she is a chronic alcoholic, a narcotic addict, has a physical defect, disease or disability that is determined by the Consulate to affect his/her ability to earn a living, or has

any other inadmissible health factors consistent with U.S. immigration policy.⁽³³⁾

Historically, the health status of people immigrating to the United States has been an area of public concern. In 1891, a federal law provided for the medical inspection of all immigrants and excluded those "suffering from loathsome or contagious disease."⁽³⁴⁾ A report on immigrant health conditions in America (1840-1920) concluded:

"It appears that on the surface at least restrictionists had reason to fear the influx of immigrants. Percentages indicated that persons of foreign birth had an excessively large proportion of those in hospitals and mental institutions as well as a disproportionately large proportion of deaths in urban areas. Upon closer scrutiny, however, one finds that the new immigrants were healthy. They had rather "favorable" mortality rates when compared with both older immigrants and native Americans, and in some cases, they even contributed to an overall lowering of the death rate. They did, however, also contribute substantially to the number of mentally-ill persons in public institutions... Nevertheless, there was little to indicate that mental illness was either endemic to the newer immigrants or a long range problem. Rather, the evidence suggests that causes of mental illness...were largely environmental and stemmed from the difficulties of adjusting to a new country....What was a legitimate fear though, was the large cost of providing medical care for the foreign born dependent. Americans might have overestimate the health related defects of the immigrants, but not the cost health care."⁽³⁵⁾

Similar cost issues have recently been raised in New York City regarding the excessive cost of delivering

health care services to new immigrants.⁽³⁶⁾ Thus an understanding of the perceptions and realities of immigrants health status is crucial to the provisions of services to this population and to the protection of the general public and welfare. As with previous immigration waves, the Caribbean population faces certain health related barriers.⁽³⁷⁾ These problems revolve around:

The dearth of research devoted to Caribbean immigrant health issues;

Unreliable demographic socio-medical and biostatistical data to effectively assess the health status of this population; and

The lack of a formal structure or organization to specifically assess, monitor and respond to the health plight of this population.

To the extent that health data is available, it is notoriously unreliable. A major reason for the difficulty in obtaining reliable data is the fact that the Caribbean cultural attributes are neglected in designing health programs to be delivered to this group. Another reason is based on the fact that this group is not a recognizable population in the census data. Hence, they are counted as generalized ethnic categories as Blacks, Hispanics or as others. Health statistics collected on this population are of questionable value, since these immigrants tend to conceal information inquiring into their health status, for fear that such

information may be prejudicial to their permanent residence in the U.S.⁽³⁸⁾ Thus, without such reliable data it is difficult to accurately correlate the health situation of Caribbean immigrants in New York City in economic, cultural, social and political parameters.⁽³⁹⁾

In this context, there is a need to design a battery of Caribbean immigrant's health survey instruments to obtain this needed statistical data.

Moreover, the impact of political, economic and social forces on the health status is illustrated in the causal scheme of poor health among immigrants in chart 3. The paradigm highlights the correlations between such variables as poverty, political and economic powerlessness, discrimination, unhealthy environment, occupational hazards, poor nutrition, low medical care capacity, morbidity, and little medical care; the sum of which results in poor health. This causal scheme is applicable in describing the health care plight of most new Caribbean immigrants in New York City.

In addition, there are health related problems that have a direct effect on this population such as:

Adjustment problems causing severe mental distress;

Cultural differences which relate to patterns of how health services are used; and

Cultural differences resulting in inadequate delivery of health services..

While these are serious problems facing Caribbean immigrants generally, as discussed in subsequent sections, the problem of adjustment stress is particularly acute among undocumented Caribbean immigrants who lack legal protection due to their status.⁽⁴⁰⁾ Further, this population lacks the political, economic and social acumen that would enable them to effectively deal with their problems. As a result they remain a marginal segment in the system. The current high levels of unemployment and economic instability in the nation also tend to compound these problems. This situation is highlighted by the following statement:

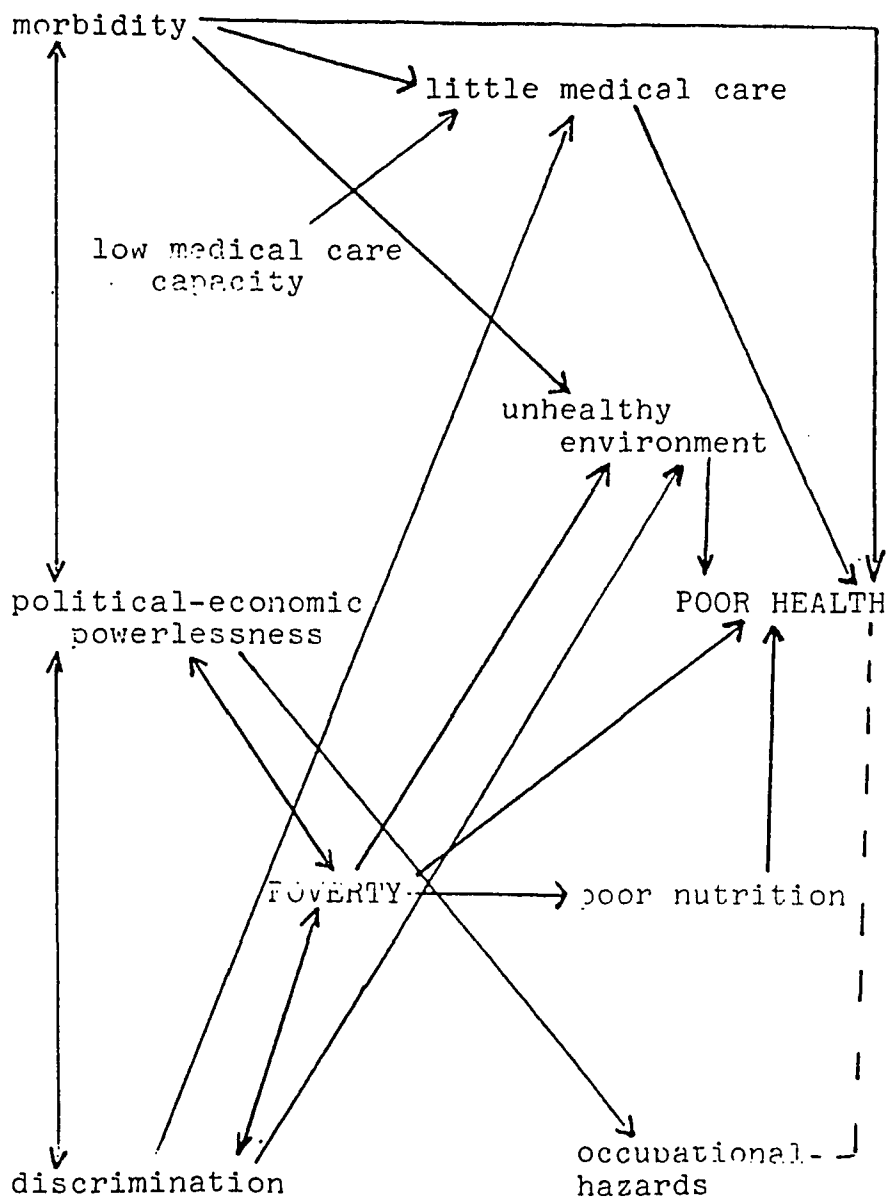
"In most industrial countries, migrants are often regarded as a reserve labor force, useful in times of economic prosperity and a cushion for unemployment during periods of economic slump. When there is a economic boom, the issues posed by immigrants are essentially social. When social problems (discrimination, low income) arise, health problems are concomitant. If the economic situation deteriorates, producing widespread unemployment, the social and health problems are further compounded by society's increasing pressure to expel the migrants."⁽⁴¹⁾

Notwithstanding the prevailing anti-immigration sentiment⁽⁴²⁾, current demographic data clearly indicate

that the Caribbean community comprises a defined constituency in New York City whose health needs are not effectively addressed. Caribbean new immigrants encounter similar health hazards as immigrants from other groups. Chart 6 illustrates the causal schemes of poor health among immigrants. This paradigm presents a useful approach to examine the correlations of the levels of morbidity, discrimination, nutrition, poverty on the health status of immigrants from developing countries.

Because there is a dearth of research devoted to the health status of Caribbean immigrants, health providers and public policy officials are essentially ignorant of the folk-medical practices and cultural patterns that are an integral part of Caribbean health care practices.⁽⁴³⁾ This ignorance on the part of persons responsible for establishing health care policy and for providing health care services contributes substantially to the health problems confronted by Caribbean immigrants in New York City. The following discussion examines some of the cultural differences that tend to result in inadequate provisions of health care services and some of the cultural factors that influence the patterns of health care utilization. These factors serve as barriers to the delivery of health services to this immigrant community.

CHART 3
CAUSAL SCHEME OF POOR HEALTH AMONG MIGRANTS



SOURCE: B.N. Shenkin, Health Care for Migrant Workers: Policies and Politics
 Bollinger Pub. Co. Cambridge, Mass. 1974, p.27

THE IMPACT OF CULTURAL DIFFERENCES AND SOCIAL
CONDITIONING ON THE PATTERNS OF HEALTH SERVICES UTILI-
ZATION

Health providers' understanding of the systems operating within the Caribbean community such as communications, language, family, politics, economics, education and religion, is basic. Each of these sub-systems is integrally related to the effective functioning of health programs serving this community. Additionally, to be effective;

"Health workers and students should also focus on their own cultural background, their biases and preconceptions, and the health program itself..... Only health workers and students who take time to examine both themselves and the health program, in addition to the society "out there", can understand clearly what roles they and the program should play to make the most relevant contributions to the community."(44)

However, these concepts are too comprehensive to expect that health providers will immediately develop and institute policies encompassing such programs. Therefore, a starting point could be to acquire a basic knowledge of the health beliefs and practices of the Caribbean people, so that health services programs could be designed to respond to their needs. There is a high correlation between health perceptions, health practices and socio-cultural conditioning. Thus,

"On a broad level...social and cultural factors have always played an important part determining the way in which public health and medical services were organized. The value system of a society helps to shape the public's attitudes, beliefs, and behaviors in regard to health and illness. Health institutions like social institutions, reflect a society's definition of what constitutes an acceptable and appropriate organization of health activity. The roles assigned to both the practitioners and recipient of medical care represent, in large measure, socially prescribed behavior. As an inherently social and cultural activity, public health is thus an integral part of the social system, and can be fully understood in terms of existing social forces."(45)

FOLK MEDICAL KNOWLEDGE, BELIEFS AND PRACTICE

Folk medicine systems have a holistic approach to medical practice, the patient is viewed as a total human entity, as a physical, mental, and emotional being subject to natural, social and personal influences.(46) Cross-cultural analysis makes a distinction between folk medicine and scientific medicine.

"Scientific medicine is rooted in a precise knowledge of cause and effect relationships and a critical attitude towards both practices and results. Folk medicine in neither precise nor critical. It is rooted in belief, not knowledge, and it requires only occasional success to maintain its vigor. The folk medicine of a given people, however, is usually not a random collection of belief and practices; rather, it constitutes fairly well organized and consistent theory of medicine."(47)

Every society has a body of trained specialized practitioners who are charged with healing illnesses and caring for the sick. These practitioners' approaches to

healing are generally, not based on the established technological, Western medical professions. However, modern scientific approaches dominate medical practices in Western societies. This dominance is largely to the "official" legitimization by licensure procedures and legislations that determine and control medical practice.⁽⁴⁸⁾ Consequently, in Western societies traditional healers tend to be viewed with suspicion or are considered charlatans, quacks, and deceptive health practitioners, thus, are usually persecuted by law enforcement agencies under the banner of protecting the public from fraudulent medical practices.⁽⁴⁹⁾ However, these fraudulent practices are carried out by some medical professionals, as well as by some traditional healers. For example, in contemporary America, there have been numerous accounts of incidents jeopardizing the public's health and welfare, due to misrepresentation, quackery, charlatanism, deception and fraud both by modern and traditional health practitioners⁽⁵⁰⁾. Therefore, these accounts should not negate the fact that non-Western traditional, folk medical knowledge, beliefs and practices are rooted in a systematic theory of medicine. A point worth noting in comparing modern health systems to folk health systems is that the "legitimate" American health system is in a state of crisis and it has failed to meet the needs of health consumers.⁽⁵¹⁾ Consequently,

many consumers tend to increase their reliance on folk medical approaches and other available alternative sources of health services.⁽⁵²⁾ This loss of confidence in the American health system, shows that:

"For the great majority of Americans, the health care crisis is...an on-going crisis of survival. Everyday three million Americans go out in search of medical care. Some find it; others do not. Some are helped by it; others are not. Another twenty million Americans probably ought to enter the daily search for medical help, but are not healthy enough, rich enough, or enterprising enough to try. The obstacles are enormous. Health Care is scarce and expensive to begin with. It is dangerously fragmented, and usually offered in an atmosphere of mystery and unaccountability. For many, it is obtained only at the price of humiliation, dependence, or bodily insult. The stakes are high-health, life, beauty, sanity and getting higher all the time. But the odds of winning are low and getting lower."⁽⁵³⁾

Moreover, the American health system is an inefficient, chaotic, archaic, unmanageable political, economic and industrial system, that is not in business for people's health. Accordingly, it is argued that,

"America is not a healthy place to live, in either a medical or a social sense, simply because health and other social services are low priority items in a nation whose resources are committed to military and economic expansion...even within the institutions that make up America's health system - hospitals, doctors, medical schools, drug companies and health insurance companies health care does not take top priority. Health is no more a priority of the American health industry than safe, cheap, efficient, pollution-free transportation is a priority of the American automobile industry. The Victims, then are not just the poor, the blacks (Caribbeans and other ethnic new immigrants), who cannot afford to buy what the health industry is selling, but also all the millions of middle-class and working-class people who try to extract health services from the

health industry."(54)

Additionally, the modern medical system is based on defined knowledge and perceived techniques which are isolated from ordinary social process.⁽⁵⁵⁾ Further, while the highly technologically sophisticated modern medical system is loosing public confidence, folk medical practice tend to be gaining public acceptance, particularly in New York City. Thus, it may be fruitful to design programs to foster closer parallels and collaborative interactions between these systems in responding to health consumers needs.⁽⁵⁶⁾ This City is uniquely suited to launch such programs, since it has more doctors, hospitals , medical schools and is more cosmopolitan than any other American City. These programs could also serve as a model to be replicated in other major urban sectors throughout the country. These designs would be viable since, folk health systems are dynamic, open and adaptive systems⁽⁵⁷⁾ that interact with and contribute to the economic, familial, ritual and moral fabric of the society. Moreover, folk medical practice is an integral component of the cultural experience of immigrants from third world countries, and play a significant role in these immigrant's adjustment process to

a megalopolis such as New York City.⁽⁵⁸⁾ The cosmopolitanism of the city's ethnic resources offers a wider range of folk medical practices, than is usually available in these immigrants countries of origin.

The socio-cultural trauma from the migration experience, tend to aggravate any long standing illness the immigrant may have had.⁽⁵⁹⁾ Family separation and culture shock tend to compound adjustment problems. Consequently new immigrants tend to be susceptible to certain diseases; for example, lung cancer⁽⁶⁰⁾ and coronary diseases⁽⁶¹⁾ frequently afflict immigrants from rural areas. In the urban setting, folk illness and cure serves as a vehicle to minimize the trauma of acculturation: A concomitant consequence could be retardation of the new immigrant socialization, acculturation and integration into the patterns of modern medical utilization.⁽⁶²⁾

The adaptability of folk medical systems is crucial to its survival in modern urban milieu. Its adaptable capacity is in part because "folk medicine may shift towards adjunct functions of healing such as prognosis, treatment of chronic or medically irremedial conditions. These shifts may be further accompanied by the development of new healer functions such as predic-

tion of future events and manipulation of fortune."⁽⁶³⁾ Another reason for its adaptability stems from the fact that folk health practitioners diversify their approaches, styles, and specializations to meet the needs of the heterogenous urban population.⁽⁶⁴⁾ As opposed to physicians, the healers take their cues from the patients, accept the patient's diagnosis and symptoms as "prima facie" evidence of the problem. Moreover, folk health systems accept input from modern medical and urban institutions.⁽⁶⁵⁾

Urban healers, as opposed to their more orthodox rural counterparts, fit scientific terms and give scientific sounding explanations for familiar patented pharmacological products such as anti-biotics. In this context, "When urban folk systems contains elements of modern origin they further ease acculturation related to pressures by allowing patients to feel more "modern" while still relying upon familiar causal concepts, remedies and healing personnel."⁽⁶⁶⁾ Unlike modern medicine, folk medicine has the flexibility of abdicating its jurisdiction over certain aspects of disease. Accordingly, compartmentalization of illness into modern-specific or folk-specific is possible; thereby, facilitating dual usage of folk and modern health services.⁽⁶⁷⁾

"Compartmentalization and dual usage encourage transition to modern health usage, while allowing individuals to retain access to traditional sources of anxiety reduction and ethnic identity."⁽⁶⁸⁾

Another reason for the visibility of folk health practices in the urban setting is the fact that the services are comparatively inexpensive. The excruciating expensive and inflated health care cost in the United States, particularly in New York City, serves as a rigid barrier to the new immigrants, who tend to lack medical support systems. Moreover, new immigrants will find that even though a host of health care facilities and services are relatively more available in this city, than in their respective native country, they will also find that these facilities and services are not only culturally non-responsive, and inconvenient in terms of location and consultation hours, but inaccessible due to cost; Contrastly, they would find urban folk health services a most accessible, convenient, culturally responsive and affordable alternative.

Folk health practices tend to survive less in industrial democracies providing socialized medicine than in those selling capitalistic medicine.⁽⁶⁹⁾ Folk health practices tend to be weaker in countries offering socialized medicine, supplemented by social welfare benefits such as comprehensive health coverage, sick pay, unemployment compensation and disabilities bene-

fits. Variables, such as education, occupation, age, and socio-economic status tend to influence the level of adherence to folk medical beliefs and practices.⁽⁷⁰⁾ For example, "The more upwardly mobile and higher income members of the immigrant group may rely less on folk health practices."⁽⁷¹⁾ Thus, folk healers tend to concentrate in ethnic lower income neighborhoods where, new immigrants tend to cluster, and offer relatively more inexpensive services than physicians.⁽⁷²⁾

The folk medical beliefs and practices of a population is an expression of their cultural heritage. Accordingly, the cultural heritage of the people of the Caribbean is an amalgamated creolized product of diverse practices from Africa, India, China, the Middle East, and from the indigenous cultures of the Americas.⁽⁷³⁾ Moreover, the relative floral, faunal and climatic diversity within this tropical region, compounded by the relative differences in historical, ethnic, economic, geographical natural resources, political, ecological and epidemiological developments of each of the nations within the circum-Caribbean region, resulted in variations of folk medical knowledge, beliefs and practices throughout the region.⁽⁷⁴⁾

Notwithstanding these variations the basic body of Caribbean folk medicine is essentially an African deri-

vative.⁽⁷⁵⁾ Africans believe that man was immortal; his spirit could never die.⁽⁷⁶⁾ Hence, man would communicate face to face with the spirits of the departed. For example, offering to the ancestral spirits were made as thanks for a spell of prosperity and good luck, or in times of anxiety or sorrow.⁽⁷⁹⁾ "African system of curing was transmitted from the slaves to their descendants. Many of the African plants and herbs were to be found in the Caribbean. One important area of ancestral African retention in the Caribbean as a whole is that of folk medicine."⁽⁷⁸⁾ For example, "The African techniques of healing have rooted themselves in Jamaican culture to such an extent that the trained physician is still perceived as secondary to the 'Black Doctor' as he is known, especially in the rural districts."⁽⁷⁹⁾ Among some of the African Retentions are:⁽⁸⁰⁾

Healing: is both herbal and spiritual for example: Balmyards, (a healing center specializing in herbal medicine; it is a place where the sick are bathed in herbal streams and bath) in Jamaica;

Water: is considered to have decisive healing powers (e.g., healing streams and bath); Baptism Rites;

Dreams/Visions: play an important role in the healing process.

Colors: considered to have healing powers (e.g., red: danger, white: purity, black: death, blue: energy, green: life)

Left and Right: the left hand is considered to be evil or impure, the right hand is considered to be good and pure.

Drums: are used for ritualistic callings.

There are some generalized folk medical beliefs and practices that tend to influence the medical behavior of members of the Caribbean community. Caribbean folk medical perceptions illustrate the correlations between cultural concepts and health factors. Among the most popular perceptions and practices are:(82)

Health and Illness - Health is perceived as feeling well, and thus, it is valued and cherished. Illness is conceived in terms of not feeling well. Moreover, conditions that are not physically or visually manifested or empirically felt are not considered illness.(83) Therefore, minor discomforts tend to be treated by traditional home remedies;(84) hence professional medical treatment is not sought, thus preventative care tends to be de-emphasized. Consequently, a person has to be seriously ill before he begins to seek professional medical treatment.(85)

Blood - is considered to be a crucial factor in the maintenance of good health. Signs of feeling enervated, or depressed without valid reasons are attributed to debilitation of the blood. Hence, efforts will be made to purify it (e.g., drinking cersie bush tea) and to improve its qualities (e.g., drinking Black beers, iron-laced or liver extract tonics or eating iron green bananas) Loss of blood is considered to have a general debilitating effect and is believed to cause sexual impotence in males.(86)

Air - A cool breeze blowing on one is considered to cause a cold, sore throat, or even respiratory/pulmonary disorders. A prescribed remedy for a cold is usually rum, with bitter lime juice and honey. A cold is considered to be aggravated by climatic change of temperature, i.e., from hot to cold.(87) Night dew air which is usually cool in the tropics is considered to be more dangerous than the warmer day breeze. Accordingly, if a person is ill he/she is usually kept in a non-ventilated area.

Purging - Cleaning of the gastro-intestinal and genitourinary tracts is considered basic to the maintenance of good health. Hence laxatives and

purgatives are periodically used to clean the blood, the kidneys, the liver, the bladder and the digestive system. Failure to do this is said to cause gases, bad breath, acid stomach, and vomiting. Some of the prescribed remedies for these conditions are aloe bitters, cersie bush tea, epsom salts.⁽⁸⁸⁾

Herbs - Herbs⁽⁸⁹⁾ are used for both dietary⁽⁹⁰⁾ and medicinal purposes. For medicinal purposes a variety of teas made from bushes, weeds, tree bark, roots, stems, leaves, flowers, fruit skins and seeds are said to have healing properties. Hence they are widely used as medications and/or remedies for a variety of health related conditions. Herbs are smoked (e.g., Ganja)⁽⁹²⁾ eaten raw, cooked in meals, used in bath, burned to yield inhallant fumes, applied directly to wounds, worn as cachets on the body, made into ointments.

Diviners, psychics, mystics and spiritualists appear in the pages of the history of man throughout the world. Their approaches of stimulating psychic activities are as varied as their names, e.g., crystalgazers, geomancers, soothsayers.⁽⁹³⁾ Psychic phenomena is a subject that is seriously studied around the world.⁽⁹⁴⁾ The spiritist movement is widely represented by members from every socio-economic strata. High on the list of Caribbean folk health practitioners are the spiritual healers, who are claimed to possess endowed supernatural, magical and mystical abilities, capable of not only curing physical and emotional illness, but capable of transcendental and metaphysical communications with spirits; and are capable of invoking benevolent or malevolent spirits to achieve their healing or

curing goals.⁽⁹⁵⁾ Spiritism is based on religious cults which adhere to Christian beliefs based on biblical passages.⁽⁹⁶⁾

The creolized African derivative folk health system was brought over to the United States by Caribbean immigrants. Accordingly, in addition to the spiritists there are a variety of folk healers within the New York City Caribbean/American communities. These folk medical practitioners include: the herb doctor⁽⁹⁷⁾, the witch doctor, the Black Magic doctor, the Pocomanian healers, the faith healers, the Rosicrucian priest, the voodoo⁽⁹⁸⁾ priest, the mystical healers⁹⁹, the Obeah-man, the Rasta man⁽¹⁰⁰⁾, all of whom are considered to have extensive herbal, mystical, occult, and medical knowledge and perform specialized health-related functions within the community. Thus their services tend to be widely sought and are viewed as compatible with the modern professional medical services.⁽¹⁰¹⁾ In order to attain the desired results one or a combination of sacred and profane healing rituals and substances are used.⁽¹⁰²⁾ These include: spells, magic, dream interpretations, automatic writings, levitation, alcohol and drug induced hallucinations, incantations, mystical signs, repetitive self deprivations and sacrifices, praying, chanting, ceremonial dances, drum beating, dividing animal entrails, reading cards, leaves, sea-

shells and knots, chastity, floggings, starvations, fastings, astrological readings, magical talisman, sumptuous feasting, cleansing, purifying baths, herbal treatments, sexual fetishes, zombie transformation, and "speaking in tongues."⁽¹⁰³⁾ Some West Indians prize and wear gold jewelry, embossed or engraved with specific signs of deities as amulets and charms to ward off "hexes", to protect them from evil spirits and/or to promote good fortune and good health.⁽¹⁰⁴⁾

ADJUSTMENT PRESSURES

Folk medicine's adaptive capacity seems to be a crucial issue accounting for the low incidence in psychiatric disorders in developing countries where rates would be expected to be higher.⁽¹⁰⁵⁾ Further it was pointed out that "few writers on the subject take objection to the general observation that (Spiritism) many such religious activities provide an outlet for nervous tension⁽¹⁰⁶⁾ and serve as therapy for real or potential psychotic and neurotic individuals."⁽¹⁰⁷⁾ It has also been noted that "folk illness functions as a psychotherapeutic device for reduction of individual stress resulting from breakdown of interpersonal relationship and failure to achieve."⁽¹⁰⁸⁾ Folk illness facilitate the displacement of responsibility for failure from self to other sources, beyond one's con-

trol.⁽¹⁰⁹⁾ Hence, folk health beliefs and practices serves as coping mechanisms for the new immigrant facing stressful situations, such as illness and adjustment problems in his new and sometimes hostile environment. Further, it could be argued that when the immigrant establishes his ethnic ghetto he is developing coping mechanisms to his adjustment problems.

"Social change and the disruption of established cultural patterns may bring about many conditions that are conducive to illness...With the drastic social changes occurring in many parts of the world today, their effect on health and illness becomes a significant factor."⁽¹¹⁰⁾ Accordingly, the immigration process tends to elicit such reaction as experiencing loneliness, insecurity, social distance and alienation from living in an unfamiliar socio-cultural environment. Environmental changes, altered social and psychological circumstances and dietary changes are some of the variables in the social, physical and biological environments which may be reflected in physical and psychological illness experienced by Caribbean immigrants. Hence, this population undergoes excruciating adjustment pressures as a result of the immigration process. This process entails a radical transitional change in the social milieu, which results in stressful adaptation.⁽¹¹¹⁾ This is partly due to the cultural shock and cultural ambiguity

encountered by the immigrant in translocating from developing countries to new surroundings in a metropolis such as New York City. These pressures are compounded by the cultural differences encountered by the immigrant and by being isolated from traditional kinship ties. These barriers tend to make accessibility to health care services difficult.

Cultural differences are contributing causes of maladjusted behavioral patterns such as divorces, and abandonment. In this context research studies examining the patterns of maladjusted behavior within the Caribbean community would shed some more light into this unexplored area. Nevertheless, among the adjustment pressures resulting from migration afflicting the Caribbean immigrants in New York City are:

The social discontinuity in cultural values, beliefs, roles and practices resulting in adaptational stress as the new immigrant confronts new and unfamiliar situations, requiring new and unfamiliar responses.

Physical exhaustion and abuse resulting in a state of constant mental fatigue, due to employment requiring hard labor and/or holding more than one job, usually at low wages, poor working conditions and lack of social support systems.

A sense of loneliness and melancholy due to the uprooting of established social, cultural, and family linkages.

These experiences tend to create a lowered physical and mental constitution and/or increasing the

predisposition towards acquiring new infections, diseases, and/or illness. Thus, these immigrants need to be examined for nutritional-related, stress-related and metabolically related dysfunctions and diseases.

MENTAL HEALTH

Adjustment problems result from the uprooting migration experience.⁽¹¹²⁾ Accordingly, there tend to be a relatively higher rate of hospital admission among immigrant groups than native born due to mental disorders.⁽¹¹³⁾ Further, there is comparatively, higher rates of mental illness among immigrants in the United States, than in Canada and Australia.⁽¹¹⁴⁾ The impact of immigration on mental health adjustment is influenced by such factors as the nature of: the host country, the sending country, the immigrant's life experience, language proficiency, level of education and socio-economic status.

There is a dearth of research studying the mental health consequences and/or psycho-social adjustment patterns and process of Caribbean immigrants in the United States. However, note that anguish, anxieties, acculturation, tensions and adjustment pressures to become "Americanized"⁽¹¹⁵⁾, (e.g., adopting the language patterns, individualistic attitudes and other such cultural attributed prevailing in the American society) as

opposed to other groups tend to be greatly resisted by Caribbean immigrants. The solid reliance on their kinship ties, social networks and ethnic identification⁽¹¹⁶⁾ in their communities tend to insulate these adjustment pressures. The Caribbean/American communities tend to shield the mental health tensions imposed by the stress-full and alienating immigration experience. Hence, the community serves as a coping mechanism, largely resisting the acculturation process, while providing these immigrants a sense of ethnic and cultural solidarity. Other reason for the resistance seems to be that many arrive with the intention of seeking better educational, and economic opportunities in the United States, afterwards they will return home to their tropical paradise. Therefore, these immigrants tend to maintain strong allegiance to their native countries whose geographic proximity enables frequent contacts and visits.

This allegiance is reflected in the fact that West Indians have the lowest rate of citizenship of all immigrant groups according to the Immigration and Naturalization Service.⁽¹¹⁷⁾ It is also argued that generally, their fierce struggle for economic survival leaves little time for broader acculturation.⁽¹¹⁸⁾ However, as with other immigrant groups in the past the adjustment and acculturation process takes approximately twenty

years; thus, it can be argued that this population should now be adjusted and acculturated into their new milieu, considering that the wave of Caribbean immigration to the United States basically resulted from the changes in the 1965 Immigration Law.

In this context also note that the status of a large undocumented segment in this population serves as a serious adjustment barrier. As a result the undocumented live under the constant threat of deportation, and tend to suffer from the persecution phobias and insecurity anxieties peculiar to refugees.⁽¹¹⁹⁾

Considering the high correlations between immigration and adjustment problems there is a clear need to:

- Assess the resulting health status of immigrants;
- Monitor the resulting levels of morbidity; and,
- Develop preventative approaches to respond to these problems.

The issues and constraints effecting the delivery of health services to this population are inherently complex. For example:

What is the health status of Caribbean immigrants upon arrival?

What are the health needs of this population?

What is the biostatistical profile (natality, morbidity, mortality, etc.) of this population?

What barriers make health services inaccessible to this population?

What is the pattern of health care utilization of this population?

What forces influence their patterns of service utilization?

What are the roles of the various levels of government in providing services to this population?

What are the possible policy implications; the fiscal impact and consequences in providing health care services to this population?

Notwithstanding the complexities involved, any attempt to address the health care needs of Caribbean immigrants, needs to be done within a framework that includes an analysis of the characteristics of this population viewed from their cultural perspective.

Moreover, there is a need for health and social services providers to gain some insights into the cultural dynamics of this community; particularly providers need to gain some basic understanding of those issues related to cultural differences, such as the folk medical beliefs and practices discussed herein. Such an understanding can serve as a framework for meeting such needs as: Providing services based on collaborative approaches from both folk medical and modern medical systems as follows:

Removing the cultural barriers that results in inadequate delivery of health care services to this population;

Developing culturally compatible models of health services provision.

Developing socio-cultural awareness training programs for health providers.

An understanding of the cultural framework of health consumers (in this case Caribbean immigrants) and of the cultural impact on the health consumer behavior in clinical situations, and patterns of health services utilization is basic to the professional medical practitioner. An awareness of the effects of culture on behavior and some general knowledge about the particular attitudes, points of view, values, beliefs, and behavior patterns of Caribbean health consumers would shed some light on behavioral patterns that otherwise might be ascribed to individual perversity, indifference, apathy, illness or ignorance. Understanding Caribbean culture would enable health providers to be more responsive and to engage this population.

NOTES

CHAPTER II

1. The terms West Indian and Caribbean are used interchangeably. See Note 14, *infra*.
2. For a contextual framework of this see Bryce-Laporte, Roy S. (ed), Sourcebook on the New Immigration: Implications for the United States and the International Community, Transaction Books, New Brunswick, New Jersey, 1980.
3. See discussion in Health Context, *infra*.
4. See Bryce-Laporte, Sourcebook, 1980.
5. The statute consists of 173 pages; it is within the jurisdiction of the United States Attorney General, the Secretary of State, the Secretary of Labor, the Public Health Service, and Congress. Further, the statute is supplemented by 169 pages of Visa Department regulations.
6. Such pressures led President Carter to appoint the Select Commission on Immigration and Refugee Policy, which made its recommendations in 1981 for substantive changes in the 1965 Immigration Act.
7. Roy S. Bryce-Laporte, (ed), "The New Immigrant Wave", Society, (14/6): 18-79, Sept./Oct. (Special Issue), 1977, p. 19.
8. Most English-speaking Caribbean countries became independent in the 1960's. For example, Jamaica gained its independence from the United Kingdom in 1962.
9. Bryce-Laporte, Society, p.19.
10. Charles Keely and Patricia Elwell, "International Migration: Canada and the United States", Global Trends in Migration, (ed) by Mary Kritz, Charles Keely and Silvano Tomasi; (New York: Center for Migration Studies), 1981, p. 182.
11. Bryce-Laporte, Society, p.20.
12. Charles B. Keely, "Effects of United States Immigration Act of 1965 on Selected Population Characteristics of Immigrants to the United States,"

Demography, 8(2), 1971.

13. See, Elsa M. Chaney and Constance L. Sutton (ed), "Caribbean Migration to New York" (Special Issue) International Migration Review, (Center for Migration Studies, New York, Vo. 13, Summer, 1979).
14. The region consists of the English Caribbean, the French Caribbean, the Spanish Caribbean and the Dutch Caribbean. It includes more than forty-eight territories; four mainland territories and forty-four insular territories which are as follows: Anguilla, Aruba, Antigua, Bermuda, Bonaire, Bequia, British Virgin Island, Belize (Commonwealth mainland in Central America), San Andres Island, Caicos Islands, Cayman Islands, Costa Rica (Spanish speaking, on Central American mainland, with a large West Indian concentration in areas such as Limon), Carriacou, Cuba (non-commonwealth, Spanish speaking, with second and third generation West Indians), Dominican Republic (a non-commonwealth, Spanish speaking, on the island of Hispaniola), Desirade, French Guiana, Guadeloupe, Grenadines, Guyana (Commonwealth member on mainland in South America), Haiti (French speaking non-commonwealth, Haitians in N.Y.C. live in the Caribbean communities), Jamaica, Les Saintes, Marie Galante, Montserrat, Martinique, Nevis, Panama (Spanish speaking on the mainland in Central America, large concentrations of West Indians are in the Provinces of Boca del Toro, Panama and Colon. West Indian Panamanian's are an integral component of the N.Y.C. Caribbean communities), Puerto Rico (U.S. territory, Spanish speaking, a key member of N.Y.C. Hispanic community), Saba, Saint Barthelemy, Saint Croix, Saint Kitts, Saint Lucia, Saint Martin, Surinam, Saint Thomas, Saint Vincent, Tobago, Turks Islands, Trinidad, Tortola.
15. For comparative analysis on West Indians in the United Kingdom and the United States, See Nancy Foner, "West Indians in New York City and London, A Comparative Analysis," International Migration Review 13:284-297, 1979.
16. Mary M. Kritz, "International Migration Patterns in Caribbean Basin: An overview, Global Trends in Migration", p. 219.
17. See Robert Warren, "Volume and Composition of United States Immigration and Migration" in Sourcebook on New Immigration: Implications for

the United States and the International Community, Roy S. Bryce-LaPorte, 1980.

18. Kritz, Global Trends in Migration, p. 219.
19. Roy S. Bryce-Laporte, "Introduction: New York City and the New Caribbean Immigration: A Contextual Statement", International Migration Review, Center for Migration Studies, N.Y., 1979, pp. 215-216.
20. See notes #14 Supra.
21. Aubrey W. Bonnett, "An Examination of Rotating Credit Association Among Black West Indian Immigrants in Brooklyn" Sourcebook on the New Immigration: Implications for the United States and the International Community, Roy S. Bryce-Laporte, ed., (Transaction Books, New Brunswick, New Jersey, 1980) p. 271.
22. e.g., CARICOM is an expression of Caribbean Solidarity.
23. See, Roy S. Bryce-Laporte, "New York City and the New Caribbean Immigration: A Contextual Statement", in Caribbean Migration to New York, Elsa Chaney and Constance Sutton, International Migration Review (Special Issue) (Vol. 13, Summer 1979) pp. 214-234.
24. Ibid., et passim, pp. 227-229.
25. The Monroe Doctrine advocated by President Monroe in 1822 against European intervention in the hemisphere. The Roosevelt Corollary, 1904, advocated the United States to exercise international police power in the hemisphere.
26. Bryce-LaPorte, Caribbean Migration to New York, International Migration Review, Vol. 13, 1979, pp. 227-229.
27. See: Joanmarie Kalter, "Caribbean Immigrants Clout" Newsday, The Long Island Newspaper, (N.Y. edition) 1/12/84.

Gary Larkin, "Caribbean Commission Sought", The Legislative Gazette, (Albany, N.Y., February 13, 1979) p. 7.

28. Note the following Demographics:

Caribbean population in New York City (Total).....*1.3 million.

Caribbean undocumented population in New York (minimum number).....*350,000.

Caribbean population in Brooklyn.....*64% of Brooklyn's 800,000 Blacks.

Caribbean population in the 18-35 years of age group....*67%

Caribbean population Purchasing Power in New York.....*\$4 Billion.

New York State Black and Puerto Rican Legislative Caucus members of Caribbean background 16 out of 26. (SOURCE: OMNI Resources Corporation, Brooklyn, N.Y., *1984 Estimates)

29. Informal analysis suggest that Brooklyn has the highest numbers of first and second generation Caribbean immigrants.

30. The 1982 elections gave Brooklyn two predominantly Black Congressional Districts (11th and 12th).

31. Based on findings of the New York Urban League Undocumented Immigrants Research Project.

32. Boris Velimirovic, "Forgotten People: Health of Migrants" (Special Feature), Bulletin of the Pan American Health Organization, Vol. 13, No. 1, 1979, p. 72.

33. Ibid.

34. Jenna Joselit Weissman, "The History of Immigrants and Health Issues in the United States," paper prepared for the Select Commission on Immigration and Refugee Policy, 1981.

35. Ibid.

36. Fred Arnold, "Providing Medical Services to Undocumented Immigrants: Cost and Public Policy," International Migration Review, Vol. 13, No. 4, p. 707.

37. Weissman, Ibid.
38. Velimirovic, Ibid.
39. The survey instruments in Exhibit C in the Appendix is designed to retrieve such basic information.
40. Velimirovic, Ibid.
41. Ibid.
42. See: Introduction in Roy S. Bryce-Laporte, "The Study of New Immigration: Political and Methodological Deterrents, Quantitative Data, and Immigration Research", in Quantitative Data in Immigration Research, (Research Institute on Immigration and Ethnic Studies, Smithsonian Institution, Washington, D.C., 1979).
43. An excellent introductory framework on Health and Culture is presented by Ann Templeton Brownlee in Community, Culture, and Care: A Cross-Cultural Guide for Health Workers, C.V. Mosby Co., St. Louis, 1978.
44. Ibid, pg. VII.
45. Edward Suchman, Sociology and the Field of Public Health, Russell Sage Foundation, N.Y., 1963, p. 15.
46. A.J. Hallowel, Ojibwa "World Views and Disease," in Man's Image in Medicine and Anthropology, Iago Galdston, ed., International University Press, N.Y., 1965, pp. 258-315.
47. Andrew C. Twaddle, Richard M. Hessler, A Sociology of Health, The C.V. Mosby Co., St. Louis, 1977, p. 159.
48. The Medicine Show, by Consumer Report, Columbia University, N.Y., pp. 170-177.
49. Among the major U.S. agencies charged with protecting the public from health service abuse and from non-conventional medical practitioners are: The United States Postal Service, The Food and Drug Administration, The Federal Trade Commission, The American Medical Association's Bureau of Investigation.

50. See, James Hardy Young, The Medical Messiahs: A Social History of Health Quackery in Twentieth Century America, Princeton University Press, 1963.
51. See: David K. Kotelchuck (ed.), Prognosis Negative: Crisis in the Health Care System, Vintage Books, New York, 1976.
- Barbara Ehrenreich and John Ehrenreich, The American Health Empire: Power, Profits and Politics, Vintage Books, Random House, New York, 1971.
52. This also partly explains the current phenomena of maintaining "good" health through proper dieting (eating chemical-free natural foods) and exercising to maintain physical fitness.
53. From the Introduction of Ehrenreich's American Health Empire.
54. From the Preface of Ehrenreich's, American Health Empire.
55. See, Peter Manning and H.F. Fabrega Jr., "The Experience of Self and Body: Health and Illness in the Ghipar Highland" in Phenomenological Sociology, George Prathar, ed., John Wiley, N.Y., 1973: 251-301.
56. See, -A. Kleinman and L. Sung, "Why do Indigenous Practitioners Successfully Heal?" Social Sciences and Medicine 13B(1979): 7-26.
- David Landy, "Role Adaptations: Traditional Cures Under the Impact of Western Medicine," American Ethnologist, 1974(1): 103-121.
- Joan D. Koss, "The Therapist Spiritual Training Project in Puerto Rico: "An Experiment to Relate the Traditional Healing System to Public Health System" Social Science and Medicine, Vol. 146, No. 4, Nov. 1980, pp. 255-266.
57. See- Irwin Press, "Urban Folk Medicine: A Functional Overview, American Anthropologist, Vol. 80, 1978.
- Irwin Press, "The Urban Curandero", American Anthropologist, 1971(73) pp. 741-756.
58. Loc. Cit.

59. See Ari Kiev, Transcultural Psychiatry, Free Press, New York, 1972.
60. W.D. Haenzel and M. Sirhen, "Lung Cancer Mortality as Related to Residence and Smoking Histories, Journal of the National Cancer Institute, 1962 (28) 949-1001.
61. H.A. Tyroler and Cassel, John, "Health Consequence of Culture Change II, The Effects of Urbanization on Coronary Heart Mortality in Rural Residence, Journal of Chronic Disease, 1964(17) 167-177.
62. Press, 1978, p. 75.
63. Irwin Press, "Bureaucracy Versus Folk Medicine: Implications from Seville Spain, Urban Anthropology, 1973(2): 232-247.
64. Ibid.
65. See: Press, 1978, p. 75.
- Note that some of these folk practitioners have formidable western-based scientific training, e.g., See; Marline Simmons "Power of Voodoo, Preached by Sorbonne Scientist" The New York Times, Dec. 15, 1983, p.2.
66. See:Irwin Press, "Urban Illness: Physicians Cures and Dual Use on Bogota, Journal of Health and Social Behavior, 1969(1) 209-218.
- Cervando Martinez and Henry Martin, "Folk Disease Among Urban Mexican Americans: Etiology, Symptoms and Treatment", Journal of the American Medical Association, 1966(196): 161-164.
67. Press, 1978, p. 76.
68. See: Michael Whiteford, The Forgotten Ones: Columbian Countrymen in an Urban Setting, Gainesville, University of Florida Press, 1976.
69. Press, 1973, p. 245.
70. Richard Hessler, M.F. Volan, B. Ogburu, and P. New, "Intraethnic Diversity: Health Care of the Chinese Americans," in Human Organization, 1975 (34): 253-262.

71. The rural and urban poor tend to rely more on folk technological development in the Caribbean region is decreasing this reliance among younger West Indians.
72. Press, 1978, p. 79.
73. See: Vera Rubin, "Cultural Perspectives in Caribbean Research" in Caribbean Studies: A Symposium, Vera Rubin, ed. Jamaica: Institute of Social and Economic Research, 1957.
- Edward Braithwaite, "Contradicting Omens: Cultural Diversity and Integration in the Caribbean, Mona, Jamaica: Savacou Publications (Monograph No.1) 1974.
- Nichlas Gullen, "The Black Man and the Caribbean as seen by Nicolas Guillen and Lius Pales Matos," Caribbean Quarterly 25: 72-79, March-June, 1979.
- Walter Rodney, "The Role of the Historian in a Developing West Indies," Social Scientist, 1:13-14, 1963-64.
- Derek Walcott, "Caribbean: Culture or Mimicry?" Journal of Interamerican Studies and World Affairs 16:3-13, February, 1974.
- Vincent R. McDonald, Caribbean Issues of Emergence: Socio-Economic and Political Perspectives, Washington, D.C., University Press of America, 1980.
- Virginia Radcliffe, The Caribbean Heritage, New York: Walker, 1976.
- Peter J. Wilson, Crab Antics: The Social Anthropology of English-Speaking Societies of the Caribbean, New Haven: Yale University Press, 1973.
- J.S. and L.D. McDonald, "Transformation of African and Indian Family Traditions in the Southern Caribbean," Comparative Studies in Society and History 15:171-198, March 1973.
74. For interregional comparisons and variations in folk medical approaches, See the following:

E.A.V. Abraham, "Materia Medica Guian," Timehri, 3rd Series 2(19) July 1912: 179-196.

Joan Eldridge, "Bush Medicine in the Exumas and Long Island, Bahamas: A Field Study," Economic Botany, 29(4) October/December, 1975: 307-332.

S.C. Scott, "Health and Healing Practices Among Five Ethnic Groups in Miami, Florida" Public Health Reporter, (89) 1974: 524-532.

Morris Steggerda, "Plants of Jamaica Used By Nations for Medicinal Purposes," American Anthropologist (New Series), 31(3) July/September, 1929: 431-434.

George Eaton Simpson, "Folk Medicine in Trinidad," Journal of American Folklore, 75(298), October - December 1962: 326-340.

David Stevenson, "Intervillage Preference of High Blood Pressure Medicinal Plants on St. Kitts, West Indies," Medical Anthropology Vol. 3, No. 4, 1979, pp. 503-524.

Kathryn Staiana, "Alternative Therapeutic System in Belize: A Semiotic Framework," Social Science and Medicine, Vol. 15B, No. 3, July 1981, pp. 317-332.

75. See the following: Margaret Craham and Franklin W. Knight, Africa and the Caribbean: Legacies or a Link, Baltimore: John Hopkins University Press, 1979 (John Hopkins, Studies in Atlantic History and Culture).

Leonard E. Barrett, "The Portrait of a Jamaican Healer: African Medical Lore in the Caribbean," Caribbean Studies.

Leonard E. Barrett, The Sun and the Drum: African Roots in Jamaican Folk Traditions, Kingston Sangster's Book Store and Heinemann London, 1967.

Leonard E. Barrett, Soul Force: African Heritage in Afro-American Religion, Anchor Books, N.Y., 1974.

Ann Pescatello, "Old Roots in New Lands: Historical and Anthropological Perspectives on Black Experiences in the Americas", (contributions in

Afro-American and African History Series No. 31, Westport, CT: Greenwood, 1977.

- Frankin E. Knight, The African Dimension in Latin American Societies, New York: McMillan, 1974.

76. G.K. Osei, The African Philosophy of Life, The African Publication Society, London, U.K., 1970.
77. Ibid.
78. Barrett, Caribbean Studies, p. 6.
79. Ibid.
80. Ibid.
81. Barrett, 1967.
82. Note: These African retentions are present in the popular folk practices throughout the Caribbean region.
83. Folk illnesses are categorized as resulting from a) dislocation of internal organs or b) based on magical origin or c) based on emotional origin.
84. Iris Bayley, "The Bush Teas of Barbados," Journal of Barbadian Museum Historical Society, 16(3), May 1949: 103-109.
85. Joseph L. Long, Jamaican Medicine: Choices Between Folk Healing and Modern Medicine, Ph.D dissertation, Southern Methodist University, 1973.
86. Note A similar notion prevail in Hispano-Caribbean cultures, where the term "sangre debil" (weak blood) means sexually impotent.
87. Note: The complex isothermal (Hot-Cold) theory, argues that diseases can result from hot/cold imbalances. This hot/cold approach is also a derivative of the Greek Humor Theories (phlegm, blood, black bile and yellow bile). This theory argues humors are hot and cold and that imbalances between them caused illness (e.g., head colds, stomach upset, nausea, etc.) To treat these conditions, folk health practitioners would prescribe herbal and dietary prescriptions based on hot and cold herbs and/or foods (e.g., ice is hot, since it can burn, while citrus fruits, which are aci

dous are considered cold. This hot/cold prescription is also practiced in Hispano-Caribbean culture, e.g., in Mexico, Vide: (Mark, 1970) in Bibliography II)

88. See: Saddle Campbell, "Bush Teas: A Cure All," Jamaican Journal, 8(23), Summer, 1974: 59-60.
- Barbara Burland, "Some information on Herbs, Medicinal Plants and other types of Remedies Used in the Past in Bermuda for Various Aliments," Hamilton, Bermuda Historical Society: Occasional Publication, No. 6, 1965.
89. See: C.D. Adams and K.E. Magus., "Some Jamaican Herb Remedies are Poisonous," Information Bulletin of the Research Council, 6(4) March, 1965: 105-109.
- Martha Warren Beckwith, Notes on Jamaican Ethnobotany, Poughkeepsie, N.Y., Vassar College, Publication of the Folklore Foundation, No. 8, 1927.
90. See: W. Aykroyd, "Nutrition in the Caribbean," Journal Hygiene 63(1) March, 1965: 137-153.
- Saddle Campbell, "Folklore and Food Habits," Jamaican Journal, 8(2-3), Summer 1974:56-59.
- Sybil M. James, "When Your Patient is Black West Indian," American Journal of Nursing, November, 1978.
91. See: Joan Eldridge, "Bush Medicine in the Exumas and Long Island Bahamas: A Field Study," Economic Botany, 29(4) October/December 1975: 307-332.
- B. Weniger, "Plants of Haiti, Used as Antifertility Agents," Journal of Ethnopharmacology, Vol. 6, No. 1, July 1982, pp. 67-84.
- Morris Sterggerda, "Plants of Jamaica used by Natives for Medicinal Purposes," American Anthropologist (New Series) 31(3), July-September, 1929: 431-434.
- David Mulcaky, "A Sketch of Vincentian-Portugese Folk Botany and Medicine," in Thomas M. Fraser (ed.) Windward Road: Contributions to the Anthropology of Saint Vincent, Amherst, University of Massachusetts, Department of Anthropology, (Research Report No.2) 1973: 108-122.

- D.C. Feng, "Preliminary Survey of the Medicinal Plants of British Guiana," West Indian Medical Journal, 5(4), December 1956: 265-270.
92. See: Tracey Nicholas, Rastafari: A Way of Life, Garden City, N.Y.: Doubleday, 1979.
- Vera Rubin, (ed), Cannabis and Culture, the Hague, Moutin, 1975.
93. Note: other such practices includes: (goetry, calling and commanding demons), clairvoyancy, clair audience, psychosymbology, Baptism (frantification by submergence in the spirit), symbolic sacrifices (usually using a dove and using it's blood to cleanse, purify or to foster hope, faith and peace), metapsychometry, naturopathic medicine, hypnocyberkinetics, numerology, sorcery, meditation, Rosecrutianism, the eye-and-the pyramid, possession and exorcism, Zombie, casting spells, hexes, curses, vision, influencing dreams, etc.
94. Note: The following organizations may be contacted for information on current works in the area: The Society for Psychical Research of London, and the America Society for Psychical Research in New York City.
95. See: William Wedenoja, Religion and Adaptation in Rural Jamaica, Ph.D dissertation, University of California, San Diego, 1978, Ann Arbor, University Microfilm, 1979.
- Julius Jerome, Rasta Doctor and a Unique Medical Clinic in Jamaica, West Indies, The Divine Theorcratic Government of Ras Tafari, Selassie I.
- Ramon Cervantes, "Oja de Mal," Belizean Studies, Vol. 10, Nov. 1, 1982, pp. 2-9.
- William Penn Bradford, "Puerto Rican Spiritism; Contrast in the Sacred and Profane," Caribbean Quarterly.
- Robert Borofsky, Obeah: A Description of an Occult Medical System in Trinidad, Waltham, Mass., Brandeis University, Department of Anthropology, 1968.
- Hesheth J. Bell, Obeah: Witchcraft in the West Indies, Wesport, Conn., Negro University Press, 1970.

- Martha Warren Beckwith, "Some Religious Cult in Jamaica," American Journal of Psychology, 34(1) January 1923:32-45.
96. See: Mary Baker Eddy, Science and Health with Key to the Scriptures, The Christian Science Publishing Society, Boston, 1918.
97. Note: Herb doctors use some of the common arboreal derivatives due to their medicinal and healing capabilities: (In balmyard healing bath, roots are not used only weeds, bushes, and leaves Ganja, tamarind, lime, comfrey, dandelion, camomile, flowers, wide grape bush, aliba weed, wild cinammon, ballad weed, rosemary, sage, cayanne, peppermint, garlic, cloves, soap bush, leaf of life, willow bush, sower sop bush, cash warrior, valerian root, sweet root (Licorice), fever grass, papaya leave, pepper tree leaves, rose oil, winter-green oil, eucalyptus oil.
98. See,- Laenec Hurbon, Dieu Dans Le Voudou, Haitian, Paris: Payot, 1972.
- Alfred Metraux, Voodoo in Haiti, New York: Schochen, 1972 (Translation from 1959, French edition).
- Sidney W. Mintz, Working Papers in Haitian Society and Culture, New Haven: Yale, 1975.
- Robert W. Pelton, Voodoo Charms and Talismans, New York: Drake, 1973.
- J. Bevilacqua, "Voodoo: Myth of Mental Illness," Journal of Psychology of Nursing, (18) 1980: 17-23.
- Bernard Diedderick, "On the Nature of Zombie Existence: The Reality of a Voodoo Ritual," Caribbean Review, Vol. XII, No. 3, December, 1983.
99. See: Vittoria Laternari, The Religions of the Oppressed: A Study of Modern Messianic Cults, Lisa Sergio, translator, N.Y.:Knoff, 1963.
- Seth and Ruth Leacock, Spirit of the Deep: A Study of an Afro-Brazilian Cult, New York: Natural History Press, 1972.

- George Eaton Simpson, Black Religions in the New World, New York: Columbia University Press, 1978.
100. See: Leonard E. Barrett, The Rastafarian: Sounds of Cultural Dissonance, Boston: Beacon Press, 1977.
- Leonard E. Barrett, The Rastafarian: A Study in Messianic Cultism in Jamaica, Rio Piedras, Puerto Rico, Institute of Caribbean Studies, University of Puerto Rico, Monographs Series, No. 6, 1968.
- Sheila Kitzinger, "Protest Mysticism: The Rastafarian Cult of Jamaica," Journal of Scientific Studies of Religion, Fall 1969, 8(2): 240-262.
101. See: William R. Acho and Kimlan Minott, "Creole and Doctor Medicine: Folk Beliefs, Practices and Orientation to Modern Medicine in a Rural and Industrial Suburban Setting in Trinidad and Tobago," Social Sciences and Medicine (Vol. 11, No. 5, March: 1979) pp. 349-355.
- Laquerre, "Health Belief and Practices of Haitian-Americans" in Handbook of Ethnicity and Medical Care, Alan Harewood, ed., N.Y., 1978.
102. Among the substances and materials that may be found in an Obeah man's chest are: Kerosene Rum, oils, urine, feces, ashes, blood, talcum, grease, rose water, parrot beak, spiders, lizards, feathers, perfume, grave dirt, sea urchin, alligator teeth, broken glass and mirrors, animal skull, cat claws, egg shells, coral, rusty nails, magnet, human hair, clay dirt, salt, sand, epsom salt, dry leaves, etc.
103. See,- F.D. Goodman, "Glossolalia: Speaking in Tongues in Four Cultural Settings," Contemporary Psychology, 1969: 12(2-4): 113-129.
104. This practice is particularly common among Hispano-Caribbeans, and West Indian Panamanians, for more on West Indian Panamanians, See: Bryce-LaPorte, Roy S., "Crisis, Contraculture, and Religion Among West Indians in the Panama Canal Zone" in Norman E. Whitten, Jr. and John F. Szwed (ed.) Afro-American Anthropology: Contemporary Perspectives, N.Y., Fress Press, 1970: 103-118.
105. Bradford, Caribbean Quarterly, p. 53.

106. Ibid, p. 48.
107. Ibid, p. 51.
108. Press, 1977.
109. Ibid.
110. Stanley H. King, "Social Psychological Factors in Illness," Handbook on Medical Sociology, Howard Freeman, et. al. (eds), Prentice Hall, Englewood Cliffs, N.J., 1963.
111. See: S.K. Hoope and P.L. Heller, "Alienation, Familism, and the Utilization of Health Services Social Behavior, 1975, 16(3): 304-314.
- J. Ex, Adjustment After Migration, Publication of the RES Group for European Migration Problems, 1966.
 - E.H. Erikson, "Identity and Uprooting" in Uprooting and Resettlement, World Federation of Mental Health, proceedings of the 11th Annual meeting, 1958.
112. See: J.H. Abramson, "Emotional Disorder, Status Inconsistency and Migration," Questionnaire Survey in Jerusalem, Israel Medical Journal, 1963.
- M.Z. Almeida, "Psycho-Social and Psycho-Pathological Aspects of Transplantation," La Sante des Immigrants, Comite Medical et Medico-Social d'aide aux migrants, Paris Societe d'Edition Droit et Liberte, 1972 pp. 105-128.
 - Jervis Anderson, "Uprootedness: A Jamaican Negro," Commentary, Vol. 40, November, 1965.
 - Christopher Bagley, "Sequels of Alienation: A Social Psychological View of the Adaptation of West Indian Migrants in Britain," paper presented at 34th Annual Meeting of the Society for Applied Anthropology, 1975.
 - J.L. Cox, "Psychiatric Assessment and the Immigrant Patient," British Journal of Hospital Medicine, (16) No. 1, 1976: 30-40.
113. D. Friessem, "Psychiatric Disorders Among Foreign Workers in a Metropolis in South West Germany," in

L. Miller (ed.) 4th International Conference on Social Psychiatry, Jerusalem, Alv Coop, 1972.

114. H.B.M. Murphy, "The Low Rates of Mental Hospitalization Shown By Immigration to Canada," in Uprooting and After, by C. Zimmerman and Maria Pfister-Amendi, Springer-Verluz, New York, 1973: pp. 221-231.
115. Thomas C. Wheeler, (ed) The Immigrant Experience: The Anguish of Becoming American, Penguin Books, N.Y. 1970.
116. Megan E. McLaughlin, West Indian Immigrants: Their Social Networks and Ethnic Identification, Ph.D dissertation, Columbia University, 1981.
117. Kalter, 1984.
118. Ibid.
119. See: Maria Pfister-Amende, "Uprooting and Resettlement as a Sociological Problem," in Uprooting and Resettlement," London, World Federation for Mental Health, 19600.
 - J. Heiss, "Factors Related to Immigrant Assimilation: Early Post-Migration Situation," Human Organization, 26, 1976.
 - F.F. Kino, "Refugee Psychosis in Great Britain: Aliens' Paranoid Reactions," Journal of Medical Science (97) 1951.

CHAPTER III
BACKGROUND
PILOT STUDY
ON
UNDOCUMENTED CARIBBEAN IMMIGRANTS
IN
NEW YORK CITY

INTRODUCTION

The lack of information about undocumented immigrants presents a major obstacle to planning, financing and delivery of services to this group.⁽¹⁾

The continuing controversy surrounding the issues related to undocumented immigration, prompted the New York Urban League to conduct a research project designed to examine some of the major issues related to undocumented Caribbean immigrants in New York City. This writer served as the Project Director of that study which was conducted over the two year period from 1980 to 1982. That study served as a precursor to accomplishing the goals and objectives of this project ⁽²⁾

The study's problem was related, in part, as follows:

That study will examine the social environment of undocumented immigrants and the consequence of their presence for the distribution of services and resources to New York City. The site for investigation is the East Flatbush-Crown Heights sections of

Brooklyn. Following the lead of other researchers, that the undocumented live among the documented, this large Caribbean community was selected to enhance our understanding of the life circumstances of the West Indian undocumented immigrants in New York City.⁽³⁾

METHODOLOGY

The methods used for the study consist of:

A comprehensive literature review of immigration to the United States (both documented and undocumented) focusing on Caribbeans in New York City;

Use of data sources such as Immigration and Naturalization Services (INS), fielding of instruments to subject population and persons working with the population.

It is increasingly acknowledged that sound social scientific research on immigration is a growing need. There are two basic reasons for scientific immigration research.⁽⁴⁾

1. To further scientific theory and knowledge about migration and related fields; and
2. To make it possible to arrive at rational social policies concerning migration.

The difficulties in migration research are multi-dimensional.⁽⁵⁾ For example, there is currently, no source of immigration data that is appropriate or adequate for conducting quantitative research. Basic to the problem is the distinctions between scholarly research and research motivated by private and governmental interests.⁽⁶⁾ Scholarly research seeks to gain

reliable knowledge on the migration phenomena and to understand its facts and causes.⁽⁷⁾ Policy research seeks to find solutions to policy questions. However, the problem of the scientific value of both types of immigration research is often called into questions because the funding for scholarly research as well as policy research is often comes from governmental sources. Moreover, immigration flows and the data recording these flows are determined by the government's migration policies.

Some of the prominent questions raised about immigration research relate to the reliability, validity, objectivity and scientific value of the data collected. The major concerns include:

What value if any, does quantitative research have for the formulation of informed public policies dealing with immigration?

Can objective quantitative data be obtained about events that are under direct government control?

How valid for purposes of scientific research, is quantitative data collected by governmental agencies such as Immigration and Naturalization Services?

Because it is viewed as primarily a "law enforcement" agency, The Immigration and Naturalization Services (INS) data comes under severe attack from researchers in the field of immigration study⁽⁹⁾ INS data are said to

be for non-research purposes and oriented toward social control.⁽¹⁰⁾ One of the strongest areas of criticism is the absence of a legitimate independent mode of evaluating works conducted or commissioned by INS. Nevertheless, INS data remain the major "official" source on which immigration research is based. While, in theory, the potential for using quantitative research to formulate informed policies is great, a major limitation is that,

Data collection and use fall prey to political pressures...policy is usually made on the basis of political considerations rather than on the basis of scientific knowledge. Seldom do we find policy makers interested in supporting research in formulating opinions on issues and developing informed public policy. Rather, data are used to justify policy opinions held by the policy makers, and "research" is supported which selects only the data and results consistent with previously held political positions.⁽¹¹⁾

Hence, the methodological difficulties revolving around quantitative immigration research are based on how, why and where data are obtained; how it is used; and what are its limitations. These difficulties are greatly intensified when the research is on undocumented immigration. By definition, the problem of obtaining data on undocumented immigrants is challenging, because of the patterns of migratory flows, location, composition distribution and other basic characteristics of their population is not monitored. Moreover,

To yield information specific to the population, regarding the pattern of service utilization by the population.

To overcome problems related to the fielding of the instruments such as reluctance on the part of immigrants to participate because of their undocumented status.

To construct instruments in the three basic languages of the population; English, Spanish, and Haitian Creole.

Pre-testing the instruments were conducted with a small sample of the subject population and with officials of immigrant related service agencies.

Local residents who were well known and trusted by many of the undocumented immigrant population in the Crown Heights/East Flatbush section were hired and trained to use the instruments and to conduct field interviews. This approach alleviated the initial resistance by the undocumented immigrants. A sample of 21 agency officials with a record of community leadership were selected and surveyed. These officials were drawn from a cross-section of social, community, labor, health, education, arts, and culture, legal, ethnic, and civic organizations. The pre-test identified any deficiencies in the survey instrument, consequently, those instruments were revised. Exhibit C in the appendix contains the battery of these revised survey instruments.

Ethically it must be asked if government (funded) data are likely to be used in favor of the people providing the data or if the data are more likely to be used against those people to the benefit of others. (12)

Recognizing the many difficulties attendant to designing and implementing a research project on undocumented immigrants, the methods used for the New York Urban League project were designed to ameliorate, to the extent possible, the inherent problems of conducting research on this population. Hence, the approaches used included:

COMMUNITY RESOURCE COMMITTEE

This committee was formed to encourage greater community participation in the research efforts. It consisted of resource people with a record of demonstrated leadership in the Caribbean American community concerned with immigration-related matters.

TECHNICAL COMMITTEE

This committee played a key role throughout the planning and implementation of the project. The members were renowned researchers, academicians, policy makers, that were specifically selected, based on their expertise in the area of immigration. This committee provided on-going technical assistance in refining the project's goals and methodology. (13)

DATA COLLECTION

In addition to collecting secondary data from the INS, several data collection approaches were used, including:

1. Small Group Meetings

This involved conducting four meetings throughout the city's Caribbean communities with community agency personnel and community leaders. These meetings were not intended to be used to gather valid, reliable scientific data. The primary purposes were:

- a. To establish contact and a relationship with people dealing directly with immigration issues;
- b. To develop a referral contact to other sources of information on undocumented immigrants;
- c. To gain the perspective of these community groups on the problems related to undocumented immigrants.

Additionally, the project staff attended more than twenty (20) study clinics, workshops and seminars on Immigration. More than four hundred (400) potential data resource persons and agencies were contacted via mail and/or telephone. Approximately two hundred (200) participated in the final study. Major participants included: U.S. Congressional Research Service; U.S. Catholic Conference's Migration office; The Select Commission on Immigration; New York City Planning Commission; numerous public officials, researchers, academicians,

and community leaders with knowledge of the subject population. These persons and agencies were valuable in identifying and/or providing reference material on Caribbean undocumented immigrants and other information on the critical concerns of this population.

2. Literature Review

Particular focus was placed on materials which addressed the issue of undocumented immigration in New York City. To the extent possible, the review included past and current materials drawn from a variety of sources. Books, government documents, unpublished manuscripts, articles from newspapers, professional journals, and magazines were all included as resources. (14)

3. Instrument Construction and Pre-Testing

Although interview schedules are difficult to construct and are time consuming and relatively costly, researchers report that there is no other method that yields the information they do. (15) Personal interviews are perhaps the most powerful and useful tools of social scientific survey research. (16) The following areas were of concern in constructing the instruments:

To yield basic background information about population;

ANALYSIS:

In New York City, housing, employment and health were identified as serious issues affecting undocumented Caribbean immigrants. Housing because of exploitation by landlords, due to the immigrants status, which took the form of rent gouging and intolerable living conditions.⁽¹⁷⁾ Employment because of exploitation by employers in wages and working conditions and which took the form of low level and health threatening jobs due to status.⁽¹⁹⁾ However, health emerged as the most serious problem.⁽¹⁹⁾ This conclusion was based on two factors: The first is the policy position taken by New York City health officials regarding utilization of health care facilities by undocumented immigrants.⁽²⁰⁾ The second issue is the actual physical, mental, psychological, social and cultural conditions of the immigrants, all of which impact on the health of this population in New York City.

To the extent that undocumented immigrants receive any social service, it tends to be health care. New York State officials reported that it appears that illegal aliens have considerable economic impact on medical programs. The impact can be greater on state and local funded services than on federal services.⁽²¹⁾ Experience in New York State suggests that undocumented immi-

grants are receiving medical care at a cost to state and local taxpayers. Further, it is said that since health care for undocumented immigrants is not reimbursable by the Federal Government, New York City must bear the cost (22)

It is reported that the New York City hospital system, municipal and voluntary, is heavily burdened by the need to provide services to undocumented immigrants who do not have the means to pay for care and do not qualify for health insurance programs.⁽²³⁾ In fact, New York City's health officials assert that non-payment for emergency out patients and in-patients care for undocumented immigrants contributes significantly to fiscally depressing the City's health care system. ⁽²⁴⁾ For example, Kings County Hospital, a municipal hospital claimed a \$12 million annual bill for treating undocumented immigrants. ⁽²⁵⁾ In 1979, Brooklyn Jewish Hospital, a major New York City voluntary hospital, declared bankruptcy, blaming non-reimbursed costs for serving the undocumented immigrants.⁽²⁶⁾

Hospitals continue to attribute non-payment for services rendered to undocumented without presenting evidence to support such allegations. There is no adequate methodology for assessing the cost impact of providing health care to the undocumented.⁽²⁷⁾ Analysis

suggest that this population primarily utilizes obstetrics, pediatrics, and out-patient services.⁽²⁸⁾ While a New York City indicated study that 44.5% of the Haitian and 76.5% of the Dominicans use hospital clinics,⁽²⁹⁾ A California study on undocumented Mexican immigrants, found that settled undocumented underutilized medical services, but use hospitals for the delivery of babies and for emergency care. Temporary workers, who are primarily males, living alone, use hospitals only in emergency cases.⁽³⁰⁾

Another Study found that 27.4% of their sample of undocumented immigrants use hospitals or clinics but only 4.6% use free medical services. The others paid the bill themselves or were covered by work-related health programs. Because undocumented immigrants tend to be young and fairly healthy, their use of health services tend to be minimal. ⁽³¹⁾

Even if undocumented immigrants receive health care services, the lack of data impedes determination of this population's use of such services. However, a study on financing hospital care for the medically indigent found that:

Despite the growing role of government in financing health care services, the provision of these services to the poor remains a national problem. Thus, substantial segments of the nation's popula-

tion still cannot pay for needed health care services.

Despite the dramatic growth in private and public health insurance, a substantial proportion of the population remains uncovered. Many characteristics of New York City's population, including the type of employment, and low labor force participation and the presence of large numbers of illegal aliens, suggests that the uninsured population in the City is a greater proportion of the population than national experience indicates.

Both voluntary and municipal hospitals in New York City are experiencing severe financial problems. Almost half of all voluntary hospitals sustained operating deficits in 1978, amounting to a total of \$77 million. A major source of these deficits is uncollected bills which largely represent services provided to medically indigent.⁽³²⁾

Evidence suggests a high correlation between socio-economic levels and the prevalence and incidence of diseases and dysfunctions.⁽³³⁾ Therefore, since most undocumented immigrants arrive from developing third world countries, bring the disease of poverty with them and arriving to conditions of relative poverty in the United States, this population is at high risk for illness.⁽³⁴⁾ Several factors contribute toward making this a high risk group.

Due to their socio-legal status, undocumented immigrants tend to be employed in occupationally hazardous health/and or safety conditions, earning subsistence wages with minimal or no health insurance coverage.⁽³⁵⁾ Housing is frequently substandard though rents are usually higher than other residents. These

living conditions in themselves, present a health hazard.⁽³⁶⁾

Due to the threat of deportation, undocumented immigrants avoid seeking immunization or approaching health service facilities unless it is a critical emergency. The primary reason for this avoidance is fear of collaboration by health facilities with Immigration and Naturalization Service.⁽³⁷⁾ This reluctance to seek primary and preventive care is a prime cause of the need for emergency services.⁽³⁸⁾ Consequently, this population tend to be more acutely ill by the time they go to health facilities for treatment or services.⁽³⁹⁾

Migration also tends to be accompanied by psychosocial stress resulting from adapting to an unfamiliar and/or hostile environment. In addition to having a detrimental health impact, this stress can cause and exacerbate acute physical symptoms. Such conditions make immigrants usually susceptible to acute infections and illnesses caused by viral and bacterial agents; to respiratory, digestive and nervous system ailments; to hypertension and coronary diseases.⁽⁴⁰⁾

Language and similar socio-cultural variables tend to serve as obstacles in the delivery of health services to this population.⁽⁴¹⁾ Additionally, the non-white immigrants encounter institutional racism, in their

pursuit of health services, manifested by such practices as "patient dumping", similar to their indigenous, indigenous counterparts.

Another crucial health issue is the epidemiological impact of undocumented immigration. For example, in Los Angeles, an estimated 22% of the 1592 tubercular cases reported in 1975 were attributed to undocumented immigrants. In 1978, a 17% increase was reported in New York City.⁽⁴²⁾ Further, not only are there reports of an increase in tuberculosis cases but also, to the alarm of health officials, an increase in the leprosy rate. A Daily News article stated:

The rising number of immigrants from the Caribbean Islands and South America has caused the leprosy rate in the metropolitan area to more than triple since the mid-1960's and it could get much worse in the next 15 years.⁽⁴³⁾

Because of their status undocumented immigrants either cannot avail themselves of the social support systems and legal protection given other immigrants or they are denied access to these services. While United States policies do not restrict providing health care to immigrants lawfully within its territory, these policies exclude the undocumented immigrants. While some statistics indicate that undocumented immigrants make use of some health care facilities, there is no reliable data available to document this situation. The present eco-

conomic and social status of this population appear to have created a new pariah class of Caribbean Immigrants who are exposed to increased health risks. At present there is no mechanism for either assessing their medical problem or for providing the services that will meet the health care needs of this population. (44)

FINDINGS

Health Care: Research suggests that patterns and perceptions are established in the country of origin and persist after migration. Like Americans of similar social placement, undocumented immigrants make use of emergency rather than preventive services. Health needs of this population are believed to be significant due to stress related illnesses emanating from the migration process and cultural dislocation. There is evidence to suggest that the methods used to determine the cost of providing medical care to this population are less than reliable. It is to the advantage of the general public that this group receive needed health care since many of them are employed in food service industries.

RECOMMENDATIONS: The recommendations stemming from the Pilot Study were that:

The Federal Government must take the leadership role in developing mechanisms which assure fundamental health services to all persons facing economic, political, social or legal barriers

to such care.

There should be a separation of law enforcement from health care delivery systems - there should be no discriminatory billing or collection practices based on suspicion regarding resident status.

The New York City health providers must reach out to the undocumented immigrants to make certain that basic health needs such as, immunizations for children, prenatal services and control of contagious diseases are assured.

Health care should be delivered in a manner which both maintains the patient's cultural integrity and informs him or her of American concepts of health, illness and treatment.

DISCUSSION

This project was designed to be conducted in two phases:

- a) an exploratory phase, and
- b) an in-depth study phase.

The pilot study was the exploratory phase. During the course of the pilot study, health was identified as an area to be further examined. Therefore, a special health supplement was developed as part of the battery of instruments constructed for field study. Attempts were made to obtain funding for the field study phase. These attempts were not fruitful and the effort was terminated. The pilot study established the framework for further examining issues related to health care to Caribbean immigrants in New York City. The convening of a major conference on Health and Caribbean Immigrants in New York City was perceived as the mechanism through which to pursue the development of an advocacy group to

respond to the health care needs of the Caribbean population in New York City.

NOTES
CHAPTER III

1. See: George J. Stolnitz, "U.S. Immigration Now and In Prospect: Some Population and Policy Aspects", Sourcebook on the New Immigration: Implication for the United States and the International Community, Roy S. Bryce-Laporte ed., Transaction Books, New Brunswick, N.J. (1980), pp 51, 52.

Illegal Aliens: "Analysis and Background", Committee on the Judiciary, U.S. House of Representatives, 95th Congress, U.S. Government Printing Office, Washington D.C., 1977.
2. The New York Urban League Study yielded a body of information on Caribbean immigrants in New York City and a reservoir of organizational resources and community and professional contacts all of which facilitated the accomplishment of this project.
3. Extract from New York Urban League's undocumented immigrant's research project proposal.
4. Stephen R. Couch, "Quantitative Immigration Data, Scientific Knowledge, and Public Policy: Possibilities, Limitations, and Interrelationships," in Quantitative Data and Immigration Research, Stephen R. Couch and Roy Simon Bryce-Laporte ed RIIES Research Notes No. 2, Research Institute on Immigration and Ethnic Studies, Smithsonian Institution, Washington, D.C., 1979, p. 259.
5. Stephen R. Couch, Op. RIIES Research Notes No. 2 p.26.
6. Gilbert Cardenas, "Critical Issues in Using Government Data Collected Primarily for Non-Research Purposes", RIIES Research Notes No. 2, p. 260.
7. See generally, discussions by Gilbert Cardenas and Stephen R. Couch, RIIES Research Notes No. 2.
8. Ibid
9. See discussion by various contributors in RIIES Research Notes No.2.

10. See generally, articles by Roy Bryce-Laporte, Gilbert Cardenas, Stephen R. Couch and Charles B. Keely, RIIES Research Notes No. 2.
11. Ibid, Pgs. 271-272.
12. Stehen R. Couch, RIIES Research Notes No. 2, p. 267.
13. The Technical Committee consisted of the following persons: Dr. Robert Hill, Director of Research, National Urban League (Chairman); Dr. Roy S. Bryce-Laporte, Director RIIES, Smithsonian Institute; Dr. Saskia Sassen-Koob, Queens College; Ms. Evelyn Mann and Mr. Frank Vardy, City Planning Commission; Dr. Charles Keely, Population Policy.
14. Additionally, the project staff attended more than twenty (20) study clinics, workshops, and seminars on Immigration. More than four hundred (400) potential data resource persons and agencies were contacted via mail and/or telephone. Approximately two hundred (200) participated in the final study. Major participants included: U.S. Congressional Research Service; U.S. Catholic Conference's Migration Office; The Select Commission on Immigration; New York City Planning Commission; numerous public officials, researchers, academicians, and community leaders with knowledge of the subject population. These persons and agencies were valuable in identifying and/or providing reference material on Caribbean undocumented immigrants and other information on the critical concerns of this population.
15. Fred Kerlinger, Foundation of Behavioral Research (2nd ED), Holt, Rinehart and Winston, N.Y. 1973, pg. 412.
16. Ibid., pg. 412.
17. Illegal Alien, Analysis and Background.
18. Ibid, pg. 20.
19. Consistent with the thrust of this project the analysis of the pilot study only discusses the area of health care.

20. See: New York State Officials reports: Peter Beichman, Health Care of Undocumented Aliens, (A project Proposal), The Assembly of the State of New York, Subcommittee on Urban Health Care, October 1979. State of New York Executive Chamber, (Michael Patterson, Press Secretary), Governor Hugh L. Carey Urges Federal Reimbursement for Services to Refugees and Aliens, July 1, 1980.

Berman, Richard A., Director, New York State Office of Health System Management, Testimony before the Select Commission on Immigration and Refugee Policy, on the Interrelationship of Refugee, Immigrants and Aliens with Health Care Systems, January 21, 1980.
21. Ibid
22. Ibid
23. Evelyn S. Mann, "The Impact of Legal and Illegal Immigration on Social Services, Health, Education, and Housing in New York City," Testimony before the U.S. House of Representatives Select Committee on Population, April 6, 1968.
24. Ibid
25. See, supra footnote 20.
26. Fred Arnold, "Providing Medical Services to Undocumented Immigrants: Cost and Public Policy," International Migration Review, Vol. 13, No. 4, pg. 707.
27. Evelyn S. Mann, "The Impact of Legal and Illegal Immigration on Social Services, Health, Education, and Housing in New York City".
28. U.S. General Accounting Office (December 1977) "Impact of Illegal Aliens on Public Assistance Programs: Too Little is Known", Washington, D.C.
29. Charles Keely, et. al. (1978), "Profiles of Undocumented Aliens in New York City: Haitians and Dominicans", Center for Migration Studies.
30. Wayne Cornelius, "Illegal Mexican Migration to the United States", Recent Research Findings and

Policy Implications, Select Readings on U.S. Immigration Policy and Law. Congressional Research Service, Library of Congress, October 1980.

31. David North and U.F. Houston, "The Characteristics and Role of Illegal Aliens in the U.S. Labor Market: An Exploratory Study", Manpower Study, Washington, D.C., Liton and Co., Inc., March 1976.
32. Geraldine Alpert and Melvin Krasner, Financing Hospital Care for the Medically Indigent: An Analysis of the Problems Facing Patients, Providers, and the General Public, December 1979.
33. Ibid., Part V.
34. Geraldine Dallek, "Health Care for Undocumented Immigrants: A Story of Negligance", National Health Law Program, Santa Monica, California, p. 1.
35. Ibid.
36. Arnold, Providing Medical Services to Undocumented Immigrants: Costs and Public Policy.
37. Ibid., p. 708.
38. Ibid
39. Ibid
40. Boris Velimirovic, "Forgotten People Health of the Migrants", (Special Feature) Bulletin of Pan-American Health Organization, 13(1), 1979, p. 78.
41. Noemi Santana, NYC Health and Hospital Corp., "Some Notes on Barriers to Health Care Services", paper delivered at Conference on Health and Caribbean Immigrants in New York City, St. Joseph's College, December 1982.
42. Dallek, P. 4.
43. Daily News (New York), June, 1981.
44. New York Urban League Press Statement by Horace W. Morris, Executive Director, NYUL, on study findings of Undocumented Caribbean Immigration in New York City, April 1982.

CHAPTER IV
METHODOLOGY

Design Rationale

A research design has been described as "The blueprint of the research architect and engineer... [it] tells, in a sense, what observations to make, how to make them and how to analyze the quantitative representation of the observation."⁽¹⁾ However, note that "A mechanically consecutive sequence of procedures in which one step is entirely completed before the next is begun, is rarely, if ever, the experience of social scientists."⁽²⁾ A design is contingent upon the purpose of the study. "A research design must be practical. [It] is not a highly specific plan to be followed without deviation, but rather a series of guideposts to keep one headed in the right direction."⁽³⁾ Further, "The problem of design becomes one of wedding the logic of scientific method to social pressures of many internal and external considerations."⁽⁴⁾

This was a multifaceted project of a pioneering nature, namely, to convene a major health conference and from this, to organize and institutionalize a formal body, to respond to the health care needs of Caribbean

contacting resource persons and institutions dealing with the issues;

Foster the conceptualization of the empirical aspects of the problem;

Facilitate idea formulation, theoretical generalization and concept clarification through information gathering in the form of literature review of related materials and through discussions with persons having knowledge or expertise in the area of health and Caribbean immigration;

Serve as a framework for constructing information gathering instruments for use in developing the health conference and in organizing the formal health structure.

Hence, the exploratory research design was uniquely suited for this project. Further, this design provided the flexibility to follow through from the pilot study to this project. While adjustments had to be made to accommodate for this project's focus on only health and on Caribbean immigrants in general rather than on the undocumented, much of the data gathered and many of the methods used in the pilot study were utilized here. The process of integrating the data and methods used in the two projects is discussed in the following sections.

RESOURCES IDENTIFICATION AND DATA RETRIEVAL PROCESS

Literature Review Process

The process involved in surveying the literature was based on reviewing past, and present works. "One of the simplest ways of economizing effort in an inquiry is

immigrants in New York City. Because the project had these qualities, the process developed to conduct it had to have a design flexible enough to facilitate coordinating all its various phases. Accordingly, the process undertaken consisted of a variety of nonsequential, but interrelated activities directed toward achieving the project's objectives. This process was based on an exploratory design.

In constructing research design, it should be noted that in "The case of problems about which little knowledge is available, an exploratory study is usually appropriate."⁽⁵⁾ In defending the merit of the exploratory design note further that, occasionally there is a tendency to underestimate the importance of exploratory research and regard only experimental work as scientific;"⁽⁶⁾ However, "Perhaps half the research in psychology and education and most of the research in sociology and anthropology, is non-experimental."⁽⁷⁾

In an exploratory design, the major emphasis is on the discovery of ideas and insight.⁽⁸⁾ Such a design has the virtue of enabling the researcher to set the problem up for a more precise investigation.⁽⁹⁾ More specifically, an exploratory design could:

Facilitate the formulation of priorities;

Serve as a practical tool for identifying and

to review and build upon work already done by others... More frequently, however, an exploratory study is concerned with an area in which hypotheses have not yet been formulated. The task then is to review the available material with sensitivity to the hypothesis that may be derived from it.⁽¹⁰⁾ The extensive search and review conducted for both this project and the pilot study is discussed in Chapter III. The literature review in the pilot study identified health care as the crucial issue affecting immigrants and gave impetus to this project.⁽¹¹⁾ Overall, this literature search and review involved a process encompassing the following steps:

Identify resources people, researchers, articles, reports, dissertations, etc., that deal with the problem.

Select relevant materials, review tables of content, bibliographies, charts, appendixes, and indexes.

Determine framework; identify key variables and assumptions; determine definition of conceptual terms.

Note sources quoted and used in determining policies, reliability and validity of data used.

Select relevant arguments, premises and quotations that agree or disagree with the project's concepts.

Collect and record bibliographic data (author, article, publishers, etc.), annotate synthesis of the substantive issues and analysis.

Cross-file data retrieved into categories (e.g. demographic, epidemiological, theoretical, methodological, health services, social services, etc.).

While the literature search was extensive, it did not yield considerable resources on health care to Caribbean Immigrants, either in New York City or elsewhere in the country. The search revealed that literature addressing this issue is very limited.⁽¹²⁾ Therefore, considerable reliance was placed on the community field study for gathering the data and making the contacts necessary to implement the health conference and to form the health structure.

Community Field Study

Field studies are conducted in live situations and were aimed at discovering the relations and interactions among sociological variables in social structures such as communities and institutions.⁽¹³⁾ Thus,

"The investigator in a field study looks at a social or institutional situation and then studies the relations among the attitudes, values, perceptions, and behaviors of individuals and groups in the situation... In designing research it is important not to underestimate the large amount of time, energy and skills necessary for the completion of most field studies. The field investigator needs to be a salesman, administrator and entrepreneur, as well as investigator"⁽¹⁴⁾

The field study approach was particularly appropriate for this project. The processes used here, incorporated many of the methods used in the pilot study as well as other activities related to the specific area of health. These activities included on site visits to

health facilities including hospitals; consultations with experts in the field of health care, particularly in the area of treatment and care of the Caribbean population. Major inquiry was in the form of fieldwork, much of which was conducted by this investigator. This work included numerous meetings and personal interviews with various professionals and lay persons with knowledge of the subject area; participation in panel discussions, community forums and conferences related to the area. Conceptualized as a data collection strategy, this approach was used for the following reasons:

The pilot study facilitated the accessibility of data, fostered the participant observer approach, and enabled the tapping of community resources within the New York City Caribbean Community.

The investigator had operational, technical and personal knowledge of this community which enhanced the community study approach.

The high degree of socio-cultural pluralism within this community and the fact that various Caribbean groups resided in a common, clustered, compact geographical boundary facilitated a more comprehensive analysis of both the formal and informal social and institutional arrangements within the community.

This approach facilitated conducting surveys, fact-finding tours and information gathering questionnaires within the community.

The community study model served as an effective framework to identify available resources within the community and as a mechanism to monitor and assess the pattern of health care services provided to and utilized by this population.

An integral part of the community study was to utilize some of the many persons identified by the pilot study such as health officials, community health providers, academicians, community leaders and others. In addition, persons dealing with some of the crucial health issues related to Caribbean immigrants were identified and contacted.⁽¹⁵⁾ These persons provided valuable insights on some of the most recent research in the area of health care and Caribbean health issues.⁽¹⁶⁾ They were also instrumental in providing information identifying some of the crucial health issues affecting this population.⁽¹⁷⁾

One of the critical considerations in the data gathering process for this project was the lack of a socio-cultural perspective on the part of the health care providers working with this population. This was identified as a deficiency that seriously affects the delivery of effective health care to Caribbean immigrants.⁽¹⁸⁾ This problem takes on even greater significance when it is noted that the New York City Caribbean population consists of persons from many different nations. It is therefore important to examine what kind of approach to use that would yield empirical data based on an adequate consideration of these circumstances. An empirical generalization is described as follows:

"A proposition summarizing observed uniformities of relationships between two or more variables... such generalizations may be of greater or less precision, but this does not affect their logical place in the structure of inquiry... If and when empirical uniformities are discovered they have direct consequences for theoretical system."⁽¹⁹⁾

The following approach was developed in order to obtain the cross-cultural perspectives necessary to acquire the data for a comparative analysis of the New York City Caribbean population.

A series of four (4) interviews were conducted with ten (10) respondents selected from diverse groups and agencies, as well as individuals from the various nationality groups of the subject population. These interviews provided generalized information which facilitated forming tentative conclusions that went beyond the observations of any one respondent.

Four (4) meetings were held with six (6) selected resource persons who were identified as experts, or as having extensive knowledge of or experience in Caribbean health issues. These meetings served as a framework for obtaining input and feedback on problems to be addressed.

Contacts were made with two (2) selected health facilities and hospitals in New York City Caribbean Community. These contacts provided the opportunity for discussions with personnel that had first hand experience with the Caribbean immigrants, particularly in the health area.

To enhance the use of these activities as a research tool, the following approach was used as a basis for inquiry and discussion:

What is the participant's area of knowledge expertise or experience?

What are the areas of agreement among the participants; areas of disagreement; and areas of conflict;

What is the contribution of the agencies, individuals, government, etc., regarding the issue of health care to Caribbean Immigrants?

What is currently being done in the area; what is being planned as future projects?

What has worked and why; what has failed and why?

What implications or consequences does the issue have among scholars, public officials, and community leaders?

The community field study activities were crucial to achieving the project's goals and objectives. The discussions held explored approaches for collaborative efforts between modern medical professionals and folk health practitioners; and approaches to provide culturally compatible services to Caribbean immigrants. These discussions also explored approaches to provide health support services to these immigrants. A major accomplishment of the field study was the identification of a number of potential panelists, moderators, participants, sponsors and co-sponsors, several of whom ultimately consented to participate in a health conference. Beyond a health conference, the activities of the field study were instrumental in initiating discussions with persons concerned with the issue of Caribbean health care regarding the development of an on-going Caribbean health advocacy group.

Operationally this project focused on convening a conference as an approach to clarify issues related to the health status of Caribbean immigrants. It also served as a forum to publicize these issues, to mobilize a cross-section of resource persons to address these issues and as an initial step in organizing a Caribbean health advocacy group. The following chapter (Chapter V MODALITY OF IMPLEMENTTION), discusses the planning, organizing and implementation of the health conference and the efforts to establish a Caribbean health advocacy structure.

NOTESCHAPTER IV

1. L. Festinger and D. Katz, Research Methods in the Sciences, (N. Y. Holt, Rinehart and Winston, 1953).
2. Edward A. Suchman, The Principles of Research Design: An Introduction to Social Research, John Doby, et. al., Chapter 10, (Stackpole Co., 1954).
3. Claire Sellitz; Marie Jahoda, Morton Deutsch, Stuart W. Cook, Research Methods in Social Relations, (Henry Holt and Company, Inc., Revised edition, April 1969), p. 98.
4. Delbert C. Miller, Handbook of Research Design and Social Measurement, third edition: (McKay Co., Inc., N.Y. 1977), p. 41.
5. Claire Sellitz, et. al., Research Methods in Social Relations, p. 52.
6. Ibid.
7. Fred N. Kerlinger, Foundations of Behavioral Research, Second Edition: (Holt, Rinehart and Winston, Inc., N.Y. 1973), pg. 346.
8. Claire Sellitz, et. al., Research Methods in Social Relations, pg 51- 53.
9. Ibid.
10. Ibid.
11. The Pilot Study investigated five areas; housing, education, labor, social services, and health. The NYUL findings identified health, housing and employment as areas of major concern. However due to the public controversy in New York City regarding the fiscal impact of providing health care to undocumented immigrants, health emerged as the most crucial issue in this city.
12. See note 3, Supra, Chapter I.
13. Fred N. Kerlinger, Foundations of Behavioral Research, p. 405.

14. Ibid.
15. Since the Pilot Study was investigating several areas, a cross-section of people were contacted. The efforts for the health conference concentrated only on persons dealing in health.
16. The health resource persons were instrumental in identifying unpublished dissertations and research on special health problems related to Caribbean Immigration.
17. One of the crucial problems identified was the high incidence of breast cancer found in Caribbean women. These findings resulted from a study conducted at the Downstate Medical Center and was one of the papers presented at the health conference.
18. New York Urban League findings.
19. Robert Merton, Social Theory and Social Structure: The Bearing of Sociological Theory on Empirical Research, Revised Edition, (Free Press, Glencoe, Ill., 1957), pp. 95-99.

CHAPTER V

MODALITY OF IMPLEMENTATION

Introduction

As a faculty member in the Department of Health Administration at St. Joseph's College, this investigator was able to convene the Health and Caribbean Immigrants Conference under the auspices of the college. (1) The conference focused on the more inclusive category of immigrants, generally. Note, however, that the pilot study described in Chapter III herein focused exclusively on the undocumented Caribbean population. A major reason for this change in target population was in order to assess the health status of the entire Caribbean community in New York City, and to examine some of the crucial health issues affecting this community. Another reason for this change because the illegal and/or clandestine nature of undocumented immigration make the gathering of information very difficult. As a result, there is no accurate figure on the size of this population in the United States nor in New York City. Current estimates are unreliable, polemical and controversial. The most comprehensive assessment on the subject is the final report of the Select Commission on Immigration and Refugee Policy, submitted to the United States Congress and the President in April, 1981, stated that the number of undocumented immigrants in the United States remains

uncertain.(2)

Because of the multidimensional nature of examining the health needs and corresponding delivery of health care services to Caribbean immigrants in New York City, it was necessary to have a design that contained the flexibility to effectively address the complexities of the problem. Among the designs considered was the development of a service delivery model to provide direct health care services to Caribbean immigrants or to set up a system of referral to direct health care services. However, after discussions with Caribbean organizations and community leaders as well as scholars and health providers this approach was rejected. A primary consideration in this decision was the lack of an established formal structure currently operating that could be used either as a referral resource or to provide the direct services. Accordingly, the institutionalization of a health advocacy group was the approach selected as the specific vehicle through which the issues of health care to Caribbean immigrants could be most effectively addressed.

GOALS AND OBJECTIVES

The major goal of this project was to organize and institutionalize a Caribbean Health Advocacy organization. A health conference was identified as a step to be used to accomplish this goal.

Having identified the goals, the objectives of the project were considered. In describing the importance of establishing objectives it was noted that, objectives have the effect of providing a frame work in which all subsequent management action takes place. Objectives channel the planning and are a prerequisite of effective planning. The decision-making process will not operate effectively if it is not oriented toward the accomplishment of objectives. (3)

Objectives are described as, "The most important consideration in decision-making."⁽⁴⁾ In determining what the objectives should be, the basic questions are: What are we trying to achieve and why are we trying to achieve it? These questions, together with the problem as identified, limited this project's goals and objectives to the following:

Goal: To improve Health Services to Caribbean Immigrants.

Objectives: The objectives were:

To convene a major organizing conference on "Health and Caribbean Immigrants in New York City."

To bring together the leadership of the Caribbean Community, immigration and health experts, and other source persons from organizations involved in immigration and health related matters.

To review with conference participants available data on the health context, impact and implication

of Caribbean migration to New York City.

To learn the participants views of the issue.

To stimulate working relationships and communication networks between the Caribbean community and organizations involved with immigrant health issues; exchange information on panelists' current work or other interests related to the subject matter.

To mobilize participants around crucial immigrant health issues providing detailed analysis which will serve as a basis for future collaborative and advocacy work

To solicit recommendations from participants regarding subsequent plans and activities toward the development and implementation of programmatic approaches and a service model to respond to the health needs of this population at risk.

To organize and institutionalize a Caribbean Health Advocacy Group to respond to the health care needs of the Caribbean immigrant population in New York City.

Once the goals and objectives were established it provided the prerequisite to setting the plans necessary to achieve them.

Project Planning

The ultimate success of a project is directly related to its planning. The function of planning is defined thusly:

"Planning is the definition and evaluation of alternative courses of action, and the selection of one alternative course which can be used more effectively to satisfy the requirement of a balance between long range and short range goals. Planning as a process results in a set of initial decisions

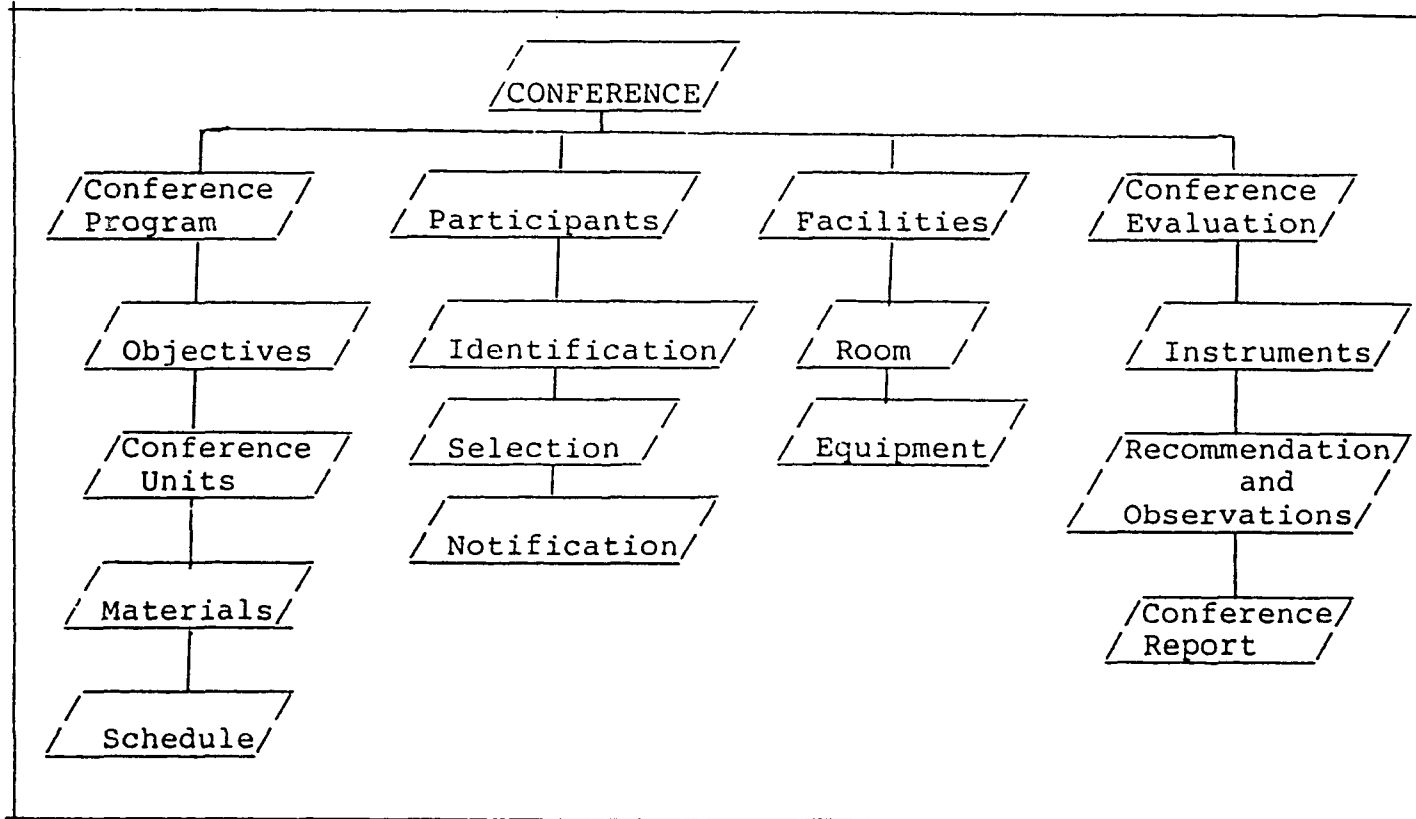
which are considered necessary to accomplish the future state of affairs desired by the planner."⁽⁵⁾

A Workbreakdown Structure (WBS) plan was used in developing and implementing the requirements of this project. The utilization of the WBS,

"Ensures that the entire project will be fully and properly related to the total project objectives....The workbreakdown structures defines the project tasks, or work to be performed and establishes the relationship between the tasks and the major project objectives."⁽⁶⁾

Chart 4 demonstrates how the goals of organizing and planning the conference was accomplished by using the WBS model. However, the WBS model could not be used as a planning mechanism for accomplishing the project's major objective of organizing a Caribbean Health Advocacy organization. Since the committee to organize this advocacy group was conceived as a by-product of the health conference, the establishment of the formal advocacy structure was dependent upon the successful fulfillment of the conference objectives. Thus, the concepts of constraints and dependency was pivotal in this process. In this context, "Constraints mean that a given activity may not start until the preceding activity is completed. A succeeding activity, however, cannot begin until its preceding event has been reached."⁽⁷⁾ Chart 5 illustrates how this process was used to show the relationship among the stages involved

CHART 4

Project's Workbreakdown Structure

in accomplishing the goals of both the conference and the health advocacy committee.

CHART 5

Project Work Flow A B

1----->2----->3

Illustration of Constraint

1=Pilot Study, 2=Conference, 3=Health Advocacy Committee

The following sections discuss the various activities that constituted the planning and implementation of the conference goals and objectives. In addition, the status of the formal health committee is discussed. The first discussion examines the responsibility of management in the successful accomplishment of the project.

Project Management

As manager and planner of this project the approaches used by this investigator were based on a variety of management models. Managerial functions are categorized as planning, staffing, directing and controlling. These functions are highly correlated and interdependent as illustrated by Chart 6.

CHART 6

Interdependence of Management Functions

Planning<----->Organizing<----->Directing<----->Controlling

The manager plays a key role as planner of any project. "If any one managerial function could be labelled as the primary function, it would be planning...."(8) Planning requires that the manager establish specific objectives and procedures for the allocation of resources available to attain the desired objectives. It includes budget plans, advertising plans, program plans, time-schedule plans, personnel and materials. "Simply defined, planning is the systematic process by which we decide what will be done in the future and how it will be done." (9)

The pilot study provided the basic framework for organizing a health conference and, although the conference envisioned by that study never came to fruition, many of those plans were still applicable to this project. (10) Those plans were reviewed and revised. In addition, new plans were developed to meet the particular needs of this project.(11) In doing this, manage-

ment strategies were key. Accordingly management models were described as follows:

To oversimplify, there are two types of management. That which is done at the top of an organizational structure is strategic management. Everything else is operational management.... Strategic management provides guidance, direction, and boundaries for operational management.... (Strategic planning) is a process that begins with the setting of organizational aims, defines strategies and policies to achieve them, and develops detailed plans to make sure that the strategies are implemented so as to achieve the ends sought.⁽¹²⁾

Accordingly, the first step in the project's implementation was the formulation and implementation of the management process strategy. This process includes: establishing goals; setting objectives; planning strategies; developing a philosophy; providing personnel; establishing procedures; providing facilities; providing capital; setting standards; establishing management programs and operational plans; providing control information and activating people. Based on these steps, a model for developing strategic plans was constructed and adhered to. An adaptation of this model is illustrated in Chart 7.

The first act of strategic management in bringing the health conference to fruition was to develop a master guide for accomplishing the goals of the project. Included in this guide were provisions stipulating the task development and schedule of the key personnel and

CHART 7.

SAMPLE OF CONCEPTUAL MODEL FOR DEVELOPING STRATEGIC
PLANS FOR PROJECT IMPLEMENTAION

1. Formulate Project mission, thrust, purpose, and objectives (Short-term and Long-term)
2. Formulate the tasks to be accomplished
 - . Define scope of plans
 - . Define results sought
 - . Determine how plans are to be developed
 - Who does what:
 - Timing
 - Informational request
3. Analyze Actors (Service Providers, personnel, consultants, participants, panelists, sponsors, target population)
 - . Who are they?
 - . How should they be classified?
 - . What is their interest in project?
 - . How will project be marketed?
 - . What are their needs?
4. Develop and Analyze Input
 - . Issues, trends, pacesetters, needs, legislation, Literature review.
5. Identify project's strengths, weaknesses, opportunities, constraints, momentum, activities.
6. Identify strategies to exploit opportunities and strengths and to minimize weaknesses.
7. Evaluate alternative strategies.
8. Select feasible strategies; determining which strategies will achieve which objectives.
9. Prioritize strategies and prepare detailed plans to implement them.
10. Develop contingency plans.
11. Translate plans into budget.
 - . Determine financial needs.
 - . Prepare fund development strategies
12. Prepare other project related plans
 - . Manpower requirements, allocation and deployment.
 - . Organizational requirements.
13. Monitor and Evaluate Performance.
14. Replication, Recycle.

the support personnel. Key Personnel: These included conference convener, a protocol position headed by the Dean of General Studies of St. Joseph's College; Conference Coordinator, who was responsible for managing the entire conference operations; Assistant Coordinator, responsible for the day-to-day programmatic and operational aspects of developing and implementing the conference; Public Relations Specialist, responsible for organizing the press conference, media promotion and publicity; Technical Committee, which provided guidance and technical assistance toward the development and implementation of the conference; Conference Committee consisting of volunteers who assisted in programmatic operations such as correspondence, registration, reception, luncheon, publicity; Reception Committee which was responsible for planning, funding and catering the reception.

Support Personnel: Provided auxiliary services and included photographer, printer, caterer, recorders, runners, floor guides, translators, security, set-up and clean-up crew, child care personnel, registration desk crew, exhibit table crew, and audio-visual technicians.

The conference planning guide provided the framework for management of the project. It was the mechanism for determining time, costs, and personnel

specifications. It contained provisions for each stage of the project provided information down to the smallest conference detail. A copy of the conference masterplan is included in the appendix.

The next step in planning for the conference was to identify and recruit staff for the pre-conference activity. This process consisted of identifying activists, students and other persons who were willing to commit their time and energy toward achieving the project's goals. Due to budgetary limitation (which is discussed below), the major task of the manager here, was to obtain the services of willing volunteers. To resolve part of the staffing needs without any expenditure of funds, a student was recruited from St. Joseph's College, Independent Studies Program, to use as Assistant Project Coordinator for the duration of the project. Other volunteer staff included a college professor, a lawyer, a doctor, a photographer, a public relations specialist, health administrator, a nurse, a child psychologist, and the project manager's family members and friends. Student volunteers were assigned to compile a health resource directory on health related organizations, agencies and officials. This directory was one of the tools used in soliciting conference participants.

This staff formed the core personnel to accomplish

the pre-conference activities. Due to the professional status of the volunteers in the project, the manager had to be sensitive to super-ordinate/sub-ordinate roles.

The traditional superior-subordinate role becomes inappropriate when working with (professional) individuals. These professionals often are concerned with how the task is accomplished and may conflict with the project manager who is more concerned with the what and when of task accomplishment.⁽¹⁴⁾

In this context, building group morale and maintenance was highlighted. In addition, because the manager had experience in negotiation and problem solving, he was able to negotiate solutions to the many small problems that arise in projects such as this and to establish positive relations with and among both the staff and the community. The responsibility assumed by the staff included:

Administration

- Designed program and printed material
- Drafted correspondence and program
- Monitored support operations

Communications

- Drafted press releases, flyers, posters, etc.
- Promoted media relations (radio, t.v., newspapers)
- Corresponded with panelists, co-sponsors, and participants
- Conducted telephone outreach operations

Performed mailing tasks

Day of Conference

Staffed registration desk

Acted as hosts/hostesses

Organized luncheon and reception catering

Provided technical support

One of the major concerns in implementing this project was obtaining an institution to sponsor the conference and which would serve as the conference site. Among the available alternatives, ⁽¹⁵⁾ St. Joseph's College was selected for the following reasons:

The conference coordinator was a faculty member at the college;

The college is centrally located, with a large Caribbean student body in its Community Health and Health Administration program;

This student body and alumni association could serve as an interested, targeted audience to participate in the conference; and

The college is located in the accessible periphery of the largest Caribbean community, the Crown Heights/East Flatbush area of Brooklyn.

These features made St. Joseph's College the ideal site to have the conference. Therefore, a proposal was submitted to the college administration and it subsequently agreed to serve as the principal conference convener, sponsor and host. However, in negotiating the specifics related to implementing the conference design,

infra-structural tensions emerged. Because the introduction of this project into the college's organizational and operational structure implied additional demands on the institution's allocation of resources and personnel, conflicts arose.⁽¹⁶⁾ In this context:

Many persons are upset and disturbed when existing systems and procedures are abandoned, and new ones employed. The unique nature of project management systems is likely to create some anxiety when terms like management, planning and control are used. Misunderstanding these concepts can create emotional reactions which (may) block successful implementation.⁽¹⁷⁾

The resistance by the college was not just limited to use of its facilities for pre-conference activities. The college administrator also attempted to absolve the college for having primary fiscal responsibility for the cost of the conference. The role of the manager in the resolution of this type of conflict is:

To integrate and coordinate organizational resources to accomplish objectives as effectively and efficiently as possible...Integration of technical, social, and environmental requirements calls for active involvement, dynamic and flexible behavior and intellectual awareness on the part of the manager. Planned change is directed at alterations in the utilization of resources.... (It) aids in moving from the actual condition to the desired one.⁽¹⁸⁾

Thus, with the consent of the college, the project manager opted not to rely on either the college's resources or its structure for implementation of activity, instead, to create an off campus base of operations.

Conducting pre-conference activities off site enabled him to maximize authority, and gave him the functional autonomy and territoriality, all of which facilitated effective implementation of the project. The off-campus office served as a central command post, a communications, monitoring and control center with independent personnel and materials capable of meeting the project's programmatic and operational demands. However, the college remained the site where the conference would be held and the original proposal served as a policy statement, stipulating to the college administration as follows:

- a) the organizational and operational aspects of the project;
- b) the resource network that would be tapped for support;
- c) the work flow plan and other technical dimensions of the implementation.

In addition, the following concerns were discussed with the college administration in anticipation of the approaching conference date:

- Closer control of complex project planning;
- More efficient use of resources;
- More detailed planning and scheduling;
- Forecasting any eventual bottlenecks;
- Identifying critical activity requiring immediate attention;

Testing alternative solutions;

Securing better coordination between operations.

While the off-campus office provided distinct advantages in the organizational and operational aspects of the project's implementation, this separate arrangement created fiscal demands from the project manager. Because of the college's resistance to deploying its fiscal resources, the major responsibility for funding fell on the project manager. These demands required diplomatic fiscal negotiations in order to obtain subsidies for necessary expenses. Numerous funding sources such as private philanthropic organizations, health agencies, government agencies and private individuals were solicited for funds. As noted previously, much of the budgetary expenses were relieved because the manager was able to obtain an all volunteer staff. In addition, some agencies which were unable to contribute money, contributed by way of permitting the use of equipment such as office machines, or donated supplies of paper or other materials. By using creative planning, the project manager was able to keep expenditures far below that which would ordinarily be incurred by a conference of this magnitude and quality.

The project manager provided the leadership for integrating and systematizing decisions, policies and

managerial priorities for the various functional and organizational elements. The basic approach was to mobilize support networks and resource organizations; reach out to the political elite or those within the Caribbean health profession and academic community who occupy leadership positions. A personalized or one-to-one contact by telephone, mail or, preferably, in person, was found to be most effective. The final structural design for implementing the health conference is described in the following sections.

STRUCTURAL ARRANGEMENTS

Essential to the execution of this project was the creation and successful operation of various committees. The functions required were assigned to three committees. The first committee, the technical committee was responsible for assisting with the initial planning for the conference. The second committee, the conference committee was responsible for conference implementation. The final committee, the post-conference committee was responsible for carrying out the mandate of the conference. The following discussions addresses some of the specific duties of each of these committees.

The Technical Committee

This committee served the same function here as

that of the technical committee in the pilot study. It was the mechanism for convening a distinguished, multi-disciplinary panel of Caribbean, immigration and health specialists. Its functions included:

Providing direction and technical assistance in refining the project's design and methodological thrust.

Identifying resources and operations to enhance and achieve the project's goals.

Frequent briefings with the project manager to report progress made, problems encountered or other activities.

Providing guidance toward implementing the project's mission.

Frequent informal meetings were held with individual members of this committee. These persons helped to identify various resource agencies and other persons that were concerned about the health status of Caribbean immigrants. They provided the bases for developing the programmatic and operational aspects of convening the conference.

Conference Committee

This committee was composed of a cross-section of volunteers previously identified as key and support personnel. This was the "working" committee. Its responsibilities included: preparing, mailing and following-up on correspondence; selecting, contacting and confirming participants; constructing publicity

tools including posters, flyers and pamphlets; organizing media coverage such as newspaper items; planning and monitoring luncheon and reception activities; carrying out registration and other conference tasks. This committee was divided into the following sub-committees:

CONFERENCE SUBCOMMITTEES

Communications

- Secure specialized mailing list
- Pre-Conference outreach letters
- Conduct telephone followup campaign

Sponsorship

- Identify resource agencies as prospective co-sponsor
- Determine the terms for co-sponsorship
- Contact prospective co-sponsor

Credits and Accreditation

- Outreach to health-related professional organizations regarding conference accreditation.
- Determine procedure for Creditation (continuing education credits)
- Issue certification to participants registered for credits

Fund Development

- Develop budget and funding strategy for the Conference
- Solicit grants

Maintain accounting record of expenditures used monies

Journal

Develop editorial schedule for the conference

Determine the readership breakdown and project circulation

Determine advertising rates

Design advertisement contract

Public Relations/Publicity

Develop flyers, invitations, brochures, posters, etc.

Develop and disseminate pre and post-publicity announcements i.e., press releases, public service announcements, etc.

Develop media strategy

Mobilize printed and electronic media coverage

Develop promotional folders for distribution to conference participants

Assign photographer for event coverage

Arrange press desk and on-site press conference

Publication

Retrieve panelist papers for pre-conference review

Duplicate papers for dissemination

Develop publication strategies (note: solicit grant)

Arrange publication of conference proceeding and papers presented

Research

Data collection, data analysis and data synthesis to document crucial health issues, (e.g. health statistics, demographic profile)

Develop fact-sheet on the health status of Caribbean immigrants for dissemination at conference

Registration/Reservation

Set-up and monitor registration table

Distribute name tags for participants

Pre-registration strategy

Collect registration fees,

Provide "tax-deductible" receipts

Participations lists

Reception

Provide coffee, doughnuts and refreshments for coffee breaks

Make catering arrangements for luncheon and cocktail reception

Arrange luncheon and reception program and speakers

Make arrangements for plaques to be awarded to the honorees.

Speakers

Establish criterion for selection of speakers based on:

Expertise in area

Leadership/professional involvement in area

Demonstrated willingness to participate in future Caribbean health and community programs.

Formulate program format (i.e. roles of panelists, moderator) and presentation schedule.

Conference Implementation

The intent of this health conference was to formulate a Caribbean Health Advisory group as the ultimate goal of this project. However, it became apparent that this could not be accomplished without further assessment of the issues through an examination of some of the information obtained for the conference panel discussions. Therefore, a post-conference committee was formed to examine the issues and develop a framework for accomplishing the goal of the health advocacy group. This committee was not formed until after the conference. However, the technical committee and conference committee performed all the tasks necessary to plan, organize and implement the health conference.

One of the key considerations in developing the conference was to identify the special problems that needed to be addressed. This was necessary in order to develop an effective plan of action for improving health care to Caribbean immigrants which was the final mission of the project. One of the key planning issues then was, what should be the format of the conference. With input from the joint committees, and the consultative advice of health officials, community leaders, academicians, immigration officials and immigrants, a conference pro-

gram was developed. The following four areas were identified as crucial areas to be discussed:

An assessment of crucial health issues in the Caribbean community in New York City;

The policy aspects of delivering health services to Caribbean immigrants;

Cultural patterns influencing health practices of Caribbean immigrants;

Strategies for improving the delivery of health services to Caribbean immigrants.

On December 16, 1982, major conference, "Health and Caribbean Immigration to New York City: Context, Impact and Implication," was held at St. Joseph's College Brooklyn, New York. This conference was a major undertaking since it was the first forum of such caliber to assess these crucial issues in New York City. The conference was convened by St. Joseph's College, Department of Community Health and Health Administration. Agencies such as the New York Health and Hospital Corporation, the Local District 1199 (Health and Hospital Workers Union), the New York Urban League and the New York Migration Forum readily agreed to co-sponsor the program. (see the appendix for other co-sponsors). The issues were presented in the format of panel discussions. Each of the panelist was either engaged in research relevant to the area of discussion or was employed in the field of health in New York City. The

appendix contains a list of the names of the panelists.

The conference was designed to provide a forum for specialized information regarding the health care status of Caribbean immigrants. Accordingly, there was a need to obtain the opinions of persons from diverse backgrounds in health or Caribbean immigration issues. Therefore, in addition to the panelists, selected health professionals, policy makers, community leaders, legislators and officials from international, diplomatic and service agencies were invited. It was felt that such a select group of individuals would insure maximum participation in the discussions and would also provide valuable information based on their experience in the subject area. In fact, the exchange between these participants and the panelists during the question and answer period further delineated some of the problems and provided essential clarification of some issues.⁽¹⁹⁾ The conference proceedings were audio taped to facilitate future publication of these proceedings. The following discussion summarizes the salient points of the panel discussions.

SUMMARY OF PANEL DISCUSSIONS

The conference format included an overview discussion and four panels. The overview was intended to provide the foundation for the issues to be addressed

by the panelists. The panel discussions focused on each of the areas identified earlier as crucial issues affecting the health status of Caribbean immigrants in New York City.

The overview addressed the pilot study's findings and recommendations. It emphasized the need to further examine issues related to immigration generally and the specific issue of Caribbean immigration, with a focus on health care.

Among the problems identified by the panel in discussing Crucial Health Issues in the Caribbean Community, were the following: Physical and mental problems caused by the inherent stress resulting from the immigration process. These problems are often manifested by feelings of depression, irritability, apathy, resentment, loss of control and other mental states.⁽²⁰⁾ Immigrants also often experience marginality in the system which sometimes results in mental problems.⁽²¹⁾ Caribbean immigrants often encounter social and cultural adjustment problems. For example, it is often necessary for parents to migrate and leave their children with relatives in the Caribbean. Sometimes the separation is for several years. When the young people finally migrate and join their families they are faced with renewing relationships with the absentee parents, while at the same

time, adjusting to a new and oft times hostile environment. The result usually is difficulty such as, performing at less than academic capacity dropping out of school or other inappropriate behavior.⁽²²⁾ Another crucial health issue presented based on a recent study conducted by Downstate Medical Center indicates that Caribbean women are found to have a high incidence of breast and cervical cancer in advanced stages, resulting in the highest mortality rate due to these diseases in New York City.⁽²³⁾

The panel on Policy Aspects of the Delivery of Health Services to Immigrants consisted of persons who were either employed by government agencies or had a demonstrated involvement in health or immigration.⁽²⁴⁾ The question posed by the moderator to be addressed by the panelists was, "Is there a need for a Caribbean policy on health." One panelist responded "there is a need for a health policy for Caribbean immigrants just as there is a need for a health policy for any large immigrant group."⁽²⁵⁾ Poverty was cited as a serious barrier to obtaining proper health services and to practice preventative health care was viewed as critical.⁽²⁶⁾

The problem of getting reliable statistics on undocumented immigrants and the high risk confronting

this population was emphasized.⁽²⁷⁾ The Simpson-Mazzoli Bill currently pending in the U.S. House of Representatives, contains provisions for limited medical assistance for legalized aliens. However, the Senate bill provides for an absolute bar to aliens participating in any Federal benefit programs.⁽²⁸⁾

The city government's policy of maintaining the health of persons living in New York City was pointed out with the additional statement that these services were available without regard to immigrant status.⁽²⁹⁾ The monitoring of the health status of persons entering the United States was also discussed. However, it was noted that there were no programs addressing immigrant health issues.⁽³⁰⁾

The third panel, entitled, "Exploring the Cultural Patterns of Health Practices of Caribbean Immigrants," presented various discussions dealing with the socio-cultural perspective on health and the Caribbean immigrant in New York City. Some immigrants experience difficulty in adapting to new society because of cultural differences. Some times, victim-blaming results when the immigrant is unable to adjust. On the other hand, health providers are often ignorant of the cultural background of the Caribbean immigrants.⁽³¹⁾ Cultural practices such as the use of therapeutic baths to treat

illnesses and other cultural practices such as praying in the time of crisis must be known and acknowledged in order to deal effectively with health problems in this population.⁽³²⁾ This includes an understanding of the practice of an alternative approach to health care in the form of spiritual healing.⁽³³⁾

The final panel discussed issues related to developing "Strategies to Improve the Delivery of Health Services to Immigrants." It was pointed out that there was a need for health providers to develop a strategy to address issues related to the different levels of health problems among immigrants in the city.⁽³⁴⁾ For example, there were three generations of immigrants in the city's population. Each of these groups had health problems that were specifically related to their immigration status. However, most medical schools did not preparing doctors to treat these problems. The second generations and subsequent generations tend to suffer from alienation and a feeling of loss of cultural identity. While, many among the earlier generation have been away from their native country so long that they tend to loose some of the cultural and social ties. However they are still not assimilated into the new culture. As a result, they experience severe mental and emotional stress which is manifested by many of the symptoms discussed earlier.⁽³⁵⁾

The third generation suffers the same health problems as native Blacks or white lower economic groups. These problems include occupational diseases from exposure to hazards connected to lower socio-economic type jobs; a lower life expectancy due to poor living conditions or neglect of health care; lower survival rates of newborn because of poor health and living environments.⁽³⁶⁾ Some related problems include variety of tropical type diseases, hypertension, and stigmatization and certain diseases (such as the case of (AIDS) in the Haitian population.

Another area of concern in developing strategy to improve health care delivery to immigrants is the problems of inadequate communication. While the New York City Health and Hospital's policy may be to provide health services to everybody, the lack of an adequate communications process often pose a block to access for proper service.⁽³⁷⁾ Many immigrants seeking services do not speak English. Often there is not enough health provider personnel conversant in the relevant language. Even where translators are available, the current service procedures are haphazard and communication is often misdirected and misinterpreted. Vital information is often omitted or a different meaning is ascribed to words resulting in erroneous health assessment.

Any attempt to resolve these various problems must use a diversified approach. Consideration must be given to the differences in culture and the proper communication medium must be used. An important requirement for resolving the problem is to state the problem to the proper agencies, using the proper channels. These are usually the health advisory boards, state, local or federal representatives and select community agencies.(39)

One approach to developing a program to focus on health issues related to Caribbean immigrants is to establish a Caribbean American Health Resource Registry Bank in New York City, which identifies health related professionals with specialities focusing on problems affecting this immigrant group and with an insight into the cultural ethos of this group. Another approach is to establish transnational programs directed to both the local Caribbean community and to those within the Caribbean region. For example, the New York based Caribbean Medical and Educational Foundation is currently developing plans to establish a Medical Research Institute in Barbados, W.I.(40)

Such programs could be the vehicle to provide technical studies on diseases in the Caribbean area and Caribbean communities worldwide. The curriculum would

include educational programs to train allied health personnel and would create a communications health monitoring network among the various islands and the United States.⁽⁴¹⁾

CONFERENCE EVALUATION: REPORT OF FINDINGS

A conference evaluation instrument was constructed to obtain feedback from the conference participants. Several important issues were considered in developing the instrument. For example, the instrument had to be non-intrusive and simple enough that a maximum number of participants would complete it. At the same time, the response needed to be complete enough to provide information to aid in the formation of the proposed health committee. Further, it was envisioned that the information obtained from the conference questionnaire would assist the committee in developing a framework for a program to address the health problems facing the New York City Caribbean population. A copy of the instrument is contained in Exhibit C.

Consistent with these concerns, a two part instrument was constructed. The first part requested evaluations of specific panel topics and discussions. This part basically required a yes or no response. However, there was space for additional remarks.⁽⁴²⁾ This format was thought to be sufficient for this section because

the panel of experts were relied on to provide the primary data in this area. Nevertheless, any additional remarks by participants were considered on the conference evaluation.

The second part of the instrument requested additional analysis of the conference's content and presentation. It also asked for suggestions and other information related to health care. In addition, information was elicited regarding the participant's background and experience in the health care field and whether they were willing to participate in future efforts directed at resolving health care problems confronting Caribbean immigrants in the city. Chart 8 is a sample of the responses received from 45 of the 150 conference participants.⁽⁴³⁾ Note that the Evaluation instrument (questionnaire) is in the conference program, Exhibit B - Appendix.

The aspects of the conference that participant's viewed as most valuable, (question #9), were first, the general information provided by the conference and second, the opportunity for networking. The least valuable aspect, (question #10), was identified as the lack of time to develop the various areas and obtain more information through questions and answers.

Question #11 provided valuable information regard-

CHART 8 - CONFERENCE EVALUATION

PANEL	QUESTION	RESPONSES		TOTAL # OF RESPONDENTS
		YES	NO	
Overview	1. Were issues effectively addressed?	32	3	35
Crucial Health Issues	2. Were the critical issues identified?	30	6	36
Policy Aspects	3. Were relevant issues highlighted?	31	7	38
Cultural Patterns	4. Were key issues explored?	32	4	36
Strategies to improve services	5. Were innovative alternatives presented?	28	8	36
Conference Assessment	6. Was it informative and provided new ideas?	33	5	38
	7. Did it make you more aware of barriers to services?	32	8	40
	8. Was information gained helpful to providing services to immigrants?	38	4	42

ding the major concerns of the conference participants. That question asked which of the conference participants. That question asked which of the conference topics needed to be developed more fully. The area referred to most related to immigration and listed concerns such as:

Amnesty and the Immigration Reform Bill;

Immigration and Naturalization Services policies;

Haitian problem;

Undocumented immigrants (payment for medical care/legal status/confidentiality).

Concern was also voiced regarding the need for more information on crucial health issues and more specific health care delivery planning, including how to obtain grants and financing for providing services. Thirty of the participants, (question #12), indicated a willingness to work with a task dealing with Caribbean immigrant health care.

Question #13 was aimed at identifying participants who were involved in health care and/or immigration. 39 persons responded, of these, 23 reported involvement in one of these areas. Agencies listed included, New York Migration Forum, Haitian Center Council, Wyckoff Heights Hospital, Coney Island Hospital and Downstate Medical Center.

The final question (#14) was included to provide the conference participants an opportunity to comment on any aspect of the conference related to the issues of presented. While responses were generally favorable, several referred to time limitation as a problem. For example, "This conference was a very high caliber. I think it should be spread over more days." "It brings to light a lot of hidden health factors. Future conferences such as today's event is appropriate." "We certainly need a followup on this conference, with less speakers and more subjects more deeply debated." The consensus of opinion held the view that the conference was well organized and informative and that they would support efforts to resolve the health care problems facing Caribbean Immigrants in New York City.

A luncheon press conference was held to enable the moderators to publicize their reports formulated from respective panels and to provide an opportunity for the panelists to defend their positions. At this Luncheon a resolution was introduced by the Conference Coordinator and ratified by the conference participants calling for the establishment of a Caribbean Health Advocacy Task Force. This Task Force's goal was to monitor health issues impacting on the Caribbean Community in New York City and to lobby for the effective delivery of culturally compatible health-related programs directed

to this population. The reception which followed the conclusion of the conference provided a more informal setting for exploring and examining the issues presented. The Conference provided a forum for the expression of many points of views on the health status of Caribbean immigrants; it presented and analyzed up-dated research findings and current legislation on immigrant health issues. The conference outcome yielded the following:

Convened participants with direct or related involvement in immigration and/or health matters.

Facilitated exchange of information crucial to a better understanding of the health context, impact and implication of Caribbean migration to New York.

Focused on the health aspects of immigration, clarifying immigration policy issues, eliciting innovative ideas and concerns of participants towards providing health services to immigrants.

Outlined subsequent plans and activities to be carried out by participants, particularly by the Caribbean Health Advocacy Task Force.

POST CONFERENCE ACTIVITIES

Post conference discussions were held with some of the conference participants, selected by the coordinator, regarding the development of a framework for institutionalizing the Caribbean Health advocacy task force.⁽⁴⁴⁾ As a result of these discussions, the Conference Coordinator agreed to Chair the Task Force with an initial responsibility to explore the feasibility of

incorporating the Task Force into an existing Caribbean organization.

This decision was based on the fact that there were numerous Caribbean organizations already in existence which focused on Caribbean health issues. After serious discussions regarding whether to set up a new organization or to integrate the proposed advocacy group into one of those already in existence the latter option was chosen. Thus it became the initial responsibility of the task force to identify the organization. Among the groups considered were some of the well established nurses associations (i.e., Barbados Panama, Guyana); The Caribbean Women's Health Association a recently established organization of professional women concerned with health issues affecting the Caribbean population; and the Caribbean Action Lobby, concerned with advocating issues affecting this community on the local state, national, and international level.

In addition to the initial organizing functions, the Task Force established the following guidelines:

The health advocacy group will be charged with planning developing and implementing strategies and programs directed toward obtaining adequate and effective health care for the Caribbean population in the city;

The group members will be selected based on a record of leadership and/or expertise in health or immigration related issues and a willingness to

serve on a voluntary basis.

Members must demonstrate a commitment to implement a health service delivery model responsive to the needs of the subject population.

Some of the suggested activities were to:

Develop alternative programmatic approach responsive to the population. This objective was to be achieved in part, by fielding a health survey questionnaire to obtain information from both the health providers and consumers in the Caribbean community of the City of New York. (45)

Organize and conduct public forums, workshops and briefings locally, nationally, and internationally in the Caribbean communities throughout the United States and in the Caribbean. These activities would be geared toward immigrants participation.

Organize and conduct regular public conferences involving professionals and lay persons from diverse agencies working with immigrants or in areas related to immigration or health.

Prepare and circulate newsletters informing the public of emerging on-going immigrant related health developments.

Develop effective funding strategies to subsidize organization efforts and to support implementation of the health service model.

Due to the fact that the Caribbean Women's Health Association was still in it's embryonic stage with a highly enthusiastic membership that were interested in the advocacy model, this organization was selected as a viable structure to institutionalize the Caribbean Health Advocacy thrust. This integration was accomplished by transforming the Task Force into an Advisory Board of the Association. Additional Board

members were recruited by the association. Board members were invited to a briefing session on the health issues of focus, followed by a formal installation ceremony and reception. (See - Board Membership Roster and Profile of Caribbean Women's Health Association in Appendix.)

An unanticipated by-product of the conference was the development of a New York City Caribbean American Resource Directory by this writer. The need for this was highlighted by the extensive work involved in organizing the conference and the frustration encountered by not having any centralized source of information. This directory is the first and only comprehensive, updated, easy to use, centralized resource guidebook available. It yields valuable information on the wealth of resource organizations in the Caribbean American community; including not readily accessible market intelligence, demographic, and statistical data about the Caribbean population in New York City. It serves as a basic tool for professionals in Health, Education, Social Service, Diplomatic, Business and Public Service Field. In addition, it serves as a instrument to foster closer communication and interaction between the various Caribbean groups, as well as for improved interaction between these groups and other ethnic groups.

The knowledge gained from organizing and implementing the health conference called attention to the severity of the health care situation confronting Caribbean immigrants in New York City.⁽⁴⁶⁾ This situation clearly indicated a need to examine the problem from an international perspective. This investigator envisioned a program of comparative health fact finding tours to the Caribbean by New York City Health providers, as a viable mechanism for improving health care delivery services. This view is based on at least two considerations. First, this investigator participated in a fact finding health tour to Cuba in 1979. The purpose was to examine and assess the provisions of health care services in a developing country.⁽⁴⁷⁾ This tour heightened the awareness of the differences in the health policies and practices of third world countries and the necessity of conducting further studies in this area. Second, several of the panelists discussed the cultural influences on health care utilization. Additionally, other problems such as family and adjustment problems indicate a need to study issues related to immigration and immigrants in the environment of the immigrants' country of origin.

To test the feasibility of conducting these tours, this investigator visited two other Caribbean countries. The first, was a trip made to Trinidad and was for the purpose of investigating the procedures for establishing

the infra-structure to conduct health fact-finding tours to that country. Most of the activities on that trip involved meetings with various persons that held positions or had influence in the subject area. Included were officials from the Ministry of Health, officials of the Pan-American Health Organization, the Trinidadian Medical Society and other health officials. While this trip was useful in terms of providing an opportunity to examine some of Trinidad's health practices and policies, no consensus was reached regarding conducting the health fact-finding tours to that country.

The second trip was made to Jamaica West Indies. This trip was a field tour sponsored by St. Joseph's College and with participation by a group of students majoring Community Health and Health Administration. However, the decision to participate in the practicum was based on the same considerations that motivated the trip to Trinidad. Here, as there, the major focus of this investigator was to establish an infrastructure to conduct health fact-finding tours.

Jamaica was chosen as the site for investigation because it was viewed as the logical environmental prototype or model.⁽⁴⁸⁾ In addition, the health administrators in Jamaica demonstrated a strong willingness to participate in comparative, international and trans-

cultural projects. These officials facilitated access to the institutions and officials who were necessary to accomplish the project's goal.⁽⁴⁹⁾ Some of the persons with whom discussions were held included: The Minister of Tourism; Caribbean Nurses Association; Jamaican Nurses Association; officials from the Jamaican Ministry of Health; officials of the University of the West Indies.

The objectives of the health fact-finding tours were envisioned as follows:

To provide the opportunity to observe the Caribbean health care system to gain insight into how it is administered; the degree of its effectiveness; and how the system compares to the New York City system.

To afford the opportunity for first-hand observation of the cultural variables that influence how Caribbeans utilize health care services.

To provide first hand observations of the political, economic, and social conditions that might influence health status and health care.

To provide the basis for developing an on-going relationship between overseas Caribbean health providers and health providers in New York City. This would facilitate the exchange of professional expertise and would form the basis for broadening the perspective of the New York City's health providers, as a whole, regarding specialized situations affecting health care to both the Caribbean community here and abroad.

These initial studies regarding the feasibility of

such tours have resulted in preliminary plans to conduct a series of seminars, targeted to American business executives, in two Caribbean countries under the auspices of the New York State Department of Commerce, United States Department of Commerce, United States Department of Commerce and the Agency for International Development (AID). These programs are geared to stimulate user relationships, particularly in the area of the health industry, between the public and private sector in the American and Caribbean Communities.

NOTES

CHAPTER V

1. This investigator had more than seven years experience as a faculty member in the Department of Community Health and Health Administration at St. Joseph's College, Brooklyn, New York. He has actively participated in numerous Caribbean community projects.
2. Public Law 95-412 ratified October 5, 1978 established the select commission on Immigration and Refugee Policy, to study and evaluate...existing laws, policies, and procedures governing the administration of immigrants and refugees to the United States and to make administrative and legislative recommendations to the President and to Congress as are appropriate.
3. Desmond Cook, Educational Projects Management, Columbus Ohio: Charles Merrill Publishing Co., 1971, p. 32.
4. Ibid., p. 33.
5. Ibid., p. 19.
6. Ibid.
7. Ibid., p. 88.
8. Ibid., p. 19.
9. Theo Haiman, Supervisory Management for Health Care Institutions, The Catholic Hospital Association, St. Louis, Mis., 1973, p.8.
10. As part of the pilot study, preliminary plans for a major conference on Caribbean Immigrants in New York City convened by the NYUL and sponsored by B.C. African Studies Department and the Caribbean Student Union were made. However, initial funds for the pilot study ran out and the project was not refunded.
11. The pilot study conference was to focus on Caribbean Immigrants in New York City generally. The instant project deals specifically with the health status of Caribbean Immigrants in New York City.

12. George Steiner, Strategic Planning: What Every Manager Must Know, London: Collier MacMillan Publishers, 1979, pp. 4-14.
13. Marvin Bower, The Will To Manage: Corporate Success Through Programmed Management, New York: McGraw Hill, 1969, pp. 17-18.
14. Cook, Educational Project Management, p. 10.
15. Prospectives included the New York Urban League; Brooklyn College and Hunter College and the Rockefeller University.
16. Given that these conflicts were predicted, planned solutions were at hand in the event conflicts were not ultimately resolved.
17. Cook, Educational Project Management p. 216.
18. Margaret Fenn, Women Executives in a Changing Environment, Prentice Hall Inc., Englewood, N.J., 1980 p. 211.
19. For example, a member of the audience questioned the representatives of the New York City Department of Health regarding the reluctance of undocumented immigrants to seek medical services because of fear of collaboration of the health facilities with immigration authorities. Charles Rogers, M.D., of Kings County Hospital and William Nute, of the New York City Department of Health stated that it was the policy of the Department to render to all people, without question, all services that it is funded to provide.
20. Dr. John Cardwell, Evax Corporation.
21. Dr. Bert Thomas, Brooklyn College.
22. Ms. Hazel Reid, Hunter College.
23. Ms. Barbara Habenstreit, Downstate Medical Center.
24. Dr. Waldada Stewart, Mid Brooklyn Health Association; Ms. Harriet Dronska, New York City Health and Hospitals Corporation; Dr. Sally Guttmacher, Rutgers University; Dr. Earl Huyck, National Institute of Health; Dr. William Nute, New York City Department of Health.
25. Dronska.

26. Ibid.
27. Huyck.
28. Guttmacher.
29. Nute.
30. Huyck.
31. Dr. Charles Green, Hunter College
32. Dr. Carroll Weiss, West Brooklyn Feasibility Study.
33. Dr. V. Rex Archibald, Rama Institute.
34. Dr. Roberto Belmar, Montefiore Hospital.
35. Ibid.
36. Ibid.
37. Ms. Naomi Santana, New York City Health & Hospitals Corporation.
38. Ibid.
39. Ibid.
40. Dr. Milton Haynes, Caribbean Medical & Educational Foundation.
41. Ibid.
42. Some of the relevant remarks are noted supra p. 112.
43. There are approximately 100 participants; including panelists, moderators, etc. A portion of the evaluation forms were misplaced.
44. Members of the Task Force were: Ms. Yvonne Graham, Caribbean Womens Health Association; Dr. Rex Archibald, Rama Metaphysical Institute; Lamuel Stanislaus, D.D.S. Provident Medical Society; Marco Mason, Chairman of the Task Force; Dr. Waldaba Stewart, Mid-Brooklyn Health Association.
45. See Battery of instruments in the appendix.
46. Three of the most serious issues were: The high incidence of breast and cervical cancer reported

among Caribbean women and the resulting high mortality rate; the severe mental and adjustment problems experienced by many immigrants and particularly the youth; the crisis in health care to undocumented immigrants because of their continued reluctance to utilize health care facilities due to their status.

47. The Cuban fact-finding tour provided a framework to examine international health programs in the field including socialized medicine; folk medical practices and other health practices from a cross-cultural perspective.
48. For example: Jamaica is the largest and most populous Caribbean Island; the University of the West Indies Medical School is located there; the island plays a pivotal role within the Caribbean Community of Nations.
49. Jamaican officials conducted site visitation to hospital facilities in Montego Bay; they organized a seminar focusing on the public health situation in Jamaica. Panelists included representatives from academic organizations.

CHAPTER VI

SUMMARY AND CONCLUSION

This project was intended as a vehicle through which to establish and institutionalize a health care advocacy group for Caribbean immigrants in New York City. The objectives of the project were to convene a body made up of various individuals and representatives from organizations in the areas of health and/or immigration for the purpose of:

- a) examining the context, impact and implications of the health care status of Caribbean immigrants in New York City;
- b) eliciting recommendations for developing a health service delivery model;
- c) developing a working committee to implement that model and to advocate on behalf of health issues impacting the Caribbean community in New York City.

This project was grounded on the following premises:

- a) The increase in the Caribbean population was a result of the more favorable provisions of the 1965 Immigration Act which created the demand for specialized services to meet the needs of this population;
- b) health care was identified as one of this population's most critical needs;
- c) Caribbean immigrants share certain characteristics such as socio-cultural conditioning which effects how they perceive and utilize services;

- d) The current policies regarding delivery of health care to this population are ineffective; and
- e) an innovative alternative health care delivery model needs to be developed to effectively respond to the health care needs of this population.

The viability for further research studying this population are based on the following practical considerations:

- a) The Caribbean population in New York City is increasingly becoming one of the fastest growing ethnic groups. (See Demographic Chart in Note 28, Chapter 2.)
- b) The Caribbean population generally reside within defined geographic boundaries in the City of New York.
- c) The various Caribbean groups within these areas share a common cultural affinity.

This project presented an opportunity to examine a host of health and immigration related problems. Among these were: the range of adjustment problems related to the immigration process; socially conditioned perceptions of health and illness; and specialized health problems of Caribbean immigrants.

The subject population included immigrants, from the more than 20 Caribbean nations, who reside in the New York City area, particularly in the Crown Heights/East Flatbush sections of Brooklyn, the Cambria Heights and Laurelton sections of Queens, and Harlem in

Manhattan.

One of the by-products of the post-1965 increase in immigration was the creation of a large population of immigrants who lack the proper documents and are therefore not in the country legally; and as a result tend to experience serious adjustment problems due to their status. This presence has caused considerable controversy among New York officials much of which involve issues related to the cost of providing services to this population. Because of their status, they cannot or will not readily seek the medical care necessary to gain or maintain good health. Moreover, New York City health officials have attributed much of the financial difficulty of maintaining health and hospital facilities generally to the financial drain on the system caused by providing services to undocumented immigrants since these services are not reimbursable by the Federal government provisions. This implies a lessening of efforts to provide adequate health care services to this population, thereby increasing the health risks of all New Yorkers.

The health conference, "Health and Caribbean Immigrants in New York City" was envisioned as a means to examine the broader issues related to the delivery of health care services to Caribbean immigrants in New York

City.

The major areas examined by the conference panelists and participants yielded significant information about the health care services to Caribbean immigrants in New York City. For example:

There are physical and adjustment problems that are inherent consequences of the migration process. Some manifestation of these problems are depression, apathy, loss of control and irritability.

The immigration experience can cause cultural and identity conflicts and social marginality patterns which tend to have an impact on the mental health of the immigrants.

Immigration often results in a breakdown of traditional family linkages which may have a long term effect on interpersonal relationships among family members.

Recent research reveals a high incidence of breast and cervical cancer in advanced stages, resulting in a high mortality rate among Caribbean women over forty (40) years of age.

Caribbean Folk beliefs, practices and other such cultural attributes are foreign to health providers in New York City and many aspects of American health practices are foreign to these immigrants.

There is often misunderstanding and misconception on the part of both providers and users of care due to different socio-cultural experiences.

The New York City Caribbean immigrant population is made up of at least three generations of immigrants. Many are found to have health problems related to the time and circumstances of their immigrant status.

Some related problems include a variety of tropical type diseases, hypertension feelings of and alienation, stigmatization such as the case of the Haitian population and Acquired Immune Deficiency Syndrome (AIDS).

The Caribbean community and organizations serve as coping mechanisms for immigrants.

Adequate communication between providers and users of care is crucial to the delivery of health care.

Immigration reform, and health issues related to undocumented immigrants are priority concerns to the Caribbean population.

The numerous problems revolving around immigrants' health issues as presented at the conference point to the need to employ an interdisciplinary approach in examining these issues. Prominent among the participants of such an effort are public health administrators, health professionals, and other specialists such as demographers, medical sociologists, cultural anthropologists and social workers and etc. The conference was only a means to the end. As envisioned by this investigator, the ultimate resolution would come through establishing and institutionalizing a formal Caribbean health advocacy organizational structure. This mission was achieved by the formation of a Caribbean Health Advocacy Task Force which subsequently became the Advisory Board of the Caribbean Women's Health Association (See C.W.H.A. profile in Appendix), a New York City based non-profit community service organization whose membership consists of professional women in the allied health fields.

The Board consists of a cross section of professional persons in the fields of health, public service, law, labor, business and education. The Board was charged with assisting the organization with developing and implementing health service delivery models and programs responsive to the needs of the Caribbean/American communities. This organization in conjunction with its Advisory Board, is currently working with public officials at the highest levels of federal, state and city government in formulating approaches to meet the health care needs of the Caribbean immigrant population.

The Exploratory Design proved to be well suited to this project, providing the flexibility to coordinate the various stages of the project. The initial stages consisted of the literature review, and community field study. While there is little or no literature addressing the issues of health care to Caribbean immigrants, the community field study efforts yielded valuable information related to this issue, and the survey instruments constructed can serve as a viable tool for data collection in this area.

Through various meetings, personal interviews, community forums, conferences and panel discussions, valuable resources were identified. In addition,

crucial issues and research related to the health status of Caribbean immigrants were identified. The community field study activities complemented the health conference by delineating the health issues to be addressed; identifying panelists, sponsors, and recruiting prospective members of the health advocacy group.

The workbreakdown structure (WBS) described in Chapter V herein was found to be a useful planning tool in organizing the Conference. It served as a guide to ensure that the tasks performed were directed to meet the delineated objectives. However, the Conference Planning Guide (See Appendix) proved to be the most valuable administrative and planning model used in organizing and monitoring the conference development and implementation. This guide identified who was doing what, when and how. Its virtue lies in its flexibility (it is an effective tool for use in program development) and its logistical capabilities for tactical deployment of human, material and technical resources.

PROJECT OUTCOME

When the conference information was analyzed, there emerged a clear indication of ineffective and inadequate health care services to Caribbean immigrants in New York City. This data strongly supported the need for a definite plan of action. The goal of this

project, to establish a formal Caribbean health advocacy structure, was viewed as the initial step in such a plan of action. On a practical level, such a plan was too ambitious to be accomplished at the conference itself. However, the conference proved to be a valuable forum for beginning the work of organizing the formal health advocacy structure.

The problems related to the Caribbean immigrants' sociocultural conditioning was recurrent throughout each phase of the project. This situation highlighted the need to study the original environment of the immigrant. Coincidentally, this investigator participated in international comparative health fact-finding field tours to the Caribbean in Cuba, Jamaica, Trinidad, and Barbados. These tours specifically examined the folk health practices and the health care delivery system in these countries. They also emphasized the need for further, more in-depth study in this area.

The extensive bibliography and other relevant by-products in the appendix can serve as valuable resources to those pursuing more in-depth study related to the health status of Caribbean immigrants in New York City.

CONCLUSION

This project found that the Caribbean immigrant communities in New York City face serious non-medical

barriers to health care services. Among these barriers are immigration status, adjustment problems, folk medical beliefs and practices, language barriers, socio-culturally conditioned perspectives and attitudes toward health and health care. In addition there exists the barrier caused by the racism that is endemic in America's treatment of Third World communities. The It was also found that the problems related to the health status of Caribbean immigrants in New York City is consistent with the causal scheme of poor health among migrants illustrated in Chapter Two herein. This paradigm suggests that poor health among migrants is a result of the interrelationship of contributing variables such as poverty, discrimination, political and economic powerlessness, occupational hazards, unhealthy environment, poor nutrition, low medical care capacity, morbidity and the delivery of inadequate medical care. These variables are solid indicators in examining the health status of Caribbean immigrants. The project findings also highlighted the need for designing health programs that are compatible with the socio-cultural orientation of Caribbean people.

A major issue in this context is the need for collaborative approaches to build bridges between Caribbean folk medical and the modern medical systems. Such collaborative models are instrumental, since the fin-

dings indicate that the Caribbean population tend to rely on the folk medical approaches not only to meet their health care needs but also their human, social and cultural needs.⁽¹⁾

Immigration is a local and a neighborhood problem, as well as a nationwide issue. As such the monitoring and assessment of the changing needs caused by immigration and its corresponding impact on local service delivery systems rest within the purview of the political structure. Accordingly, there is a need for a collaborative concerted effort between the established community based Caribbean organizations and the various levels of government to address Caribbean immigrant health care problems in a comprehensive and systematic manner. These efforts should not merely be for better services, but also for more effective top level administrative and policy participation of the Caribbean people in designing and delivering health care services to this community. This process should focus on designing innovative culturally compatible models of health care services provisions. The initiatives should also include the collaborative involvement of health and social services professionals, and should also include the Caribbean immigrants themselves. This collective input is critical to effectively responding to the social trauma created by migration.

In addition to the above, to deliver effective health care services to Caribbean immigrants the following are needed:

Services provided on a continuous basis in accessible places, and in a form acceptable to this population;

Reliable information on the size of this population;

Reliable demographic, socio-cultural, epidemiological, and economic, data on this population.

The development of a comprehensive and systematic plan of action to deliver and expand health care services, would serve as a catalyst to services, to adapt technologies and human resources, to restructure the health care system on the basis of functional levels of care. Crucial to this arrangement is the inclusion of comprehensive health coverage. The proposal for a National Comprehensive Health Coverage program is a logical consequence of the acceptance of health care as a basic right. However, the United States, with the largest technologically sophisticated and wealthiest health establishment in the world, is the only major western industrial power whose policy does not support the principle of health care as a basic human right. Advocating the principle of health as a basic right, the following recommendations are made:

Government must take the leadership role in deve-

veloping mechanisms to remove socio-economic, cultural and legal barriers in the delivery of basic health services;

There should be no discriminatory billing and collection practices based on immigration status, in the delivery of health care services;

The city must develop outreach programs to insure that Caribbean immigrants receive basic health care information such as, patients bill of rights, services available (e.g., immunization of children, prenatal care) and contagious disease control.

The effective training of health care providers to deliver services to Caribbean immigrants, raises questions regarding what structural arrangements could be used for this training. Included among the alternatives are: in-service training programs at health care services facilities such as hospitals and community health centers. The curriculum should include the integration of Caribbean socio-cultural perspectives and Caribbean Folk Medical approaches into the existing Behavioral and Social Medicine curriculum in schools offering health related degrees. This could be initiated under the auspices of such public agencies as New York State and New York City's Department of Health, the State and/or City University systems; and/or New York City's Health and Hospital Corporation. The Caribbean health advocacy thrust established by this project plans to lobby for the achievement of these goals. In this context, it should be noted that:

The teaching of sociological concepts and methods relevant to public health and preventative medicine has benefitted greatly from the general growth of interest on the part of medical schools in a more comprehensive approach to medical care"....."In medical schools the accent is likely to be on the physician-patient relationship, while in schools of public health the major emphasis will be on the social and psychological factors affecting the success and failure of public health programs.⁽²⁾

Any such curriculum design should highlight the socio-cultural dynamics in delivering health care services to Caribbean immigrants.⁽³⁾ This should include epidemiological and health related problems peculiar to this group, Caribbean folk medical beliefs and practices, food preferences, migration impact on adjustment and acculturation patterns, social and communication networks, ethnic identification, coping and supporting systems, among other such non-medical factors that may serve as barriers to the provision of adequate health services.

New York City has more hospitals, more medical and public health schools than any other city in the country. These institutions should take the leadership initiative in launching innovative culturally compatible programs to respond to this fast growing ethnic community. These programs could be based on establishing consortia arrangements with the wealth of established yet untapped local Caribbean organizations. These programs would facilitate the accessibility of the

the City's/State's health and social service systems to this ethnic community. These arrangements would also foster improved understanding, communications and working relationship between this immigrant community and the City/State health systems, while providing a framework to monitor the health situation in the Caribbean community.

Local Caribbean organizations are viable resources which tend to be neglected. Many of these organizations are concerned with the health aspects of the community. These organizations have a record of leadership and commitment in the Caribbean community and could serve as organizational conduits to more effectively introduce transcultural health projects. An examination of the roles of these organizations would indicate that:

Caribbean organizations in the United States have a long tradition serving as centers for social, economic, political and cultural development of their communities. Nationally prominent organizations such as the West Indian Benevolent and Social League, established in 1893 and the Urban League were organized to respond to the needs of the Caribbean population in the United States.⁽⁴⁾ Currently there are approximately 400 viable such organizations in the greater New York Metropolitan area.

Pluralism and diversity prevails within the Caribbean community; thus, the community speaks with many voices through these organizations to address issues of common concerns. The support and assistance from these organizations play a crucial and traditional role in the initial phase of settlement and adjustment of the immigrants; serving as a primary source of assistance with material and emotional support. Moreover, Caribbean immigrants

tend to be clanishly linked and interwoven into a social network which is dominated by kin, friends and organizations transposed from their native countries.

Recent studies indicate that this population has a high reliance on the American counterpart organizations.⁽⁵⁾ The data indicated that when services were required there was an expressed preference for Caribbean professionals, who were thought to better understand other Caribbeans. Findings regarding their participation in organizations indicate that, contrary to native-born Blacks, they reported low participation in churches, although the majority maintained church affiliations. Many had been members of a Caribbean rotating Credit Association.⁽⁶⁾ Most of those who were affiliated with formal organizations belonged to Caribbean organizations. The aforescribed Caribbean American Resources Directory was an effort to make these organizations more visible and accessible to the wider New York City community.

The following additional recommendations are made based on the project analysis:

Collaborative efforts between folk healers and medical professionals is a viable approach in designing health care programs targeted to the Caribbean community.

The status of undocumented immigrants creates great stress for which new legal remedies should be found.

The curriculum Training programs for health care providers should include subject matter that is culturally relevant to the health consumers to be served. Thus, special attention should be given to language barriers, folk health beliefs and practices, and similar cultural factors.

Funds must be made available for research and community education regarding crucial health problems affecting the Caribbean population such as certain types of cancer.

International exchange programs should be implemented to enable health professionals in the United States and in the Caribbean nations to

study comparative health systems.

Programs must be instituted to educate immigrants about health care rights, available services and the value of seeking preventative care.

Immigrant's settlement programs need to be instituted to respond to the special adjustment and stress related problems resulting from the trauma of immigration.

The health care needs of the Caribbean population in New York City remains virtually underserved as a general observation, the issues associated with health care services to Caribbean immigrants are similar to those of other disadvantaged ethnic minority groups in American society. Therefore, any program to address these problems cannot be viewed as affording special treatment to the Caribbean immigrant population. Moreover, these programs would also improve the quality of life of all the people in New York City.

Finally, the Caribbean health advocacy structure established by this project will lobby for the implementation of the stated recommendations, and is entrusted with implementing the envisioned ultimate mission of this project which is insuring the effective delivery of culturally compatible and quality health care services to the Caribbean population in New York City.

NOTESCHAPTER VI

1. For perspectives on some of the problems and issues involved in the delivery of health care services based on collaborative intercultural approaches between folk health and modern medical systems, see the following:

George M. Foster, "Problems in Intercultural Health Programs," Social Science Research Council, Pamphlet, No. 12, New York, 1958.

Nancie S. Gonzalez, "Health Behavior in Cross-Cultural Perspectives," Human Organization 25(2): 122-125, 1966.

Alan Harwood, (ed), Ethnicity and Medical Care, Harvard University Press, 1981.

David Landy, "Role Adaptations: Traditional Cures, Under the Impact of Western Medicine," American Ethnologist, 1974 (1) 103-127.

Joan D. Koss, "The Therapist Spiritual Training Project in Puerto Rico: An Experiment to Relate the Traditional Healing System to Public Health System," Social Science and Medicine, Vol. 146, No. 4, 1980, pp. 255-266.

Marline Simmons, "Power of Voodoo, Preached by Sorbonne Scientist," New York Times, December 15, 1983, p. 2.

2. Edward Suchman, Sociology and the Field of Public Health, Russell Sage Foundation, New York, 1954, pp. 138-141.
3. Megan E. McLaughlin, West Indian Immigrants: Their Social Networks and Ethnic Identification, Doctoral Dissertation, Columbia University, 1981.

Sidney Mintz, "The Caribbean as a Socio-Cultural Area," In Peoples and Cultures of the Caribbean, Michael Horowitz, ed., New York: The Natural History Press, 1971.
4. Herman Hall, 200 Years of West-Indian Contributions, New York: Herman Hall Associates, 1976.

5. See McLaughlin, 1981.
6. Aubrey W. Bonnet, An examination of Rotating Credit Associations Among Black West Indian Immigrants in Brooklyn, in Sourcebook on the New Immigration; Implications for the United States and the International Community, ed., Roy Simon Bryce-LaPorte, Transaction Books, New Brunswick, New Jersey, 1980.

APPENDIX

Exhibit A: Conference Program

Exhibit B: Profile of the Caribbean Women's Health Association

HEALTH AND
CARIBBEAN IMMIGRANTS
IN
NEW YORK CITY

CONTEXT, IMPACT AND IMPLICATIONS



THURSDAY
DECEMBER 16, 1982

ST. JOSEPH'S COLLEGE
245 Clinton Avenue
Brooklyn, N.Y. 11205

MARCO A. MASON
CONFERENCE COORDINATOR

STC SAINT JOSEPH'S COLLEGE
DIVISION OF GENERAL STUDIES

December 16, 1982

Dear Participant,

St. Joseph's College, Division of General Studies Welcomes you to the conference on "Health and Caribbean Immigrants in New York City".

This conference is designed to make you more aware of the special health needs, issues and problems currently confronting the Caribbean population. It is intended to provide a forum for discussion between you and the distinguished panel which has been drawn from health, academia, social services and governmental organizations.

The panel will address various health issues from a professional perspective based on the work and research that each has done in the area.

We encourage your participation in the panel discussions and we solicit your input in formulating the recommendations and proposals that will come out of the conference. It is our goal that the conference will provide a framework for making recommendations to governmental, social services and health agencies for policy changes in the area of health care to Caribbean immigrants.

For those of you that are health care providers, the conference offers you current information that we believe will enable you to more effectively respond to the needs of the community.

Your shared commitment understanding and support is essential to improving the calibre of health care services to immigrants. Thank you for your participation.

With warmest regards,

Marco A. Mason

Marco A. Mason
Conference Coordinator

245 CLINTON AVENUE, BROOKLYN, NY 11205
(212) 622-4690

155 ROE BOULEVARD, PATCHOGUE, NY 11772
(516) 654-5711

ACKNOWLEDGEMENTS

We wish to express our gratitude to the panelists, facilitators, sponsoring and participating organizations, and to all those who have contributed to making this Conference a reality. Special appreciation is extended to:

Denise Hylton, (Administration), Betty Payne-Staton, Esq. (Planning), Jean Black, (Reception), Cathy Pitts and Anabel Burns, (Publicity), Mavis Polidor, M.D., (Outreach), Basil Wilson, Ph.D, Leslie Sealy, Yvonne Graham, Esther Menjor, Cynthia Ferguson, Saddle McMillan, (Technical Assistance).

EVALUATION

Please assist us in evaluating this Conference in order to improve future efforts on this topic by answering the following questions. Please return this form to one of the facilitators before you leave.

	YES	NO	COMMENTS
1. Do you feel that the overview effectively addressed the issues?			
2. Do you feel that the Panel on Crucial Health Issues identified the critical health issue confronting the Caribbean community?			
3. Do you feel that the Panel on Policy Aspects highlighted relevant issues affecting the Caribbean immigrants?			
4. Do you feel that the Panel on Cultural Patterns explored key issues related to delivery of health care services to Caribbean Immigrants?			
5. Do you feel that the Panel on strategies to improve health services provided innovative insights and alternatives to Health service provision?			
6. Do you feel that the Conference was informative i.e. new ideas, innovative techniques, etc?			
7. As a result of this Conference, do you feel that you have a keener awareness of the barriers to health care for Immigrants?			

8. Have you gained information which will be helpful to you and or your agency in improving services (i.e. health, social, legal) to immigrants?
9. Indicate the most valuable aspect of the Panel(s)/Conference:
10. Indicate the least valuable aspect of Conference.
11. Are there any areas or topics which you feel should have been addressed more fully?
12. Would you be interested in working collaborating with a task force dealing with Immigrant Health issues?
YES NO
13. Have you been involved in immigration and/or health related organizations in the last two years?
YES NO
If yes what organization and in what capacity?
14. Additional Comments:

THE PROBLEM

New immigrants are a population at risk. They face many problems related to health which are issues of grave public concern. Among these are: adjustment problems causing severe mental stress; cultural differences related to patterns of how health services are used; inability to gain access to health care services. These problems are particularly acute among "undocumented" immigrants who are essentially excluded from the health system. Given the magnitude of this problem effective leadership and collaborative involvement of health related professionals is required.

PURPOSE

This Conference is intended to provide a forum for discussion between the participants and the experts drawn from health, academia, immigration, government and international organizations who will address the issues from various perspectives. The Conference is designed for a wide range of health professionals, social scientists, educators and community leaders whose shared commitment, understanding and cooperation is essential to improving the calibre of the delivery of health services.

OBJECTIVES

- To provide participants with updated information on issues pertaining to the delivery of health care services to immigrants.
- To explore the cultural variables within the Caribbean community as they relate to both providers and users of health services.
- To address fundamental health/immigration issues as a framework for policy planning.
- To foster collaborative relationships between community, immigration, health, social service and international organizations.

If you wish to obtain copies of the Conference report contact:

Marco A. Mason
 St. Joseph's College
 Department of Health Administration
 245 Clinton Ave., Brooklyn, N.Y. 11205
 Or Call:
 (212) 622-4690

11:00 - 12:00

PANEL: POLICY ASPECTS OF THE DELIVERY OF HEALTH SERVICES TO IMMIGRANTS

MODERATOR: Waldaba Stewart, Ph.D
Mid-Brooklyn Health Association

DISCUSSANT:

SPEAKERS: Harriet Dronska, M.S.W., New York City Health and Hospitals Corporation

Sally Guttmacher, Ph.D., Rutgers University
"Implications of the Simpson Mazzoli Bill on Health Care to Immigrants".

Earl E. Huyck, Ph.D., Center for Population Research, NICHD, NIH
"Federal Research Perspective on Immigrant Health Issues".

William Nute Jr., M.D., New York City Department of Health
"New York City Perspectives on Immigrant Health Issues".

DISCUSSION: Question and Answers

12:15 - 1:15

L U N C H

1:15 - 2:30

PANEL: EXPLORING THE CULTURAL PATTERNS OF HEALTH PRACTICES OF IMMIGRANTS

MODERATOR: Carlos Russell, Ph. D, Brooklyn College

DISCUSSANT: Ursula Daniels, Ph.D, Bergen County College

SPEAKERS: Charles Greene, Ph.D, Hunter College
"The Family, Social Networks and their Impact on Health in the Caribbean Community".

Ras Tesfa, Jafrica International
"Non-Traditional Health Practices in the Caribbean Community: A Case Study of Rastafarianism".

Dr. Rex Archibald, Rama Institute
"Psychic Healing in the Caribbean Community".

Carol Weiss, M.S.W., Ph.D, West Brooklyn Feasibility Study, "Helping to Live, The Institutionalization of Dominican New Yorkers and Networks for Health Seeking".

DISCUSSION: Questions and Answers

2:30 - 3:45

PANEL: STRATEGIES TO IMPROVE THE DELIVERY OF HEALTH SERVICES TO IMMIGRANTSMODERATOR: Ann Jordheim, Ed.D., St. Joseph's CollegeDISCUSSANT: Norma Goodwin, M.D., AMRON Mgmt. ConsultantSPEAKERS: Roberto Belmar, M.D., Montefiore Hospital
"The Changing Health Care Needs of Immigrants in New York City".Noemi Santana, Health & Hospital Corp.,
"Providing Health Care Services to Immigrants: Breaking Through the Communication and Cultural Barriers"Charles Rogers, M.D., Kings County Hospital
"Institutional Strategies to Improve the Delivery of Health Services to Immigrant"

Susan Herschkowitz, National Health Screening Council, "Community Preventative Health Care Services: The Health Fair Model"

Milton Haynes, M.D., Caribbean Medical and Educational Foundation, "Strategies to Respond to the Health Needs in the Caribbean Area: Proposal for a Caribbean Health Research Center"

DISCUSSION: Questions and Answers

3:45- 4:15

PLENARY SESSION: Conclusions and Recommendations

4:15- 4:30

CLOSING REMARKS:

4:30- 6:00

R E C E P T I O N

RECEPTION COMMITTEE

Jean C. Black, Chairperson
 Allyn Underwood, Co-Chairperson
 Mary Frances Caston, Hostess

.....

CO-SPONSORS OF RECEPTION

East New York Club of Brooklyn, Inc.
 N.A.N.B.P.W., Inc.
 Mid-Brooklyn Health Association
 Hostrand Travel
 Ulica Jewelers
 715 Veterans Association
 Housing Committee

WOODHULL STAFF

Mr. William Burke
 Ms. Josette Filippi
 Mr. Peter Demoleas
 Mr. Vernon Washington

RECEPTION PROGRAM

WELCOME

SPEAKERS:

Dr. Thomas Travis, Dean
 St. Joseph's College

Dr. Calvin B. Marshall, 111
 Director of Chaplaincy
 Woodhull Medical & Mental Health Center

Public Official: Hon. Ed Towns
 Congressman - Elect.

Professor Marco A. Masca
 St. Joseph's College
 Conference Coordinator

LA SHAY - CATERERS

.....

ADDITIONAL INFORMATION:

- * LUNCH: In order to foster informal networking lunch will be available on the premises for only-\$3.00
- * Conference related materials & Health pamphlets are available at the display table.
- * The Men's Room is located on the first floor, after the stairway entrance.
- * The Women's Room is located on the second floor, first door to the right.
- * The Press Room will be located in Room 101 until 3:00 p.m.
- * The Reception will be held in Room 101 from 4:00 p.m. until 6:00
- * Coffee will be served on the premises continuously.
- *** Please feel free to walk around the "245" Building, which is a Georgian Mansion, formerly of the Pratt estate. By following the first floor hallways, you will reach the two neoclassical parlors and the formal dining room which preserve something of the life-style of Clinton Hill.

PANEL: "POLICY ASPECTS OF THE DELIVERY OF HEALTH SERVICES TO IMMIGRANTS"

WALDABA STEWART, Ph.D is the chief executive officer of the Mid-Brooklyn Health Association. He is a former New York State Senator, and is the Chairman of Community Board of Kings County Hospital. He has conducted research and written many articles on Health Economics. He is actively involved in civic affairs in the Caribbean American Community.

HARRIET DRONSKA, M.S.W. is the Vice-President for Program Development and Policy Analysis for Health and Hospital Corporation. She advises the President on program and capital planning at New York City Health & Hospital Corporation. She was previously with the New York City Human Resources Administration as Deputy Administrator of Medicaid.

EARL E. HUYCK, Ph.D is Chief of Grant and Contract Programs of the National Institute of Child Human Development (NICHD), at the Center for Population Research. He has done extensive research and written on immigration and refugee matters. He was former with the United States Agency for International Development in Costa Rica as Population officer. He co-authored research on impact of resettlement on demography of refugees, as well as contributed articles to International Migration Review; Annals of the American Academy of Political and Social Science. He is the originator and coordinator of the Washington, D.C. area group on Immigration research.

PANEL: "EXPLORING THE CULTURAL PATTERNS OF HEALTH PRACTICES OF IMMIGRANTS"

URSULA PARISH DANIELS, Ph.D is an Associate Professor, Department of Psychology and Child Development at Bergen County College, New Jersey. She has conducted extensive psychological research on the development of the Black Child. She provides research consultation services for local, state and federal programs.

CAELOS RUSSELL, Ph.D is a faculty member at Brooklyn College, and St. Joseph's College. He has written extensively on problems related to African diaspora. He is the founder/Chairman of the Black Solidarity Day Committee. He is currently a member of the Panamanian Diplomatic Corps to the United Nations.

CHARLES ST. CLAIR GREEN, M.S.W., Ph.D is a Trinidadian and currently a faculty member in the Department of Sociology at Hunter College, City University of New York. He is the former Assistant Deputy Commissioner, New York City Department of Mental Health. He has vast experience in Medical Social Work and Mental Health and affiliated with the Caribbean Counseling Center.

REX ARCHIBALD, D.D. is the President of RAMA Metaphysical Institute and President of the Big Drum Dance Company, a Caribbean-American Folklore Dance Troupe. He is the former chief executive manager of Paragant Progressive Community Association.

CAROL WEISS, M.S.W., Ph.D is the Senior Researcher for West Brooklyn Feasibility Study, Services Intergration, N.Y. State Bureau of Demonstration. She has a doctorate in Socio-Medical Sciences from Columbia University. Her publications include: "Family Network and Immigration Policy".

PANEL: "POLICY ASPECTS OF THE DELIVERY OF HEALTH SERVICES TO IMMIGRANTS"

SALLY GUTTMACHER is Associate Professor at Rutgers University, and adjunct Assistant Professor at The School of Public Health, Columbia University. She is affiliated with the Center for the Study of Human Rights.

WILLIAM NUTE, JR., M.D. is Director of Public Health Services, for the New York City Department of Health. He has done extensive work in Public Health service overseas including; Founding member of the National Council for International Health. He has served as Director of Christian Medical Council and as Medical Missionary to Turkey.

RAS TESFA is President of Jafrica International. He is author of "Living Testament of Rastafarianism". He has contributed several articles to various community newspapers on issues and conditions in Caribbean community in Brooklyn. Mr. Tesfa is also an Actor and Poet.

PANEL: "STRATEGIES TO IMPROVE THE DELIVERY OF HEALTH SERVICES TO IMMIGRANTS"

ANN E. JORDHEIM, Ed.D is the Chairperson of Community Health Department, St. Joseph's College. She is in charge of Practicum teaching in Health Education and Community Outreach. She has conducted a research study on, "The Survival Mechanism Among Caribbean Student: In Community Health and Health Administration at St. Joseph's College. She is also a certified Sex Educator and Counselor.

NORMA GOODWIN, M.D. is President of AMRON, management consultants, which specializes in Human Services program planning, developing, and evaluation. She provides consultative services to various governmental, community and professional organizations. She is a former Senior Vice-President with New York City Health and Hospital Corporation, responsible for Community Health Programs. She served on the faculty of Downstate Medical Center and Howard University School of Business and Public Administration.

ROBERTO BELMAR, M.D. is the Director of the Division of International Health and Primary Care, and Deputy Chairman of the Department of Social Medicine at Montefiore Hospital. He is a Professor of Community Health at Albert Einstein College of Medicine. He was formerly Professor of Community Medicine at the University of Chile, School of Medicine. He was Deputy Director of National Health Services of Chile from 1970 to 1973.

NOEMI SANTANA, B.A. works with Community and Patient Relations at Health and Hospital Corporation. She is an instructor of Language and Culture to Medical students at New York University. She has made many appearances on television and radio shows discussing issues related to Hispanic Health Consumers.

CHARLES P. ROGERS, M.D. is the Chief of Ambulatory Care Services at Kings County Hospital and a faculty member in the Department of Medicine at Downstate Medical Center. He has an M.B.A. from the Wharton School of Finance.

SUSAN HERSCHKOWITZ is the Health Fair Project Director for the National Health Screening Council.

MILTON HAYNES, M.D. is a native of Barbados, and President of the Caribbean Medical and Educational Foundation, a New York based organization involved with International Health issues in the Caribbean area. He is affiliated with the American Academy of Obstetrics and Gynecology.

LAMUEL A. STANISLAUS, D.D.S. is a Community Activist with extensive involvement and experience in Caribbean-American relations. He is considered to be "the mayor of the Caribbean American Community", in New York City. He is professionally affiliated with; American Dental Association, the American Red Cross, the Brooklyn Association for Mental Health, and Provident Medical Society.

MARCO A. MASON is a Doctor Social Welfare in Public Policy (candidate), CUNY Graduate Center. He is a faculty member in the Department of Community Health and Health Administration at St. Joseph's College. He is the former Director of the New York Urban League's Undocumented Immigrant Research Project, on Caribbean Immigrants in New York City. He also has extensive organizational involvement with the Caribbean-American Community in New York City.

PARTICIPATING & CO-SPONSORING ORGANIZATIONS

(Partial Listing, Alphabetized)

Amron Management Consultant, Inc.
 Bedford Stuyvesant Family Health Center
 Brooklyn College Caribbean Student Union
 Brownsville Community Health Center
 Bushwick Stuyvesant Home Attendants, Inc.
 Caribbean Civic Alliance
 Caribbean Medical Educational & Research Foundation
 Catholic Migration & Refugee Office Diocese of Brooklyn
 Guyanese Nurses of America, Inc.
 Hunter College School of Health Sciences
 Interfaith Coalition for Justice to Immigrants
 Local District 1199
 Local 23-25 International Ladies Garment Workers Union
 Mid-Brooklyn Health Association
 National Emergency Coalition for Haitian Refugees
 National Health Screening Council of Volunteers Organization, Inc.
 New York City Department of Health
 New York City Health & Hospital Corporation
 New York City Health Systems Agency
 New York Eye & Ear Infirmary
 New York Immigration Forum
 New York State Advisory Council on Ethnic & Cultural Affairs
 New York Urban League
 Omni Resources Corporation
 Provident Medical Society
 St. Joseph's College, Division of General Studies
 Susan Smith McKinney Steward Medical Association
 The Center for Medical Consumer & Health Care Information, Inc.

CARIBBEAN WOMEN'S HEALTH ASSOCIATION



314 WEST 53rd STREET
NEW YORK, N.Y. 10019

—○—
(212) 621-9177

OFFICERS

MS. YVONNE J. GRAHAM, President
DR. MAVIS POLIDORE, Vice-President
MRS. PATRICIA HAYNES-GILKES, Treasurer
MS. EDNA DuBOIS, Recording Secretary
MS. VANGELINE HUNTER, Corresponding Secretary

ADVISORY BOARD

MR. JOSEPH BAILEY, Esq.
MR. SELWYN CARTER
MR. ANTONIO CAESAR
MS. AMELIA CHARLES
DR. URSULLA DANIELS
DR. CLARENCE EVANS
DR. JOSEPHINE ENGLISH
MR. JOSE FERRER
DR. CHARLES GREEN
MR. WILLIAM GREEN
MS. GRACE IAGLETON
DR. MEGAN McLAUGHLIN
PROF. MARCO MASON
MS. MERNA MURRAY
DR. OWINO NISA OCHIENG
DR. WALDABA STEWART
REV. HARON SAM
DR. LAMUEL STANISLAUS
DR. MARGUERITE THOMPSON

PROFILE

The Caribbean Women's Health Association, Inc., (CWhA), is a non-profit organization established to respond to the myriad of health-related issues impacting the Black Communities (Afro-American, Caribbean and African) and the public's welfare.

C.W.H.A. programs are designed to:

- Stimulate working relationships and communication networks with individuals and/or organizations concerned with health related issues.
- Initiate, endorse and support policies and programs that would insure the right to health care services for all.
- Enhance professional development and to improve human relations skills.
- Develop, support and promote programs and activities aimed at responding to the health care needs of the Black Communities (in the United States as well as the circum-Caribbean region) and at improving the quality of the delivery of health care services.
- Impact governmental, health, academic, public service, international and other such organizations involved with formulating health policies and programs.
- Educate and mobilize the Black communities as well as the general public around crucial health issues.
- Provide a framework through which health providers, consumers, educators, and policymakers can interact in the interest of addressing crucial health related issues.

PROGRAMS

In addition to on-going community health education and cultural programs C.W.H.A. offers a wide variety of programs that include:

- Providing technical and programmatic assistance to health, national and international agencies dealing with health related problems impacting ethnic minorities, women, and the general public.
- Conduct cross-cultural fact-finding field tours and exchange programs to Africa and the circum-Caribbean region.
- Publish a Directory of Health Professionals.
- Conduct accredited continuing education and professional development training programs.
- Conduct Conferences, Seminars, and Workshops highlighting crucial health-related problems.
- To compile a Caribbean health resources registry bank.
- Conduct a speakers bureau providing expert speakers who are specialists in diverse areas of the health field.
- Publish a Newsletter providing information related to the organizations activities.
- Prepare and disseminate health related reports and materials designed foster public awareness of crucial health issues.
- Provide scholarship and assistance to needy students pursuing careers in the allied health field.
- Present public testimony on health-related matters to legislative and policy making bodies.
- Sponsor Annual Health Conference bringing together prominent professionals drawn from academic, health, social service, governmental, and international organizations, who discuss crucial issues and develop programmatic approaches and recommend policy changes to respond to the health care needs of the Black Communities.

PROFESSIONAL DEVELOPMENT

- C.W.H.A. serves as an invaluable asset to those interested in enhancing their professional growth and career development.
- C.W.H.A. offers a unique opportunity to those interested in making professional contributions to the resolution of health problems impacting the Black communities.
- Members will gain continuing education and solid professional experiences through participation in committees, conducting research, publishing, community education programs, cross-cultural and international projects, influencing legislation and through the myriad of other similar activities sponsored by C.W.H.A.
- Members have an opportunity to serve on selected committees of their interest and on special Task Forces, or by being elected to the Board of Directors.
- Membership consist of active volunteers, contributing organizations, and a wide cross-section of health professionals in the health field, e.g., Health Technicians, Physicians, Administrators, Nurses, Counselors, Environmentalists, Optometrists, Podiatrists, Researchers, Health Educators, Dentists, Nutritionists, Physical Therapists, Folk-Health Practitioners, Social Workers, Health Economists, Psychologists, Public Health Specialists, Epidemiologists, etc.

COMMITTEES

The work of the C.W.H.A. is performed by its standing Committees and Ad Hoc Task Force; these committees include:

THE PROGRAM COMMITTEE: Responsible for the planning and development of the organization's on-going programs and special projects.

THE PUBLIC POLICY AND LEGISLATIVE COMMITTEE: Monitors health policies and legislations and develops position papers advocating policy and legislative changes; meets with legislative and health officials; and present public testimony on health related matters.

THE PUBLIC RELATIONS COMMITTEE: Disseminates information about the organizations activities; prepares and distributes health related educational materials, provides knowledgeable speakers to the community; and is responsible for the publication of the organization's newsletter. Interact with business, health, educational, civic, social services, professional, governmental and international organizations.

THE RESEARCH COMMITTEE: Investigates specific health-related problems impacting the Black and ethnic communities, women, and the general population. Prepare reports and data-based policy papers highlighting emerging health problems and recommending policy alternatives.

OTHER COMMITTEES INCLUDE:

- Membership/Nominations and Awards Committee
- By-Laws Committee
- Fund Development Committee
- Liason Committee
- Ad Hoc Task Forces

BIBLIOGRAPHY

Abraham, E.A.V., "Materia Medica Guian," Timehri, 3rd Series 2(19) July 1912: 179-196.

Abramson, J.H., "Emotional Disorder, Status Inconsistency and Migration," Questionnaire Survey in Jerusalem, Israel Medical Journal, 1963.

Acho, William R. and Minott, Kimlan, "Creole and Doctor Medicine: Folk Beliefs, Practices and Orientation to Modern Medicine in a Rural and Industrial Suburban Setting in Trinidad and Tobago, Social Sciences and Medicine (Vol. 11, No. 5, March: 1979) pp. 349-355.

Ackerknecht, E.H., "Problems in Primitive Medicine," Bulletin of the History of Medicine, 1942, 14: 503-521.

Adams, C.D. and Magus, K.E., "Some Jamaican Herb Remedies are Poisonous," Information Bulletin of the Research Council, 6(4) March, 1965: 105-109.

Almeida, M.Z., "Psycho-Social and Psycho-Pathological Aspects of Transplantation," La Sante des Immigrants, Comite Medical et Medico-Social d'aide aux migrants, Paris Societe d'Edition Droit et Liberte, 1972: 105-128.

Anderson, Albert P., "Therapeutic Trust: The Magic in Medicine," Medicine and Man, Vol. 3, No. 2, 1978: 119-125.

Anderson, Jervis, "Uprootedness: A Jamaican Negro," Commentary, Vol. 40, November, 1965.

Arnold, Fred, "Providing Medical Services to Undocumented Immigrants: Cost and Public Policy," International Migration Review, Vol. 13, No. 4.

Aykroyd, W., "Nutrition in the Caribbean," Journal Hygiene 63(1) March, 1965: 137-153.

Bagley, Christopher, "Sequels of Alienation: A Social Psychological View of the Adaptation of West Indian Migrants in Britain," paper presented at 34th Annual Meeting of the Society for Applied Anthropology, 1975.

Barrett, Leonard E., Soul Force: African Heritage in Afro-American Religion, Anchor Books, N.Y., 1974.

Barrett, Leonard E., "The Portrait of a Jamaican Healer: African Medical Lore in the Caribbean," Caribbean Studies.

Barrett, Leonard E., The Rastafarian: A Study in Messianic Cultism in Jamaica, Rio Piedras, Puerto Rico, Institute of Caribbean Studies, University of Puerto Rico, Monographs Series, No. 6, 1968.

Barrett, Leonard E., The Rastafarian: Sounds of Cultural Dissonance, Boston: Beacon Press, 1977.

Barrett, Leonard E., The Sun and the Drum: African Roots in Jamaican Folk Traditions, Kingston Sangster's Book Store and Heinemann, London, 1967.

Bayley, Iris, "The Bush Teas of Barbados," Journal of Barbadian Museum Historical Society, 16(3), May 1949: 103-109.

Beckwith, Martha Warren, Notes on Jamaican Ethnobotany, Poughkeepsie, N.Y., Vassar College, Publication of the Folklore Foundation, No. 8, 1927.

Beckwith, Martha Warren, "Some Religious Cult in Jamaica," American Journal of Psychology, 34(1) January, 1923:32-45.

Bell, Hesheth J., Obeah: Witchcraft in the West Indies, Westport, Conn., Negro University Press, 1970.

Bevilacqua, J., "Voodoo: Myth of Mental Illness," Journal of Psychology of Nursing, (18) 1980: 17-23.

Bonnett, Aubrey W., "An Examination of Rotating Credit Association Among Black West Indian Immigrants in Brooklyn," Sourcebook on the New Immigration: Implications for the United States and the International Community, Roy S. Bryce Laporte, ed., (Transaction Books, New Brunswick, New Jersey, 1980).

Borofsky, Robert, Obeah: A Description of an Occult Medical System in Trinidad, Waltham, Mass., Brandeis University, Department of Anthropology, 1968.

Bradford, William Penn, "Puerto Rican Spiritism: Contrast in the Sacred and Profane," Caribbean Quarterly.

Braithwaite, Edward, Contradicting Omens: Cultural Diversity and Integration in the Caribbean, Mona, Jamaica: Savacou Publications (Monograph No.1) 1974.

Brownlee, Ann Templeton, Community, Culture, and Care: A Cross-Cultural Guide for Health Workers, C.V. Mosby Co., St. Louis, 1978.

Bryce-Laporte, Roy S., "Crisis, Contraculture, and Religion Among West Indians in the Panamal Canal Zone," in Norman E. Whitten, Jr. and John F. Szwed (ed.) Afro-American Anthropology: Contemporary Perspectives, N.Y., Free Press, 1970: 103-118.

Bryce-Laporte, Roy S., "Introduction: New York City and the New Caribbean Immigration: A Contextual Statement", International Migration Review, Center for Migration Studies, N.Y., 1979.

Bryce-Laporte, Roy S., "New York City and the New Caribbean Immigration: A Contextual Statement", in Caribbean Migration to New York, Elsa Chaney and Constance Sutton, International Migration Review (Special Issue) (Vol. 13, Summer 1979) pp. 214-234.

Bryce-Laporte, Roy S., (ed.), Sourcebook on the New Immigration: Implications for the United States and the International Community, Transaction Books, New Brunswick, New Jersey, 1980.

Bryce-Laporte, Roy S., (ed.), "The New Immigrant Wave", Society, (14/6): 19-79, Sept./Oct. (Special Issue), 1977.

Bryce-Laporte, Roy S., "The Study of New Immigration: Political and Methodological Deterrents, Quantitative Data and Immigration Research", in Quantitative Data in Immigration Research, (Research Institute on Immigration and Ethnic Studies, Smithsonian Institution, Washington, D.C., 1979).

Burland, Barbara, "Some Information on Herbs, Medicinal Plants and other types of Remedies Used in the Past in Bermuda for Various Aliments", Hamilton, Bermuda Historical Society: Occasional Publication, No. 6, 1965.

Campbell, Saddie, "Bush Teas: A Cure All," Jamaican Journal, 8(23), Summer, 1974: 59-60.

Campbell, Saddie, "Folklore and Food Habits", Jamaican Journal, 8(23), Summer 1974: 56-59.

Caughlin, Bernard J. and Khindaka, S.K., Social Change and Social Actions, Journal of Sociology and Social Welfare, Vo. III, No. 3, January 1976, pp. 322-331.

Cervantes, Raymond, "Oja de Mal," Belizean Studies, Vol. 10, Nov. 1, 1982, pp. 2-9.

Chaney, Elsa M. and Sutton, Constance L., (ed), "Caribbean Migration to New York" (Special Issue) International Migration Review, (Center for Migration Studies, New York, Vol. 13, Summer, 1979).

Clements, F.E., "Primitive Concepts of Disease," Publications in American Archeology and Ethnology, 1939, 32: 186-252.

Comitas, Lambros, "Caribbeana 1900-1965: A Topical Bibliography." Seattle: University of Washington Press, 1968.

Consumer Report, The Medicine Report, Columbia University, N.Y.

Cox, J.L., "Psychiatric Assessment and the Immigrant Patient," British Journal of Hospital Medicine, (16) No. 1, 1976: 30-40.

Craham, Margaret and Franklin W. Knight, Africa and the Caribbean: Legacies or a Link, Baltimore: John Hopkins University Press, 1979.

Diedderick, Bernard, "On the Nature of Zombie Existence: The Reality of a Voodoo Ritual", Caribbean Review, Vol. XII, No. 3, December, 1983.

Eddy, Mary Baker, Science and Health with Key to the Scriptures, The Christian Science Publishing Society, Boston, 1918.

Ehrenreich, Barbara and John, The American Health Empire: Power, Profits and Politics, Vintage Books, Random House, New York, 1971.

Eldridge, Joan, "Bush Medicine in the Exumas and Long Island Bahamas: A Field Study", Economic Botany, 29(4) October/December 1975: 307-332.

Erikson, E.H., "Identity and Uprooting," in Uprooting and Resettlement, World Federation of Mental Health, proceedings of the 11th Annual Meeting, 1958.

Ex, J., Adjustment After Migration, Publication of the RES Group for European Migration Problems, 1966.

Feng, D.C., "Preliminary Survey of the Medicinal Plants of British Guiana," West Indian Medical Journal, 5(4), December 1956: 265-270.

Festinger, L. and Katz, D., Research Methods in the Sciences, (N.Y. Holt, Rhinehart and Winston, 1953).

Foner, Nancy, "West Indians in New York City and London, A Comparative Analysis," International Migration Review, 13: 284-297, 1979.[D

Foster, George M., "Problems in Intercultural Health Programs," Social Science Research Council, Pamphlet, No. 12, New York, 1958.

Friessem, D., "Psychiatric Disorders Among Foreign Workers in a Metropolis in South West Germany," in L. Miller (ed.) 4th International Conference on Social Psychiatry, Jerusalem, Alv Coop, 1972.

Gonzalez, Nancie S., "Health Behavior in Cross-Cultural Perspectives," Human Organization 25(2): 1966, pp. 122-125.

Goodman, F.D., "Glossolalia: Speaking in Tongues in Four Cultural Settings," Contemporary Psychology, 1969: 12(24): 113-129.

Guillen, Nicholas, "The Black Man and the Caribbean as seen by Nicholas Guillen and Lius Pales Matos," Caribbean Quarterly, 25: 72-79, March-June, 1979.

Haenzel, W.D. and Sirhen, M., "Lung Cancer Mortality as Related to Residence and Smoking Histories," Journal of the National Cancer Institute, 1962 (28) 949-1001.

Hall, Herman, 200 Years of West-Indian Contributions, New York: Herman Hall Associates, 1976.

Hallowel, A.J., "Ojibwa World Views and Disease," in Man's Image in Medicine and Anthropology, Iago Galdston, (ed.), International University Press, N.Y., 1965, pp. 258-315.

Harwood, Alan, (ed.), Ethnicity and Medical Care, Harvard University Press, 1981.

Heiss, J., "Factors Related to Immigrant Assimilation: Early Post-Migration Situation," Human Organization, 26, 1976.

Hessler, R., M.F. Volan, B. Ogburu, and P. New,

"Intraethnic Diversity: Health Care of the Chinese Americans," in Human Organization, 1975 (34): 253-262.

Hoope, S.K. and Heller, P.L., "Alienation, Familism, and the Utilization of Health Services," Social Behavior, 1975, 16(3): 304-314.

Hurbon, Laenec, Dieu Dans Le Voudou, Haitian, Paris: Payot, 1972.

James, Sybil M., "When Your Patient is Black West Indian," American Journal of Nursing, November, 1978.

Jerome, Julius, Rasta Doctor and a Unique Medical Clinic in Jamaica, West Indies, The Divine Theocratic Government of Rast Tafari, Selassie I., 1969.

Kalter, Joanmarie, "Caribbean Immigrants Clout" Newsday, The Long Island Newspaper, (N.Y. edition), January 12, 1984.

Keely, Charles and Elwell, Patricia, "International Migration: Canada and the United States," Global Trends in Migration, (ed.) by Mary Kritz, Charles Keely and Silvano Tomasi: (New York: Center for Migration Studies), 1981.

Kerlinger, Fred N., Foundations of Behavioral Research, Second Edition: (Holt, Rinehart and Winston, Inc., N.Y. 1973).

King, Stanley H., "Social Psychological Factors in Illness," Handbook on Medical Sociology, Howard Freeman, et. al. (eds), Prentice Hall, Englewood Cliffs, N.J.,
Kino, F.F., "Refugee Psychosis in Great Britain: Aliens' Paranoid Reactions," Journal of Medical Science (97) 1951.

Kitzinger, Sheila, "Protest Mysticism: The Rastafarian Cult of Jamaica," Journal of Scientific Studies of Religion, Fall 1969, 8(2): 240-262.

Kleinman, A. and Sung, L., "Why do Indigenous Practitioners Successfully Heal?" Social Sciences and Medicine 13B(1979): 7-26.

Knight, Franklin E., The African Dimension in Latin American Societies, New York: McMillan, 1974.

Koss, Joan D., "The Therapist Spiritual Training Project in Puerto Rico: An Experiment to Relate the Traditional Healing System to Public Health System," Social Science

and Medicine, Vol. 146, No. 4, 1980, pp. 255-266.

Kotlichuck, David K., (ed), Prognosis Negative: Crisis in the Health Care System, Vintage Books, New York, 1976.

Kritz, Mary M., "International Migration Patterns in Caribbean Basin: An Overview", Global Trends in Migration.

Landy, David, "Role Adaptations: Traditional Cures, Under the Impact of Western Medicine," American Ethnologist, 1974 (1) 103-127.

Laquerre, "Health Belief and Practices of Haitian-Americans" in Handbook of Ethnicity and Medical Care, Alan Harewood, ed., N.Y., 1978.

Larkin, Gary, "Caribbean Commission Sought," The Legislative Gazette, (Albany, N.Y., February 13, 1979).

Laternari, Vittoria, The Religions of the Oppressed: A Study of Modern Messianic Cults, Lisa Sergio, translator, N.Y.: Knoff, 1963.

Leacock, Seth and Ruth, Spirit of the Deep: A Study of an Afro-Brazilian Cult, New York: Natural History Press, 1972.

Machivelli, Niccolo, The Prince (Translated with Introduction by George Bull, Baltimore, MD: Penguin Books) 1961.

Manning, Peter and Fabrega, H.F. Jr., "The Experience of Self and Body: Health and Illness in the Ghipar Highland" in Phenomenological Sociology, George Prathar, ed., John Wiley, N.Y., 1973: 251-301.

Martinez, Cervando and Martin, Henry, "Folk Disease Among Urban Mexican-Americans: Etiology, Symptoms and Treatment," Journal of the American Medical Association, 1966 (196): 161-164.

Mason, Marco A., "Leadership Networks in the Caribbean Immigrant Community: A Model of Mutual Assistance Efforts," in Immigrants and Refugees in a Changing Nation: Research and Training, Lucy M. Cohen and Mary Ann Grossnickle, Editors, The Catholic University of America Press, Washington, D.C. 1983.

Merton, Robert, Social Theory and Social Structure: The Bearing of Sociological Theory on Empirical Research,

- Revised Edition, (Free Press, Glencoe, Ill., 1957).
- Metraux, Alfred, Voodoo in Haiti, New York: Schochen, 1972 (Translation from 1959, French edition).
- Miller, Delbert C., Handbook of Research Design and Social Measurement, third edition: (McKay Co., Inc., N.Y. 1977).
- Mintz, Sidney, "The Caribbean as a Socio-Cultural Area," In Peoples and Cultures of the Caribbean, Michael Horowitz, ed., New York: The Natural History Press, 1971.
- Mintz, Sidney W., Working Papers in Haitian Society and Culture, New Haven: Yale, 1975.
- Montiero, Lois, "Immigrants Without Care." Society, Sept./Oct. 1977, pp. 38-42.
- Mulcaky, David, "A Sketch of Vincentian-Portugese Folk Botany and Medicine," in Thomas M. Fraser (ed.) Windward Road: Contributions of the Anthropology of Saint Vincent Amherst, University of Massachusetts, Department of Anthropology, (Research Report No. 2) 1973: 108-122.
- Murphy, H.B.M., "The Low Rates of Mental Hospitalization Shown By Immigration to Canada," in Uprooting and After, by C. Zimmerman and Maria Pfister-Amende, Springer-Verluz, New York, 1973: pp. 221-231.
- McDonald, J.S. and L.D., "Transformation of African and Indian Family Traditions in the Southern Caribbean," Comparative Studies in Society and History 15: 171-198, March 1973.
- McDonald, Vincent R., Caribbean Issues of Emergence: Socio-Economic and Political Perspectives, Washington, D.C., University Press of America, 1980.
- McKinlay, John B., "Some Approaches and Problems in the Study of the Use of Services: An Overview," Journal of Health and Social Behavior, June 1972, 13: 150-152.
- McLaughlin, Megan, West Indian Immigrants: Their Social Networking and Ethnic Identification (Doctoral Dissertation), Columbia University, 1981.
- Nicholas, Tracey, Rastafari: A Way of Life, Garden City, N.Y.: Doubleday, 1979.
- Osei, G.K., The African Philosophy of Life, The African

Publicaion Society, London, U.K., 1970.

Pelton, Robert W., Voodoo Charms and Talismans, New York: Drake, 1973.

Pfister-Amende, Maria, "Uprooting and Resettlement as a Sociological Problem," in Uprooting and Resettlement," London, World Federation for Mental Health, 1960.

Press, Irwin, "Bureaucracy Versus Folk Medicine: Implications from Seville Spain, Urban Anthropology, 1973 (2): 232-247.

Press, Irwin, "The Urban Curandero", American Anthropologist, 1971 (73) pp. 741-756.

Press, Irwin, "Urban Folk Medicine: A Functional Overview, American Anthropologist, Vol. 80, 1978.

Press, Irwin, "Urban Illness: Physicians Cures and Dual Use on Bogota, Journal of Health and Social Behavior, 1969 (1) 209-218.

Radcliffe, Virginia, The Caribbean Heritage, New York: Walker, 1976.

Rivers, W.H., Medicine, Magic and Religion, Harcourt, Brace and Co. Inc., N.Y. 1924.

Rodney, Walter, "The Role of the Historian in a Developing West Indies," Social Scientist, 1:13-14, 1963-64.

Rosen, George, "The Evolution of Social Medicine," in Behavioral Medicine: Theory and Practice, (ed.) by Ovide F. Pomerleau and John Paul Brady, (The William & Wilkins Co., Baltimore, 1979).

Rubin, Vera, "Cultural Perspectives in Caribbean Research" in Caribbean Studies: A Symposium, Vera Rubin, ed., Jamaica: Institute of Social and Economic Research, 1957.

Rubin, Vera, (ed.), Cannabis and Culture, the Hague, Moutin, 1975.

Sassen-Koob, Saskia, Exporting Capital and Importing Labor: The Role of Caribbean Immigration to New York City, occasional paper No. 28, New York Research Programs in Inter-American Affairs, New York University, December, 1981.

Saxton, Mary McDill, "Behavioral Epidemiology," in Behavioral Medicine: Theory and Practice, (ed.) by Ovide F. Pomerleau and John Paul Brady, (The William & Wilkins Co., Baltimore, 1979).

Scott, S.C., "Health and Healing Practices Among Five Ethnic Groups in Miami, Florida" Public Health Reporter, (89) 1974: 524-532.

Sellitz, Claire; Jahoda, Marie; Deutsch, Morton; and Cook, Stuart W., Research Methods in Social Relations, (Henry Holt and Company, Inc., Revised edition, April 1969), p. 98.

Simmons, Marline, "Power of Voodoo, Preached by Sorbonne Scientist," New York Times, December 15, 1983.

Simpson, George Eaton, Black Religions in the New World, New York: Columbia University Press, 1978.

Staiana, Kathryn, "Alternative Therapeutic System in Belize: A Semiotic Framework," Social Science and Medicine, Vol. 15B, No. 3, July 1981, pp. 317-332.

Steggerda, Morris, "Plants of Jamaica Used By Nations for Medicinal Purposes," American Anthropologist (New Series), 31(3) July/September, 1929: 431-434.

Stevenson, David, "Intervillage Preference of High Blood Pressure Medicinal Plants on St. Kitts, West Indies", Medical Anthropology, Vol. 3, No. 4, 1979, pp. 503-524.

Suchman, Edward, Sociology and the Field of Public Health, Russell Sage Foundation, N.Y., 1963.

Twaddle, Andrew C. and Hessler, Richard M., Sociology of Health, The C.V. Mosby Co., St. Louis, 1977.

Tyroler, H.A. and Cassell, John, "Health Consequence of Culture Change II, The Effects of Urbanization on Coronary Heart Mortality in Rural Residence," Journal of Chronic Disease, 1964(17) 167-177.

Velimirovic, Boris, Special Feature: "Forgotten People-Health of the Migrants," Bulletin of Pan American Health Organization, 13(1), 1979.

Walcott, Derek, "Caribbean: Culture or Mimicry?" Journal of Interamerican Studies and World Affairs 16:3-13, February 1974.

Wedenoja, William, Religion and Adaptation in Rural Jamaica, Ph.D dissertation, University of California, San Diego, 1978, Ann Arbor, University Microfilm, 1979.

Weniger, B., "Plants of Haiti, Used as Antifertility Agents," Journal of Ethnopharmacology, Vol. 6, No. 1, July 1982, pp. 67-84.

Weissman, Jenna Joselit, "The History of Immigrants and Health Issues in the United States", paper prepared for the Select Commission on Immigration and Refugee Policy, 1981.

Wheeler, Thomas C., (ed) The Immigrant Experience: The Anguish of Becoming American, Penguin Books, N.Y. 1970.

Whiteford, Michael, The Forgotten Ones: Columbian Countrymen in an Urban Setting, Gainesville, University of Florida Press, 1976.

Wilson, Peter J., Crab Antics: The Social Anthropology of English-Speaking Societies of the Caribbean, New Haven: Yale University Press, 1973.

Young, James Hardy, The Medical Messiahs: A Social History of Health Quackery in Twentieth Century America, Princeton University Press, 1963.