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The 'Healthy Migrant' Effect

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A growing body of literature describes what has come to be known as the 'healthy migrant' phenomenon—the fact that on many measures, first generation immigrants are often healthier than U.S.-born residents who share similar ethnic or racial backgrounds.¹⁻⁴ Over time, however, the migrant health advantage diminishes dramatically. In what Rumbaut⁵ calls the “paradox of assimilation,” the length of time that an immigrant spends in the U.S. is correlated with increases in low birth weight infants,^{2,6} adolescent risk behaviors^{7,8} cancer,⁹ anxiety and depression,¹⁰ and general mortality.^{3,4} This is particularly surprising because immigrants tend to have higher rates of poverty than U.S.-born residents, and because many come from countries that have lower standards of living than the U.S.

Singh and Siahpush³ used data from the National Longitudinal Mortality Study (1979-1989) and found that immigrant men and women had significantly lower risks of mortality than their U.S.-born counterparts. Muening and Fahs⁴ compared hospital utilization and mortality rates of foreign-born and U.S.-born residents in New York, and concluded that immigrants were healthier and had significantly longer life expectancies than natives.

They estimated that the overall cost of providing hospital based care to the foreign-born residents in New York would be 611 million dollars *less* than care for an equivalent number of U.S.-born persons in 1996. Dey and Lucas¹¹ calculated adjusted odds ratios of selected chronic diseases using National Health Survey Data on over 196,000 respondents from 1997-2002 and found that foreign-born residents had lower levels of obesity, hypertension, diabetes, cardiovascular diseases and serious psychological distress than U.S.-born residents.

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As we begin the new year in a decade of unprecedented immigration, what topic could be more timely than the health of foreign-born women and their children who live in the U.S.? The media are filled with reports of increases in numbers of immigrants, both in the U.S. as a whole, and in non-traditional destinations such as the Midwest. In this issue of *Healthy Generations* we present a smörgåsbord of articles on issues faced by first generation immigrants in the U.S.

You may be surprised to learn that, in general, recent immigrants are healthier and live longer than U.S.-born residents who share similar ethnic or racial backgrounds. By the second and later generations this initial health advantage is reversed, due to a number of factors, including barriers to access to care. Audrey Singer of the Brookings Institution describes the role of federal welfare reform in creating some of these barriers, and Kathleen McDonough writes about similar restrictions facing low-income pregnant women in Minnesota.

Minnesota has a higher percentage of immigrants who are refugees than any other state. One of our best-known refugee groups are the Hmong. Excerpts from *Healing by Heart*, a book of case studies of Hmong families in the United States are presented.

If the articles described above motivate you to increase your own cultural competence, we have several suggestions. You might consider contacting the innovative U.MOS training program described in the newsletter or registering for a computer-based course on Immigrant Health Issues offered by the University of Minnesota. Finally, we recommend that everyone study the “Eight Steps to Better Health for Immigrant Minnesotans” that form part of the recommendations from the Department of Health’s Task Force on Immigrant Health. We are very pleased to include Patricia Ohman’s summary in this issue of the newsletter.

Katherine Fennelly, Erica Fishman, Co-Editors



The “Healthy Migrant” Effect

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In a review of the national literature, I compared foreign-born residents and U.S.-born residents on the goals specified by the Minnesota Department of Health Initiative to Eliminate Health Disparities,¹² and found that immigrants did better on several of the indicators for which comparable data were available. These included infant mortality, breast and cervical cancer, sexually transmitted infections, heart disease, diabetes, teen pregnancy, suicide, tobacco use and alcohol use. One exception was immunization rates; Kandula et al.¹³ reviewed several studies showing that foreign-born children and adults are less likely to be fully immunized. Comparable reliable data was not available to compare rates of HIV and AIDS or accidental injuries.

The ‘healthy migrant’ phenomenon has also been observed in Canada,¹⁴ Australia¹⁵ and several countries of Western Europe.¹⁶⁻¹⁸ Hyman, of Health Canada,¹⁴ for example, has done an extensive review of the literature on immigration and health and concluded that, “in Canada national health survey data show that recent immigrants, particularly from non-European countries, are in better health than their Canadian-born counterparts.” However, in the U.S. and each of the countries cited above the migrant health advantage diminishes dramatically with each successive generation and translates into health *disparities*.¹⁴⁻¹⁹

Why is the Healthy Migrant Effect Short-Lived?

There is evidence of a deterioration in some indicators of health after immigrants have settled in the U.S.^{7,16,20-22} Noh and Kaspar²³ describe the change from health advantages to disadvantages of immigrants as a function of acculturation.

“The more ‘they’ become like ‘us,’ immigrants and immigrant children fail to maintain their initial health advantages... The process is poorly understood, but may be the result of the adoption of our poor health behaviors and life styles, leaving behind resources (social networks, cultural practices, employment in their field of training, etc), and ways in which the settlement process wears down hardiness and resilience.”

One area in which immigrants may not enjoy health advantages is mental health. The prevalence of depression and other mental health conditions may be higher for immigrants than U.S.-born Americans, although the data are not consistent. Hyman,¹⁴ for example, cites studies demonstrating that Mexican immigrants have significantly lower rates of post-traumatic stress disorder and depression than U.S.-born Mexicans. Most researchers agree, however, that refugees (a subset of immigrants) are at high risk for mental health problems as a result of exposure to deprivation, violence and forced migration.²⁴

Environmental Correlates of Health

Immigrants come to the U.S. with a variety of experiences and environmental exposures. Their experiences in the U.S. vary by age, education, professional status, wealth, English language proficiency, skills, etc. While no single profile can adequately describe



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U.S. immigrants, many are disproportionately exposed to poverty and poor housing. The nature of these exposures, and their persistence in a single lifetime, or over generations, can have important effects on health.

Poverty. Poverty is strongly associated with health risks and barriers to care. Sixteen percent of the foreign-born and 11% of U.S.-born residents in the U.S. were living below poverty in 2002.²⁵ The percentage of immigrants in poverty varies greatly by national origin group and educational levels, but regardless of national origin, immigrants are much more likely than U.S.-born residents to be poor, even though they are equally likely to participate in the labor force.²⁶

Housing. One consequence of poverty is poor housing. The lack of adequate and affordable housing has important implications for immigrant health, since over half of severely crowded households in the U.S. are inhabited by immigrants.²⁷ Although inadequate housing can contribute to stress and illness for all low-income residents, immigrants are especially vulnerable if poor housing co-exists with barriers of language and large family size. They may also be particularly susceptible to housing discrimination, either because they are unaware of their rights, or because they may fear reprisals for reporting substandard housing conditions or exploitation.

Housing is related to health in a variety of ways. Substandard housing can be a direct cause of accidents, physical ailments and stress, as well as an indirect source of health problems related to barriers to receiving services. In a recent study of children in homeless shelters in New York City, McLean et al.²⁸ found that half of the children had symptoms consistent with asthma. They attribute this extremely high incidence to both environmental risks, and to the social disruption caused when families are isolated from transportation, friends, schools and medical services. Evans and Well²⁹ reviewed the literature and described the links between poor housing and poor mental health in the general population, and Magaña and Hovey³⁰ have described similar links among Latino farmworkers in the Midwest. In the latter study, rigid work demands and poor housing conditions were associated with high levels of anxiety.

Access to Care. Barriers to access to health care in the U.S. have been strongly implicated as a source of increasing health disparities between immigrants and U.S.-born residents. Riedel³¹ notes that access is a problem facing all vulnerable populations in the U.S. However, the problem is particularly acute for the foreign-born. The Kaiser Commission²⁶ reported that in 1999, “of the 9.8 million low-income non-citizens, almost 59% had no health insurance in 1999 and only 15% received Medicaid” (compared with low income citizens of whom 30% were uninsured and 28% received Medicaid). Low levels of insurance coverage for immigrants are the result of two factors. First, although foreign-born residents have high rates of labor force participation, they are over-represented in jobs that do not provide health insurance. Secondly, federal and state legislative changes tied to Welfare Reform have resulted in severe restrictions on immigrant eligibility for Medicaid and other benefits. Restrictions are most severe for undocumented immi-

grants, who are primarily Latino.³² (See articles by Singer and McDonough in this issue of *Healthy Generations*).

Behavioral Factors

Changes in diet and increased use of tobacco, alcohol and drugs account for some of the increases in health problems among immigrants. Acculturation to an unhealthy American diet is associated with obesity, diabetes and cancer.³³ Mazur et al³⁴ discuss the ways in which acculturation (measured as time in the U.S.) increases the risk of obesity and chronic disease among Mexican American adults, as the result of increased consumption of fat, decreased consumption of fiber, and less physical activity. They describe the generally more nutritious diet of first generation Hispanics as “culture-based protection against adverse health effects normally associated with low income.” Similarly, Fishman et al.³⁵ found that children of Hispanic immigrants were less likely to eat junk food or to skip meals than their non-migrant peers, but that over time, these differences disappeared.

Several authors have also shown that rates of smoking and substance abuse among adolescents increase with time in the U.S. For example, Gfroerer and Tan³⁶ analyzed data from the National Household Survey of Drug Abuse and found lower rates of tobacco, alcohol and illicit drug use among foreign-born youth, but increasing rates with greater time in the U.S. They speculate that acculturation increases exposure to peers, adults and mass media that could influence a youth’s propensity to use substances.

Conclusion

We do not wish to over-state the health advantage of first generation immigrants. As Kandula et al. describe in their comparisons of the health of U.S.- and foreign-born individuals, we do not have good comparative data on a number of health conditions, and there are significant differences in the incidence of known conditions *among* and *within* various immigrant groups. Furthermore, the foreign-born have higher rates of some serious conditions such as tuberculosis (TB).^{*} However, as immigrants stay in the U.S., their change from health advantage to disadvantage on so many indicators underscores the deleterious effects of poverty and barriers to health care and social services. For first generation immigrants these conditions reduce, and even eliminate many of the protective factors that account for their initially superior health status and lower mortality rates. Equally disturbing is the carry-over effect of these factors for the U.S.-born children and grandchildren of immigrants. As any health professional can attest, the apparent cost-savings of restrictions in access to adequate housing, preventive care, and social service ‘safety nets’ for vulnerable families are quickly overwhelmed by the subsequent need for curative care and emergency services.

* TB rates are higher among immigrants than among U.S.-born individuals, although TB case rates for both groups have dropped dramatically since 1992⁵.

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Terminology

The term 'immigrant' can be used generically to include anyone who is foreign-born, or it can be used to refer to people who enter with an immigrant visa with plans to settle in the U.S. (as opposed to entering as tourists or students, for example).

The Bureau of Citizenship and Immigration Services (BCIS) makes technical distinctions among the following groups.

- **Refugees** are foreign born individuals who are not U.S. citizens and cannot or are unwilling to return to their home countries due to a well-founded fear of persecution because of their race, religion, nationality, political opinion or membership in a particular social group. A refugee receives this status **prior** to entering the U.S., and refugees are eligible to become permanent residents after one year in the U.S.
- **Asylees** are foreign-born individuals who are already in the U.S. and who seek asylum because they are unable or unwilling to return to their country because of a well-founded fear of persecution because of their race, religion, nationality, political opinion or membership in a particular social group. An asylee receives this status **after** entering the U.S.
- **Parolees** are foreign born persons who have been given permission to enter the U.S. under emergency conditions or when their entry is considered to be in the public interest.
- **Immigrants** can be any of the above-listed legal temporary residents (refugees, asylees, parolees). Foreign-born persons admitted to the U.S. as actual or prospective permanent residents can also be immigrants. People with immigrant visas become 'lawful permanent residents' (LPRs) once they enter the U.S.
- **Non-immigrants** are persons who can be classified under one or more of the following: undocumented individuals, tourists, visitors on business, or foreign/international students. 'Illegal aliens' or 'undocumented' individuals are persons who have entered the U.S. without passing through border inspection, or who overstay temporary or short-term visas.
- **Migrants** are individuals who change their place of residence to move to another area. International migrants are individuals who leave their country of origin to seek residence in another country.

Sources: USCIS.gov., Minnesota Department of Health



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The recent book *Healing by Heart: Clinical and Ethical Case Stories of Hmong Families and Western Providers*¹ explores the important cultural issues in working with immigrant Hmong patients and families and portrays a model of culturally responsive health care for all patients. *Healing by Heart* is story based. Fourteen case stories depict various aspects of clinical and ethical conflicts from across the life cycle. After each case story, commentaries written by Hmong and non-Hmong professionals, family members, and community members describe divergent perspectives about the conflicts. These multi-vocal commentators allow readers to better understand the complexity of culture, and the ways to address and resolve cross-cultural ethical conflicts. Also identified are questions health care providers can focus on as they seek to understand the health-related moral commitments and practices prevalent in the cultural groups they serve, ethical questions that arise frequently and with great poignancy in cross-cultural health care relationships, and points to consider when a patient's treatment wish challenges the provider's professional integrity. The following is an excerpt from the book.

Xong Mary Hang

Xong Mary Hang was a one-year-old girl whose mother brought her to the community clinic for a well-child check. She lived with her sixteen-year-old mother, who attended high school; her eighteen-year-old father, who worked; and her paternal grandparents, who took care of her during the day. Her mother's primary concern was that Xong's skin was yellow. In response to Dr. Anderson's questions, she reported that Xong was drinking up to eight fluid ounces of whole milk six or seven times a day, as well as once or twice during the night. She was a picky eater, preferring to drink milk rather than eat rice, meat, or vegetables.

On examination, Xong was overweight for her small height, pale but not jaundiced, and had a 9.2 hemoglobin (normal range is 12-14). Dr. Anderson diagnosed iron deficiency anemia, which she felt was related to too much milk consumption....

The mother explained that they simply could not get the child to change her behaviors toward milk, food, and the bad-tasting iron supplement. The mother agreed to injections of iron and agreed to let a public health nurse visit their home. Shoua Moua, the public health nurse, made weekly home visits for a month, evaluated the situation, provided education, and supported behavior change. She reported that the grandparents watched the child every day and that they had trouble insisting that the child give up the bottle and eat solid foods. They felt the child would starve without the bottle and they could not bear to hear her cry when they withheld it. Two of the grandparents' children had starved to death in Laos, including one infant who had died during the war and refugee flight from an insufficient supply of breast milk. The grandparents told the nurse they only wanted to love and care for (*hlub*) Xong.

Questions about Culture

- What cultural beliefs and practices as well as refugee experiences are contributing to Xong's iron deficiency anemia?
- What are the prevalent attitudes and assumptions about bottle-feeding in mainstream Anglo-American culture? How do they differ from those in Hmong culture?

Questions about Cross-cultural Health Care Ethics

- How did the grandparents, parents, and physician differ in their assessment of what was in Xong's best interest?
- How closely must Xong's treatment resemble the U.S. standard of care for children with anemia?

Questions about Culturally Responsive Health Care

- How can health care practitioners help refugees whose experience with trauma and deprivation provide barriers to their accepting health care recommendations?

For further cases studies and examples of issues related to Hmong health care, please read *Healing by Heart*.

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In 1996, President Clinton signed into law the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA, also referred to as “welfare reform”), which dramatically changed non-citizen eligibility for most federally funded assistance programs. This change had a substantive impact on non-citizen program participation, and also a symbolic effect, causing fear and confusion within immigrant communities. Both the substantive and symbolic effects served to reduce immigrant families’ participation in welfare programs.

The law as originally passed denied federal welfare benefits to most legal immigrants during their first five years of U.S. residence and placed other restrictions on legal immigrants’ eligibility for benefits. These programs included Temporary Assistance for Needy Families (TANF), Food Stamps, Supplemental Security Income (SSI), and Medicaid. The restrictions imposed by welfare reform rendered legal immigrants already in the U.S. (“pre-enactment” immigrants) immediately ineligible for most federally funded programs. In addition, immigrants who entered the U.S. after the date of passage of PRWORA (“post-enactment” immigrants) were ineligible for federally funded benefits during their first 5 years of residence. Refugees and asylees had a seven-year period of eligibility after entering the U.S. during which they could receive federally financed benefits. Persons in the U.S. on temporary visas (non-immigrants) were ineligible for most benefits. PRWORA explicitly denied most federal benefits to undocumented immigrants; however, they continued to be eligible for emergency Medicaid.

Prior to welfare reform, most immigrants (that is, legal permanent residents or LPRs) were eligible for federal benefits on the same basis as citizens. Now eligibility is differentiated for U.S. citizens, pre-enactment immigrants, and post-enactment immigrants. Once LPRs naturalize, they become eligible for the same federal benefits as U.S. born citizens.

Since the implementation of the law, Congress has made several important federal restorations for non-citizens in the Food Stamps and Supplemental Security Income (SSI) Programs, but non-citizen eligibility rules for TANF and Medicaid remain as they were legislated by PRWORA. The Balanced Budget Act of 1997 restored eligibility to pre-enactment immigrants who were receiving SSI prior to welfare reform and to those pre-enactment immigrants who subsequently become disabled. The Agricultural Research, Extension, and Education Reform Act of 1998 expanded Food Stamp eligibility to child, elderly, and disabled immigrants who were residents prior to PRWORA’s passage. A further expansion of Food Stamp eligibility came with the Farm Security and Rural Investment Act of 2002, which provides eligibility to all immigrant children, regardless of entry date, as well as to all legal immigrants who have lived in the U.S. for at least five years.

State and local governments also felt the effects of PRWORA. States had to decide whether to continue to use federal funding to provide TANF and Medicaid to pre-enactment LPRs or create state-funded programs for non-citizens who were

no longer covered by federal programs. Many states have these kinds of programs, including those with large immigrant populations like California: as of December 2002, 24 states were covering TANF and 13 states had food assistance programs for post-enactment immigrants for the 5-year period during which they are barred from accessing federally aided programs. In addition, nearly half of all states provide some health care coverage for ineligible immigrants.

Several recent analyses show that non-citizen participation in federal programs has declined since PRWORA was implemented. An analysis of administrative data by the Congressional Research Service (CRS) shows roughly the same pattern of non-citizen participation for the SSI, Food Stamp and TANF programs. A rise in program participation in the early 1990s was followed by a drop in participation in the latter half of the 1990s, falling to a low point in the years following welfare reform. In the 2001-2002 period, SSI participation by qualified non-citizens was back to levels seen in the mid-1990s, and TANF use by adults was lower than its peak usage in 1996.

Several analyses of participation using the Current Population Survey (CPS) by the CRS and the Urban Institute show that prior to PRWORA, the foreign born were more likely to use SSI but less likely to use Aid to Families with Dependent Children (precursor to TANF) or food stamps than the native born. Elderly and refugee non-citizens appeared to be participating in these programs disproportionately. Other studies using the CPS found a decline in program participation across the entire population between 1994 and 2002, with a sharper decline for non-citizens, including refugees who continued to be eligible for program participation. Medicaid use by U.S. born children of non-citizen parents appears to have declined in the post-PRWORA period. Many advocates are concerned that the parents of these U.S. citizen children would be reluctant to enroll them for benefits because of a mixture of confusion about eligibility or fear of public charge/deportation.

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Will Minnesota Continue to be a National Leader in Health Care for Low-Income Pregnant Immigrant Women?



Kathleen McDonough, JD

During the 1990s, the Minnesota Legislature passed significant health care reforms designed to expand access to publicly funded health care for pregnant women receiving Medical Assistance (the joint federal-state health care program called Medicaid in other states) and MinnesotaCare (the state-subsidized health insurance program for the working poor). The goal was to reduce infant mortality and improve child health.¹ Emphasis was placed on services to pregnant women because prenatal care is widely regarded as the most cost-effective way to improve the outcome of pregnancy for all women and infants.²

Starting in 1995, Medical Assistance and MinnesotaCare income eligibility standards for pregnant women was increased to 275% of the federal poverty guidelines (FPG).² Other incentives, including special work expense deductions, were added to encourage program participation. Recognizing that all babies born in the U.S. become U.S. citizens, the eligibility expansions included pregnant immigrant women. Lawfully-residing pregnant immigrants received full health care benefits, including pre- and post-natal care funded by federal/state dollars. Undocumented and non-immigrant pregnant women (including foreign students, visitors and tourists) received pre- and post-natal care funded solely by state dollars, while labor and delivery were covered by joint federal/state funding. These reforms helped make Minnesota a national leader in health care for pregnant immigrant women.

Then in 1996, Congress passed sweeping welfare reform legislation that severely restricted immigrants' eligibility for Medicaid (Medical Assistance in Minnesota) (see article by Singer, this issue). Due to the federal restrictions, the 1997 Minnesota Legislature enacted a state-funded Medical Assistance program that provides full health care coverage for lawfully-residing pregnant immigrant women. Undocumented and non-immigrant pregnant women remained eligible for state-funded pre- and post-natal care and federal/state emergency Medical Assistance for labor and delivery costs. Most low-income pregnant immigrant women could access needed health care from one of the programs.

In 2003, due to a \$4.5 billion budget deficit, Minnesota's Governor and House of Representatives introduced legislative proposals to cut back health care benefits for pregnant women. One proposal was to eliminate state-funded pre- and post-natal care for undocumented and non-immigrant pregnant women. Another proposal was to reduce the Medical Assistance income standard for pregnant woman from 275% to 200% FPG and to eliminate the special work expense deductions. Pregnant women with income above 200% FPG would have the option to enroll in MinnesotaCare and pay premiums in excess of \$300 per month. After a hard-fought battle, pre- and post-natal care for undocumented and non-immigrant pregnant women was preserved. It was decided that federal, State-Children's Health Insurance Program (S-CHIP) funds would be used to pay for the benefits.

However, the 2003 Minnesota Legislature passed the proposal that reduced the pregnant woman income standard to 200% FPG and eliminated the special work expense deductions. After the session ended, inquiries from advocates led the Minnesota Department of Human Services to determine that these reductions were a

potential violation of federal law, which would threaten Minnesota's receipt of S-CHIP funding; hence, the reductions were not implemented.

Looking ahead, health care coverage for low-income pregnant immigrant women remains in jeopardy due to persistent budget problems in the State.

References

1. Minnesota Departments of Health & Human Services, 1994. Minnesota Health Care Reform Waiver.
2. Flowers-Bowie L. 1997. America's newcomers: funding prenatal care for unauthorized immigrants: challenges lie ahead for states. National Council of State Legislatures.

Kathleen McDonough, JD, is an attorney with the Legal Services Advocacy Project, which is a part of Mid-Minnesota Legal Assistance (MMLA).

Notes on Immigrants in the Midwest

The demography of rural midwestern communities is changing dramatically, but many of our institutions have not kept pace with the needs of new African, Asian, and Latino residents. The absolute numbers of immigrants in the Midwest are significantly lower than those in southern border and coastal states. However, the draw of jobs in meat and poultry processing plants, canneries, and farms has resulted in dramatic increases in the proportion of immigrants in towns that, until recently, lacked diversity. Schools in rural Minnesota communities such as Sleepy Eye, Mountain Lake, Faribault, St. James, Willmar, Winona, Blooming Prairie, East Grand Forks, Worthington and Moorhead have enrollments ranging from 15 to 50% immigrant youth.

Between 1990 and 1998 enrollment in Limited English Proficiency programs in the state increased by 158% and the number of Spanish-speakers increased by 400%. In just the four years between 1995 and 1998, the number of Southeast Asian language speakers doubled, and the number of Eastern Europeans and Russians quadrupled. Recent immigration of African refugees from Somalia and Liberia make these settlements in Minnesota among the largest in the United States.

Health care and social service providers in the region who are accustomed to treating primarily Scandinavian-origin families and some Latino residents are suddenly seeing refugees from Somalia, Ethiopia, Laos, Bosnia, Cambodia and the Sudan. These populations present unique health care issues such as tropical diseases, female genital mutilation, and active cases of tuberculosis. Language barriers can be a challenge. Providers must also be aware of culturally specific dietary, childbearing, and religious practices of immigrant clients. They may also find themselves unfamiliar with these populations' beliefs about health and illness. The consequences of torture, violence, and extreme poverty may also need to be considered. In order to meet the needs of these new residents, it is imperative for providers to understand the context and motives for immigration, as well as the characteristics, practices and belief systems of their clients. Equally important is the need for providers to be versed in the impacts of poverty, discrimination, and the availability of basic services relating to the health and well being of new immigrants once they arrive in the United States.



Improving the Health of Minnesota's Immigrants

Recommendations from the Minnesota Commissioners' Task Force on Immigrant Health

Patricia Ohmans, MPH

Immigrant Health: A Promise Unfulfilled

Every week, at least 50 new immigrants arrive in Minnesota. They come, as they have for the past 200 years, for many reasons: to make their families whole, to earn a better living, to achieve healthier futures for themselves and for their children. However, the reality, especially in health care, is often starkly different than they expected.

The Cost of Inattention

Depending on their legal status, their assets, and whether they have health insurance, immigrants to Minnesota are among the least served by the state's excellent health and social service systems. Even when immigrant patients are seen in Minnesota social service agencies, clinics and hospitals, their distinctly different clinical and social needs are often minimized or misunderstood. The results can be costly, in many ways, including:

- Lack of insurance and crippling payment systems discourage many immigrants from seeking the health care they need. Those accessing care may feel their concerns are minimized when language and cultural differences make it difficult to be understood.

The result? Poorer health for immigrants and increased expenses to the health care system.
- Immigrants and refugees need screening and treatment for infectious diseases, chronic conditions such as diabetes and high blood lead levels, and depression. Often, they do not get them.

The result? Higher rates of infectious diseases, some chronic conditions and some mental health problems among immigrants and refugees than among non-immigrant groups.
- Health care providers, most from very different cultures than immigrant community members, may not be aware of significant communication barriers with their patients.

The result? Lower rates of comprehension and adherence to doctors' orders by immigrant patients. Such communication barriers can be cultural, rather than solely linguistic.
- Immigrants who are denied access to health care or insurance, may seek health care only in emergency situations.

The result? Higher health care costs and lower productivity in industries that employ immigrants.
- Highly trained and capable immigrant health care providers are not being integrated into our current health care workforce.

The result? A loss of human capital, as former immigrant physicians and nurses are re-trained for other work.

A Commitment to Do Better

The members of the Minnesota Commissioners' Task Force on Immigrant Health believe health care to immigrants can be improved. Sponsored by the Minnesota Department of Health and the Minnesota Department of Human Services, the Task Force consisted of over 80 representatives from the state's public, private,

non-profit, academic and health care sectors, many of them also first-generation immigrants to the state. Dr. Patricia Walker, Medical Director of the Center for International Health at Regions Hospital, served as the Task Force chairperson. The Task Force met every two months from July 2002 to July 2004, with the following mission: "To promote quality, comprehensive and culturally competent health care for all recent immigrant communities, by effecting change in statewide health delivery systems."



Eight Steps To Better Health For Immigrant Minnesotans

Focusing on improvements in the areas of information, policy, health care systems and education, members of the Task Force agreed upon eight essential ways to improve the overall health of immigrants in Minnesota. While the first recommendation, "provide equal access to care for all..." could be viewed as the most important one, the remainder are not in any priority order. All recommendations are vital and interconnected. The Task Force's Steps to Better Health for Immigrant Minnesotans are:

Provide equal access to care for all, regardless of immigration or insurance status. Differences in access to health care between immigrants and non-immigrants exacerbate health disparities.

Collect information on race, ethnicity, and language preference of all patients, and on health care organizations' ability to meet the needs of immigrant patients. Improvements in care for immigrants cannot be documented without data linking immigrant status with health status. Health care facilities should also document their capacity to provide good care to immigrants.

Eliminate financial disincentives to health care for recent immigrants. Caring for immigrant patients sometimes takes longer. This is more costly in the short run, especially given the need for interpreting, but it is cost effective in the long-term.

Diversify the health care workforce to include more immigrant and minority providers. Health care works best when patients and providers share backgrounds and values, but minorities and immigrants are under-represented in health care professions, and capable foreign-trained providers are not being used to full advantage.

Use trained interpreters. A trained interpreter facilitates communication between a patient who speaks limited or no English, and the health care provider. Despite existing legal mandates, many health care facilities are not equipped with interpreter services for LEP (Limited English Proficiency) patients.

Develop clinical guidelines and best practice orders for immigrant health care. Adherence to evidence-based best practices ensures consistency of care for immigrants.

Use community health workers. As members of the community they serve, they can be highly effective guides to better health for immigrants. Professional standards, training, and certification systems should be developed to enhance the effectiveness of these important health care providers.

Train health care providers on immigrant health issues and best practices, and teach immigrant patients how to navigate Minnesota's health care system. Providers trained to work across language and cultural barriers can be more effective in treating immigrant patients. Patients who are familiar with U.S. health care systems adhere more readily to treatment and may have better outcomes.

Resources and Models Support the Recommendations

Task Force members were careful to ensure that the recommendations they issued were well supported, credible, and feasible. They reviewed local, state and national reports and research that pertained to each of the eight recommendations. Required background reading for Task Force members included urgent and timely reports from the Institutes of Medicine, such as *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. *The National Standards for Culturally and Linguistically Appropriate Services in Health Care*, issued in 2001 by the Office of Minority Health, U.S. Department of Health and Human Services, also guided the Task Force. In addition, the Task Force identified Minnesota programs and practices that exemplify one or more of the eight steps. They also drafted suggestions for ways that policy makers, health care providers and administrators, educators and immigrant advocates can implement the eight steps.

The End Product: An On-Line Resource, a Printed Report, and a Commitment To Do More

The recommendations, action steps, program examples, and contact information are listed on the Task Force's website, designed to be a rich resource of information for anyone interested in immigrant health. (www.health.state.mn.us/refugee, click on "Immigrant Health Task Force Report") References and resources are listed after each action step.

With the production of its website and final report, the Task Force's work as a state-sponsored body was complete. Individual members committed themselves to work singly and collectively to carry out its recommendations. Ideas for further work include:

- An on-line action network with information, current research and policy initiatives on immigrant health;
- Regular follow-up meetings of Task Force members to report on successes and challenges;
- A conference on immigrant and refugee health issues; and
- Members' linkages to other relevant bodies, such as the Minnesota Task Force on Health Care Disparities.

Patricia Ohmans, MPH, provided consulting coordination to the Immigrant Health Task Force. She is founder of Health Advocates, which provides policy and program consultation on cross-cultural, immigrant and international health in Minnesota (www.healthadvocates.info). She is a graduate of the School of Public Health, University of Minnesota.

Data Moment

As health professionals it is likely that you have an interest in immigrants and maternal/child health issues. How do we define immigrants, and how many immigrants are there in the United States, or in a given community? At first glance these may seem like straightforward questions, however, they are actually extremely complex.

Think about your own geographic community. How many immigrants live there? After you make a 'guesstimate,' reflect on what different populations you had in mind. What groups are included or excluded when researchers or providers count immigrants based upon each of the following variables: place of birth? language spoken? race/ethnicity? Which definitions include and exclude the U.S.-born children of foreign-born adults? Are refugees counted as 'immigrants'?

It is also important to think about the implications of using different definitions of immigration status and race/ethnicity. To do this, ask yourself the purpose or need for the definition. The measurement choice you make may be quite different if your purpose is to determine eligibility for services vs. access to care vs. differences in health behavior or susceptibility to particular diseases. Here are some typical ways people are classified or counted:

- foreign born or foreign ancestry (e.g. self-denomination in census data)
- U.S.-born children of foreign-born adults
- INS statistics on visas issued (will you include visitors in your count?)
- Minority group members
- Limited English Proficiency (LEP) children and adults
- Refugees
- People seeking services (e.g. foreign victims of torture; attending international clinics; or seeking services from health departments, church groups, social service agencies, immigrant associations)

Given the diversity of definitions, it is important that definitions are clearly stated and consistently expressed when data are compared from more than one source.

Current Population Reports

U.S. Census reports describing the foreign born population in the U.S., contrasting them by U.S. citizenship status and by year of entry, in four time spans can be found at: <http://www.census.gov/prod/www/abs/for-born.html>.



UMOS Inc.

Hispanic and Migrant Cultural Competency

Mary Ann Borman, PhD

In 1988, UMOs began providing capacity building to individuals, organizations and communities to develop and enhance HIV prevention efforts in the Hispanic and migrant communities on a national level. UMOs, Inc. is a multi-state non-profit organization providing job training, placement, education, housing, health and social service programs targeted to the Hispanic community in Wisconsin, Minnesota, South Dakota, Texas, Kansas/Missouri and Florida. These efforts include trainings and technical assistance on HIV prevention models and cultural competency skills to reach targeted populations in social service, clinics and community-based agencies. This program is conducted in partnership with the Centers for Disease Control and Prevention (CDC).

The issue of HIV prevention education in the migrant community was controversial; there were concerns migrants might be stigmatized by participation in AIDS prevention programs. It was clear from the start that information had to be provided within the context of the cultural value system of the migrant community. Through the process of involving the migrants in planning relevant curricula to meet their needs it became evident that unless the program included a true partnership between the migrant community and the migrant service providers, it would not be viable. The challenge lay in educating staff in the health departments, clinics and human service programs that it was clear they had as much to learn about the migrant community and clients they were serving as the migrant community had to learn about HIV prevention.

To meet this challenge, the Cultural Competency Training & Technical Assistance Program was developed. The full curriculum is customized to meet the needs of the targeted provider participants, ranging from a two day, comprehensive training—to a three hour introductory session, with optional follow-up training and/or technical assistance. The curricula and training are focused on the Mexican, Mexican American and Tejano cultures since the majority of migrants UMOs serves come from these backgrounds.

The training begins with a cultural self-assessment exercise. This is followed by a discussion of diversity, competence, and sensitivity including information on the continuum of cultural competency, which ranges from cultural destructiveness to cultural proficiency. Participants examine cultural differences and similarities, utilizing hands-on exercises to understand issues within the context of the Hispanic/migrant community.

The second component of the training focuses on migrant farm workers in the US, and targeted state populations, providing a general overview of income, language, countries of origin, education and government benefits. They discuss overall health status concerns, and information about HIV and STI risk behaviors and beliefs among migrants.

The next component of the training program addresses key Hispanic/migrant cultural values and behavior including non-verbal and verbal communication styles, time orientation, family structure and dynamics, and views on health, illness, religion and sexuality. This information is provided within the context of migrant values, acknowledging the history and rationale for specific behaviors in order to help providers recognize and understand each of these areas. "Real life story" vignettes or "pláticas" are provided to illustrate specific points.

A fourth component offers providers practical suggestions on how to integrate HIV prevention services into their work. Technical assistance on how to implement and integrate cultural competency into the agency's program is also offered. An optional provider agency cultural competency self-assessment tool can be utilized to determine agency needs.

Evaluation results indicated a 90% increase in provider knowledge of the migrant culture after training. Eighty-five percent of agency participants reported that the information would be useful in their program. Follow-up after technical assistance sessions indicated significant organizational changes in program services. These ranged from a simple change in operating times to

accommodate migrant workers' schedules, to integration of culturally relevant changes in organizational operations and procedures (such as discontinuing the utilization of children, relatives and clinic janitorial/kitchen staff as interpreters.) In 2003, twenty-two Cultural Competency Training sessions were provided to 357 staff persons, representing 87 migrant serving providers. The providers participating in these trainings have included state and local health departments, community planning councils, migrant and community clinics, hospitals, Migrant Head Start, day care and after school staff, migrant parent council members, state and local social service staff; community based organizations, mental health and substance abuse providers, volunteers, and board members. For additional information on this program and other capacity building assistance trainings in Minnesota, contact Kelly Hansen at: kelly.hansen@umos.org or for all other states, contact Mary Ann Borman at: maryann.borman@umos.org.



Mary Ann Borman, PhD, is Director of Health Promotion at UMOs Inc.

Interested in making a difference?

Consider a Master's in Public Health (MPH) Degree in Maternal and Child Health (MCH)



PaChia Vue is a second-year student in the MCH program. She completed her undergraduate studies at the University of Wisconsin-Madison with a degree in biology. PaChia became interested in the field of public health when she participated in a research study to examine the correlation between sleep apnea and sudden unexplained nocturnal death syndrome in the Hmong population.

"I decided to attend the University of Minnesota-School of Public Health to learn how I could help promote and protect the health of the Hmong community. I wanted to learn how to conduct research, plan and implement programs, and educate the Hmong about their health issues," said PaChia.

For her field experience (required of all MCH students), and as part of her MCH Program traineeship, PaChia worked at Lao Family Community of Minnesota, a nonprofit organization that serves the Hmong community. She helped to coordinate a teen pregnancy advisory committee that consisted of 15 Hmong youth from several middle schools and high schools in St. Paul. The purpose of the committee was to start a dialogue in the community about teen pregnancy and possible solutions.

"As a member of the committee, each youth had the opportunity to voice his/her thoughts and opinions about teen pregnancy, learn about Lao Family's research on Hmong teen pregnancy, help disseminate the research findings to the community, and develop solutions to teen pregnancy," PaChia reports. The committee participated in activities such as games, skits, brainstorming activities, group discussions, journal writing and website development. "I enjoyed working with the youth and had a great experience getting hands-on training in the field of public health."

PaChia is looking forward to graduating and continuing to promote public health in the Hmong community.

What is the Maternal and Child Health Program? It is a training program for MPH students who are interested in promoting and preserving the health of families, women, children, and adolescents, including those with special health care needs. The Program is in the Division of Epidemiology and Community Health in the School of Public Health at the University of Minnesota.

Who are the faculty? The MCH faculty is multidisciplinary with expertise in epidemiology, medicine, nursing, psychology, sociology, nutrition, family studies, health education, and program administration. MCH faculty focus their research, teaching, and community service on children with chronic health conditions; reproductive health and family planning; pregnancy outcomes; social inequities in health; women's health; infectious diseases; substance use; and child, adolescent, family, and community health promotion, risk reduction, and resiliency.

Who should apply? People who care about vulnerable populations and want careers in program planning and development, evaluation, surveillance, assessment, teaching, or research. The program offers a special emphasis on MCH epidemiology for interested students. Clinical professionals, and others with advanced degrees who are interested in administering MCH-related health programs or conducting research projects are also encouraged to apply. Individuals with advanced degrees may have the option of completing the two-year MPH Program in one year.

For further information about the MCH Program, call 612-626-8802 or 1-800-774-8636; e-mail gradstudies@epi.umn.edu; or visit www.epi.umn.edu/mch/academic/ or www.sph.umn.edu

Immigrant Health Issues: Distance Education Course

The Hubert H. Humphrey Institute of Public Affairs and the School of Public Health of the University of Minnesota offer a distance education, computer-based course for providers and policy makers on immigrant health issues. The course can be taken from your home or office computer, and it offers a chance to interact with other professionals across the U.S. who share an interest in immigrant health. Immigrant Health Issues can be taken for undergraduate or graduate credit, or professional education credit. It has been approved for 50 CMEs, 50 nursing CEUs, or 6 U of MN general CEU credits. For more information contact Dr. Fennelly at kfennelly@hhh.umn.edu.

Healthy Generations Videoconference

Immigrant and Refugee Health
 Monday, March 7, 2005
 1-3 pm

Blue Earth County
 Courthouse
 Voyager Room
 410 S. 5th St.
 Mankato

Beltrami County
 MDH District Office
 1705 Anne Street, Suite 3
 Bemidji

Clay County
 Family Services Center
 1st Floor
 715 11th St. N
 Moorhead

Crow Wing County
 Courthouse
 Multimedia Room
 326 Laurel Street
 Brainerd

Hennepin County
 Edina Community Center
 5701 Normandale Road
 Board Room #349
 Edina

Lyon County
 Courthouse, 1st Floor
 607 W. Main St.
 Marshall

Nobles County
 Courthouse
 315 10th Street, 3rd Floor
 Worthington

Olmsted County
 VC Room 07
 2116 Campus Drive SE
 Rochester

Polk County
 Courthouse
 Videoconference, Room 3
 612 N. Broadway
 Crookston

Ramsey County
 MDH Distance Learning Center
 3rd Floor, Metro Annex
 130 E. 7th Street
 St. Paul

Stearns County
 Human Services, ITV Room
 705 Courthouse Square
 St. Cloud

Registration is free and limited by site. To register online, please go to www.epi.umn.edu/mch/events/videoconference.shtm and complete the registration form. For additional information, please email mch@epi.umn.edu. Certificates of Attendance will be provided. Please visit: www.epi.umn.edu/mch/events/index.shtm for any changes to these conference sites.

**UPCOMING
 EVENTS**

**Community-Based Participatory
 Research: Design and Implementation
 May 26, 2005**

For more information on this and other MCH track courses, visit:
<http://www.sph.umn.edu/publichealthplanet/events/institute/home.html>

**Center for Early Education and
 Development's 2005
 Minnesota Round Table
 Early Bilingual Language Development
 and Early Childhood Education
 April 13, 2005**

For more information visit:
<http://education.umn.edu/ceed/events/roundtable/default.html>

**Proceedings from the 2004 MCH
 Summer Institute**

Presenter information, PowerPoint slides, and audio records can be found at: <http://www.epi.umn.edu/mch/summer/2004.shtm>

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