PLANNING FOR THE HEALTH CARE OF THE SOUTHEAST ASIAN REFUGEES: A REVIEW

by

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ABSTRACT

In 1979-80 the Canadian government accepted 50,000 refugees from Southeast Asia as landed immigrants. These new immigrants, known as "The Boat people", are part of the changing pattern of world migration and come from an area that is different from Canada in terms of disease patterns, cultural beliefs and customs. They are probably also affected by their experiences of prolonged warfare and subsequent flight. The question is raised about the effect, if any, their health status will have on both the health of Canadians and/or their own future health.

It is postulated that both their own characteristics and those of Canadian society will determine the problem and affect the resolving of it. Using the fields of anthropology, sociology, and history, as well as those of medicine and health care, an extensive literature search is made to determine the characteristics of the refugee/immigrants and Canadian society, and from this to delineate the problems.

The problems are seen to be the immediate and longer term problems of 1) the spread of infectious diseases; 2) the importation of 'exotic' diseases into Canada; and 3) the effect of the life experiences, migration, and the process of adaptation to a new environment on the mental health of the immigrants. The resolution of the problems is found to be affected by the
attitudes and beliefs of Canada and Canadians, including the immigration, social and health policies of governments; as well as by the cultural beliefs and customs of the Southeast Asians.

Recommendations are made on factors seen to affect the effectiveness of health and social programs for immigrants. These include recommendations on the need for those planning and delivering health care, especially physicians, public health nurses and social workers, to be aware of the effect of culture on health behaviour and the giving of health care; and for physicians to be knowledgeable about the epidemiology and diagnosis of the so-called exotic diseases. Recommendations are also made on the roles of the different levels of government and the voluntary agencies in the immigration process with regard to immigrant health.
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INTRODUCTION

On July 18 1979 the federal government announced Canada's decision to accept up to 50,000 refugees from Southeast Asia for resettlement in this country. (1) These will be added to the approximately 14,000 Vietnamese who have arrived since the end of the Vietnam War in 1975, and will be the largest group of refugees ever to be admitted to Canada. (2)

It is recognised that patterns of world migration are changing from the large scale movements between areas of similar geography, race and culture, to a smaller movement between these areas and an increase in the migration between areas that are significantly different. This voluntary movement is complicated by a growing stream of involuntary migrants who have been uprooted for one reason or another and are looking for resettlement elsewhere. The involuntary migrants, or refugees from Southeast Asia are coming from an area of the world that is significantly different from Canada; and are known as 'The Boat people'.

The changes in world migration patterns are causing unfamiliar problems in the countries receiving migrants: there may be a problem with 'visible minorities' and racial tension; the new immigrants may find it difficult to adapt to a new environment; and there may be a risk of introducing diseases that
are a threat to the public health and/or a challenge to the diagnostic and treatment capabilities of the health services.

The questions asked are 1) what effect will the health status of these new immigrants have on the health of Canadians and/or their own future health, and 2) what factors determine the health status and affect the resolution of any problems arising from this?

This thesis will explore both the factors determining the health status of the new immigrants and those seen to affect the resolution of problems arising from this. While not prescribing specific programs and services for the health care of the refugee/immigrants, recommendations will be made on factors seen to contribute to the success or failure of such programs.
CHAPTER 1

METHOD OF APPROACH

The 'Boat people' are part of a large movement of refugees in Southeast Asia: this, and their resettlement in Canada are seen as part of the changing patterns of migration across the world. Statistics show that over the last decade a growing proportion of Canadian immigrants are coming from countries in Asia, India, and Africa, and the same phenomenon is happening to a different degree in the U.S.A. and Australia.

In those countries that have traditionally received large numbers of immigrants from Europe, the new immigrants are conspicuous because of colour, race, or custom. Because they come from areas of the world with different lifestyles and standards of living, there may be health problems associated with the move to a new environment. Over the last three decades, Great Britain and Europe have been dealing with the social and health problems associated with large inflows of people from Asia, Africa, the Caribbean, as well as from southern Europe.

There is concern that the health status of the Southeast Asian refugees on their arrival in this country, will threaten the health of Canadians; and that because of possible chronic health problems they will be a burden on health services rather than becoming contributing members of society. In view of
the changing patterns of world migration, it is felt that by examining the situation of the 'Boat people' in Canada some indication can be given of (any) changes required in the policies, programs and services designed for the settlement of immigrants per se in this country, especially those in the area of health and health care.

There are many factors involved in this examination. The health status of the immigrant/refugees will depend on their characteristics as well as on the immigration policies of Canada. Human characteristics are a product of race, culture, and social experience, as well as individual skills and motivation. These in their turn are a product of geography and history. Human needs are met within this framework and the health of the individual is a product of all of the above. Immigration, social and health policies are the product of the collective wishes of a given country, which again are a product of geography, history, and social experience.

Immigration policies set the standard of health required for entry into a receiving country; and social and health policies, programs and services will have some impact on the health of an immigrant once he has settled. However, it must be remembered that good health is not solely dependent on the available health services, but is a function of personal characteristics, environment and life experiences.
It is postulated that the health of the 'Boat people' is determined by their own characteristics and by Canadian immigration policies.

Political and social values produce social and health policies, not to mention immigration policies. The attitudes of Canadians will affect the way these refugee/immigrants are welcomed; how they settle down; and eventually how any health problems that might arise are resolved.

It is postulated that the resolution of any health problems arising from the arrival of 50,000 refugees from Southeast Asia will be affected by the characteristics of Canada and the Canadian people.

This thesis will approach the problem of the effect that the health status of these new immigrants may have on the health of Canadians and themselves from these two perspectives: the characteristics of the 'Boat people' as representative of the refugees; and the characteristics of the receiving country, Canada. The process is illustrated in figure 1. (page 7)

The many facets of this approach indicate the need to consult the disciplines of anthropology, sociology and history, as well as those of medicine and health care. To this end an extensive literature search will be undertaken with the following framework.
World migration patterns will first be reviewed and the trends noted. As health is at least partly a result of human needs being met, these and the health problems of migrants in general will be examined. The effect of the changing patterns of migration and migrant characteristics on the receiving countries will be explored. The experiences of selected receiving countries will be reviewed before the development of Canadian immigration policy is examined.

The characteristics of the 'Boat people' will be described, and the health problems that might arise with their arrival in Canada defined. Recommendations will then be made on factors seen to affect the outcomes of any programs and services designed to resolve these problems.
**INPUTS**

**CHARACTERISTICS OF THE IMMIGRANT/REFUGEE**

- Needs
- Experiences
- Culture
- Skills
- Expectations
- Numbers
- Location

**PROBLEM**

Risk of health status to:

1. Community
2. Individual immigrant-refugee

**CHARACTERISTICS OF THE RECEIVING COUNTRY**

- Needs
- Experiences
- Culture
- Expectations
- Attitudes

Immigration, social and health policies, programs and services needed to attain desired outcomes

**DESIRE OUTCOMES**

1. To reduce the risk to the community
2. To maximize the health of the individual immigrant-refugee

**Figure 1** Diagram to illustrate the factors affecting the health status of Southeast Asian refugees and a framework for solving problems arising from this.
CHAPTER 2

MIGRATION: CAUSES AND WORLD PATTERNS

INTRODUCTION

According to Lee, migration can be defined broadly as a permanent or semi-permanent change of residence, with no restriction placed upon the distance of the move or upon the voluntary or involuntary nature of the act. (3) Human beings have been moving from one place to another, for one reason or another, since prehistoric times; and the patterns of migration have changed over the centuries. Migration can be either voluntary or involuntary, and the problems of the movement of refugees on a world-wide basis are growing.

WHY MAN MIGRATES

The causes of human migration are those natural impulses that first drove man, especially primitive man, to emigrate in search of food and shelter, to insure his protection, or merely to satisfy his desire for movement. (4). Although we lack precise records of the early migration of man, the evidence of legends and archeology indicate that people have moved from time immemorial. (5) The motivations for moving have remained constant through the ages.
Natural phenomena such as floods and eruptions have forced man to move; and sometimes he has left an unproductive or overcrowded land in search of a better life elsewhere. Examples of this are the mass emigration from Ireland following the famines of the 1840s, the Puritans who left England on the Mayflower in search of religious freedom, and the thousands of Jews who fled from eastern Europe at the end of the last century because of persecution.

In historical times economic development has caused population movements from rural to urban areas; within regions; and between continents. (6) This is not a recent phenomenon: Flemish weavers were enticed to England by Edward III so that England's wool could be processed at home instead of abroad; and the industrial revolution in the late eighteenth and early nineteenth centuries brought thousands into the new industrial towns from the British countryside. In general, says Beijer "migration is a necessary element of normal population redistribution and equilibrium and an arrangement for making the maximum use of available manpower." (7)

**CHANGES IN THE PATTERN OF WORLD MIGRATION**

The patterns of migration changed dramatically with improvements in technology, especially in transportation; with the rapid increase in the population of Europe; and with the discovery of the vast 'empty' spaces of both Americas, Oceania, and South Africa. This transoceanic migration lasted from 1840 to 1914,
and besides the mass exodus from Europe there was considerable out-migration from China and Japan at the same time.

"This period of mass emigration is of considerable importance, since it resulted in the creation of extra-European sections of the white race, in the expansion of the yellow race, and in the formation of the imperialism of the great modern powers. 65 million have crossed the oceans in one century to find a home elsewhere." (8)

Until the Second World War, migration was primarily for economic reasons: poor conditions at home 'pushed', while the prospect of greater opportunity 'pulled' the emigrant. It appeared to be the great remedy both for the difficulties of living, and for the unemployment engendered first by the industrial revolution and later by periods of economic stagnation. The freedom of international migration which characterized the nineteenth century was part of the general 'laissez-faire' attitudes to social and economic matters. (9) In spite of the 'open door' policies there was already agitation for restriction of immigration before the end of the nineteenth century and this affected the development of immigration policies in the major receiving countries such as Australia, U.S.A., and Canada. The rate of immigration slowed down in the period between the two world wars, but it is debatable whether this was due to the restrictive policies or to the economic slow-down of the 1920s and the 1930s.
MIGRATION POST WORLD WAR TWO

The major goal of immigration since World War Two has been economic development, and the manpower needs of both the traditional receiving and sending countries are again changing the whole pattern of migration. In fact, rather than exporting surplus population, industrial northwestern Europe has been importing foreign workers on a temporary basis because of a shortage of labour. (10) For both receiving and sending countries "... human capital, expressed not only in numbers but also in skills, is necessary for their economic development." (11) In exporting surplus unskilled labour, poorer countries often receive much needed foreign capital in the money sent home by their emigrants.

Thomas noted that "a striking features of the international scene since the Second World War is the high proportion of migrants who can be regarded as human capital, i.e. 'the professional, technical and kindred grades.'" (12) He then examined the reasons for the so-called 'brain drain' from the under-developed to the industrialized countries but hesitated to predict the continuation of this trend into the future. However, Beijer saw the composition and the direction of the voluntary migration stream changing.

"In short, the streams of migrants will no longer flow between areas of European settlement, but will flow from the under-developed countries to the more developed ones in Europe and the countries of European settlement." (13)
The rebound of the European imperialist policies of the nineteenth and early twentieth centuries has also affected world migration patterns since the Second World War. The granting of independence to their former colonies has resulted in large inflows of repatriates and refugees from the so-called "Third World" countries into Great Britain, The Netherlands, France and Belgium. (14) Policies have had to be modified and programs and services expanded to cope with both "the visible tide of coloured immigrants", and the ensuing social unrest and political agitation for the control of immigration. (15) In fact, it now seems that

"...heavy immigration is a thing of the past. Today, a country wishing to benefit from heavy immigration must be able to cope with the economic and social problems involved. In other words, it must have a sufficiently sound economic base to support the investments required, combined with adequate administrative machinery. If this structure is too weak, the effects of the investment that immigration itself can be expected to generate will be problematic; simultaneously, there will be a distinct danger of disturbances, such as unemployment, lower wages and inflation." (16)

MIGRATION CLASSIFIED

Migration may be classified as follows: voluntary and temporary; voluntary and permanent; involuntary and temporary, and involuntary and permanent. Examples of voluntary but temporary migration are the movement of workers within the European Economic Community, and that of seasonal workers from Mexico and the Caribbean to the U.S.A. and Canada; while voluntary and permanent
migration is illustrated by the great population movements of the 19th and 20th centuries. Involuntary but temporary movement may be caused by natural disaster or war, with the migrants intending and able to return home or find refuge elsewhere. Involuntary and permanent migration means the forced movement of people, for whatever reason, and who have no hope or intention of going back to their place of origin. Through the centuries, the desire for religious, political or social freedom has caused men to voluntarily or involuntarily leave their homeland, but truly involuntary movement: "has not been planned, organized or participated in by individuals or groups for their preferred reasons." (17) Slavery is the classical example, but this has been overshadowed in the 20th century by massive population movements caused by war, and political and social change.

**REFUGEES**

The chief characteristic of migratory currents since 1945 has been the size and importance of political, as distinguished from economic migratory movements.

"Millions have been driven from their homes and the population structure of entire countries radically altered. Diplomacy and political upheavals involving redrawing of frontiers, transfers of sovereignty, and changes in regime have forced entire populations into exile and caused mass movements far greater than those normally resulting from the world labour supply and demand." (18)
In Europe the involuntary transfer en masse of ethnic minorities has been part of the scene since the early 1900s, and "it is a sobering thought that the number of people expelled from one country to another in the decade after the Second World War is about the same as the entire overseas migration from Europe in the 19th and the first decade of the 21st century." (19) Eight million were helped to repatriate or resettle between 1944 and 1951 by several international organizations including UNRRA (United Nations Relief and Rehabilitation Agency), and the IRO (International Refugee Organization); and nearly two million migrants and refugees were resettled by ICEM (International Committee for European Migration) between 1952 and 1970.

A large displacement of population has occurred in Asia, especially between India and Pakistan; and continues in what was French IndoChina, and between The People’s Republic of China and Hong Kong. There is also a remarkable volume of movements developing within the Latin American continent. Holborn comments that it should be recognized that often the only alternatives facing some communities are annihilation and refugee-migration: "... in its earlier stages the refugee problem was seen as a temporary and limited phenomenon, (but) it has now come to be acknowledged as universal, continuing and recurring." (20)

In response to the realization that the problem of
refugees would not diminish, and after two years of debate, the United Nations established the Office of the United Nations High Commissioner for Refugees, UNHCR, to take effect January 1951 and to replace the IRO. Most of its work is not publicized and it is thus more effective in "its single-minded humanitarian concern for the legal and material needs of the refugees themselves, whoever they may be and whereever they are found." (21)

The United Nations Organization's definition of a refugee is

"... an individual who owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is out-side the country of his nationality and is unable, or owing to such fear, unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence as result of such events is unable, or owing to such fear, is unwilling to return to it."


Maselli considers that this definition, as strictly related to the International Convention, is no longer adequate for the present situation in the world but should be more broadly interpreted. The problem of refugees will always be with us, and "the international community should recognize its collective responsibility towards one of the most outstanding phenomena of all times." (22) Because both voluntary and involuntary migration
have profound effects upon everyone involved, it is important to recognize the differences and similarities between them, and their needs.

**VOLUNTARY MIGRANTS AND REFUGEES: THEIR SIMILARITIES AND DIFFERENCES.**

In both the earlier mass migrations and the present-day migration from under-developed countries to more technically advanced countries, the migrants have tended to come from the relatively disadvantaged classes or groups who have less opportunity and fewer rights, either economically, socially, or politically. They have been able to take into consideration ethnic and cultural kinships, which may have affected the place of resettlement if not determining their decision to move. (23) The skilled migrants of today are also able to choose where they would like to live, depending on the demand for their skills.

Both groups have tended to be in the prime of life; for instance, in 1967 almost three fifths of immigrants into the U.S.A. were men and women between the ages 18 - 49 years, with children under 18 years of age accounting for less than one third, and one-ninth being 50 years and over. (24)

Refugees have generally represented all classes of a given society. Sometimes they may be only a segment of a population, ethnically, religiously, politically or racially. Even then, they are all age groups, and all educational and occupational levels are
included. Compared with voluntary migrants, who can plan some means of financial support for the transitional period in their new country and who recognise that resettlement may be stressful,

"A common factor among most refugees is that they begin their flight with no means of subsistence, and they drift lethargically ... into camps and hostels in the country in which they first receive asylum... they recognise that they are fugitives but most fail to recognise or accept the consequences of this fact, which is a hinderence to their integration and adjustment."

(25)

THE TREND IN MIGRATION PATTERNS

The trend in migration patterns is seen as follows: the voluntary movement of skilled and unskilled labour becoming more and more controlled by the policies of countries requiring that labour; and the direction of the migration flow changing from that between areas of European settlement to that from the 'Third World' to areas of industrial development. Complicating this is the continuing (unplanned) flow of refugees either within the 'Third World' countries or between them and areas of European settlement.

If, as seen above, refugees have adjustment problems over and above those of voluntary migrants, then it could be assumed that the receiving countries will have more problems with their resettlement than with that of those who move voluntarily. In order to assess this statement it is necessary to look at the basic
human and health needs of people per se, and to see if the needs of immigrants and refugees differ from those of each other.
CHAPTER 3
THE MIGRANT AND HIS NEEDS

INTRODUCTION
The physical and psychological needs of human beings may be examined within the motivational framework outlined by Maslow (albeit without discussing the validity of his theory) where needs are arranged and met in an ascending order of priorities. The basic needs for food, water and sleep are followed by the need for shelter and security; the need to belong; the need for the esteem of others; and lastly, the need for self-actualization. The immigrant adjustment process can be described in these terms, and failure to adapt can lead to mental health problems. There are other health problems associated with migration, and these can be aggravated by warfare. Compounding all this are the beliefs and customs about health and sickness that will affect the solving of health problems in the new environment.

BASIC NEEDS: FOOD, WATER AND SLEEP
The basic human needs are for food, water, and sleep. The need for sleep is self-explanatory, but sleep patterns are affected by other needs not being met. Geography determines the foods available and this in turn helps form dietary habits. For example, rice is the staple in many parts of the world and wheat in others; fish is the protein available to those living by rivers and seas, and meat to those living on grasslands.
A review of studies on food habits and nutritional status by Freedman shows some verification of the tenacity of food and eating patterns. Migrants, especially those moving from and to areas of the world that are geographically and culturally different, experience 'culture shock' in trying to adapt to new food habits, and "quite often, due to a change in climate (they) may also experience subtle and/or overt changes in metabolism. These may in turn, cause palpable changes in biochemical patterns." (27) The inter-relationship of religious tenets and food proscriptions provides another example of the persistence of traditional dietary patterns. Little sign of assimilation, that is a change to English eating patterns, was found in the adult dietary practices of Moslem Pakistani families in Bradford, England. (28).

The manner in which food is prepared and eaten also differs in various parts of the world. In discussing child nutrition in the tropics and sub-tropics, Jelliffe and Jelliffe state that all communities have many nutritionally related customs and that some may be harmless and can be ignored, and others are harmful and should be actively discouraged. (29) The need is for food, but unfamiliar food cooked in an unfamiliar manner may not be accepted, with malnutrition as the result.
SHELTER AND SECURITY

The second of Maslow's hierarchy of needs is for shelter and security, an environment free from fear, anxiety, or chaos. This includes a roof over the head, a job to support self and family, and law and order. Again, housing is related to climate and lifestyle: in the tropics it is open to the four winds and in the Arctic it is not. Different family sleeping arrangements means that the extended family in Asia actually requires less space per person than does the nuclear family in North America.

Bernard points out that the jobs available to the migrant may not be the one for which he was trained, and that he may be downgraded. Another economic aspect is that of unemployment: it is often the most recently hired who are dismissed first, and they are generally the newcomers to the community. (30) Law and order are taken for granted in most industrialized countries, but there have been attacks on immigrants conspicuous because of colour or custom in both Britain and The Netherlands and the knowledge of this can cause a sense of great insecurity in immigrants. (31) (32)

THE NEED TO BELONG

If both physiological and safety needs are fairly well gratified then there emerges a need 'to belong'. In introducing the conclusions from his study of immigrant adaptation in Israel, Weinburg observed that:
Throughout this research it has appeared that there exists a remarkable similarity between the needs of the new immigrant with those of the newborn human being. The need for belonging, the need to be loved, understood, and supported, but not to be dominated, pampered or spoiled, these needs are similar to those enabling the child to develop to a sound, mature person, satisfactorily integrated in his family, community, and society. (33)

People need to belong to a group, be it family, friends, or the larger community. "Having roots is not a question of an individual's value but rather of his relatedness." (34) Relationships with kin play an important part in promoting social integration and avoiding feelings of loneliness, (35) so it would appear that settling near one's own people is an important factor in adjusting to a new environment.

In order to belong, one must understand the relationships and values of the group and the ability to speak their language opens 'points of contact' with that group. Without this skill, migrants may also not acquire knowledge of their rights and of services from which they might benefit, and would have great difficulty in dealing with the complicated procedures that are so often necessary for the exercise of those rights. (36)

'Belonging' also means being accepted by the receiving society, and this is closely related to Maslow's fourth need, to have the esteem of others.
THE ESTEEM OF OTHERS

The feelings of self-worth, self-respect, confidence, adequacy, and of being useful and necessary come from sensing the esteem of other people. The migrant is either welcomed by the receptor networks or must deal with resistance, rejection, prejudice and discrimination. Prejudice and lack of economic opportunity constitute barriers to both acculturation, i.e. the acceptance by the immigrant of the 'ways' of the majority, and to economic integration. This prejudice may reflect the limits of the absorbative capacity of the receiving country as well as aspects of its culture. (37) A good society must satisfy these needs for 'belonging' if it is to survive and be healthy. (38) Thwarting of the need of 'belong' and to having the esteem of others leads to maladjustment and pathology, to withdrawal, loss of hope, neurosis, or to psychotic breakdown.

SELF-ACTUALIZATION

Finally, as the other needs are satisfied, there is the need for self-actualization, or to develop fully the person's unique characteristics and potential. "A musician must make music, an artist must paint, a poet must write if he is to be ultimately at peace with himself. What a man can be, he must be." (39)
THE IMMIGRANT ADJUSTMENT PROCESS

Adler uses Maslow's schema to describe the immigrant adjustment process. He sees immigration as a major disruption in the life patterns of an individual, and in the face of stress and frustration a regression to lower levels of the needs hierarchy may take place.

"Adjustment can be seen as a recovery process in which the immigrant gradually moves back up the hierarchy towards self actualization. This involves overcoming insecurity, overcoming loneliness, overcoming self confusion; in other words recovering from a temporary state of disability known as culture shock." (40)

A mentally healthy person is one who is adjusted to, or in harmony with his surroundings; and this is a function of many things including fulfillment of physical and psychological needs. The stress of adapting to a new way of life can cause depression and anxiety, if not psychosis.

THE MENTAL HEALTH OF IMMIGRANTS

Studies on the mental health of migrants are found to be descriptive rather than quantitative. Stress is continuous when there is an inability to communicate with the immediate environment because of language difficulties, to meet even basic needs; (41) and adjustment becomes more difficult with technology, urbanization and industrialization. (42) This has been seen with the movement
of workers from rural areas of Africa to France (43); from Cyprus to Britain (44); and in immigrant children in Switzerland (45). For many immigrants into Israel the chasm between the dream and reality brought shock, disillusionment, and bitterness. (46)

Sauna reviewed the literature on migration and mental illness with a special emphasis on schizophrenia, but concluded that hospital statistics are variables "too gross" for the examination of this relationship. (47) Burrowes concluded that there does not appear to be an exceptionally high incidence of mental illness among immigrants of "coloured races" in Britain, but that there is probably a vast amount of loneliness, insecurity, bitterness and anxiety which is not adequately met. However, he suggests that there is a relatively high incidence of mental illness among immigrants from eastern Europe, and notes a sensitivity to their status as immigrants "that may be due to the fact that they do not have the political attachment to this country (Britain) that many other immigrants have." (48)

Murphy raises the question of whether the association between migration and mental disorder which researchers have found in the U.S.A. and Australia is a product of the cultural setting within which the migration is taking place. It has been found that immigrants are hospitalized for mental problems more frequently than the native-born populations. According to this study, the hospitalization rates for immigrants in Canada were found to be lower when compared with those of the native-born population than those
rates in the U.S.A. and Australia. Both these countries have had the 'melting pot' attitude in which immigrants are expected to be assimilated into the culture of the majority as quickly as possible, whereas in Canada the immigrant is encouraged to maintain membership in a cultural or ethnic group. (49)

In another paper Murphy cites studies indicating that the next generation can suffer psychologically for the traumatic events endured by their parents while refugees. "Special attention would probably relieve these morbid states, but the average group (of immigrants) should not require it." (50)

A study examining the difficulties in the adaptation to Canada of some of the refugees from Hungary in 1958 concluded that "one sees in Hungarian immigrants basically no different psychopathology from that of other groups ... except that it is influenced by attitudes common to their culture." (51) Lack of knowledge and acceptance of psycho-therapeutic psychiatry caused many Hungarian refugees to resent referral and treatment at that time.

Some authors raise the question as to whether there should be a distinction between voluntary and involuntary migration, since emigration is mostly the result of an involuntary situation, i.e. a conflict. "Such a conflict may be caused by external circumstances and pressures or by inner psychological factors resulting from the personality structure of the individual." (52) Psychologically a voluntary migrant may be as much a refugee as an involuntary migrant. (53) In discussing the psychological characteristics of refugees and immigrants Bernard states that
there have been "too few" studies comparing the characteristics of these groups to determine if refugees are actually "worse off". He notes that studies of patients in mental institutions show that migrants can be "adversely affected and psychologically damaged" as a result of migration, but few studies have been concerned with whether the people examined were immigrants or refugees.

"Perhaps the refugee is more likely to be so, but the difference between his wounds and those of immigrants appear to be those of degree rather than type. It is not that the refugee develops psychoses completely unknown to the immigrant. It is just that he may acquire them more often, or perhaps more sharply." (54)

Adaptation in the context of migration is learning new ways of meeting basic human needs, and it is seen that this process can be stressful. The differences in the effect of this stress on voluntary and involuntary migrants may be a matter of degree rather than of substance. Complicating this is the fact that the transfer of numbers of people from one area to another means that migrants are a group whose health is a risk from causes other than stress. He may bring disease with him; and may meet diseases in the new environment to which he has no immunity or to which his new lifestyle may pre-dispose him.
HEALTH PROBLEMS

Imported infectious diseases. While typhus (ship fever) and typhoid were imported with the immigrants into North America in the latter half of the last century, international travel regulations are intended to prevent the spread of disease by travellers today. Today, tuberculosis and venereal disease are at the top of any list of infectious diseases among immigrants today. (55) "An immigrant groups in any community may experience a greater amount of tuberculosis than the permanently resident population irrespective of whether the immigrants come from areas of higher, lower, or approximately similar levels of tuberculosis." (56) If the overall incidence of tuberculosis in the total population is increased by the arrival of an immigrant group, then because the infective pool of disease is larger, the potential for spread is greater. (57) In Bristol, England, the percentage of new cases of tuberculosis which occurred in immigrants rose from 3.7% in 1960 to 19.2% in 1969 (58): however this is difficult to evaluate in the absence of statistics regarding the ratio of immigrants to total population over that period.

Any migrant population is prone to a high incidence of venereal disease, especially when it consists mainly of males. (59) One of the main epidemiological factors in this increase is "a recent influx of immigrants, who seldom introduce infection but contract it in disproportionate numbers after arrival." (60) The incidence of chancroid, usually considered to be a venereal disease of the tropics,
rose by more than five-fold in Rotterdam during 1977-78 (61), showing that 'exotic' variations on a disease may be imported. Rotterdam has a large immigrant population from tropical and subtropical countries as well as being a major sea port.

Immigrants may carry their parasites with them, especially if they come from areas of primitive sanitation. Worms are common, but are of public health importance only if their developmental cycle can be completed in the new environment. (62) Otherwise they are of importance only to the individual migrant and his physician. Malaria is another parasitic disease that may cause chronic ill-health in the migrant but be of little public health concern unless an appropriate mosquito vector is indigenous in the new environment.

**Non-infectious diseases.** These have received far less publicity than the infectious diseases, and include the nutritionally and genetically determined disorders. The World Health Organization has found that the protein/calorie intake of many tropical races is sub-optimal, (63) lowering resistance of disease and the capacity to work. This will be aggravated on moving to a colder climate where a still higher intake of protein and calories is necessary just to cope with the climate. Avitaminosis has been found in coloured children in Britain where the production of vitamin D by the action of ultra-violet light on the skin is diminished because of the lack of sunlight. (64)
Some genetically transmitted diseases are seen more frequently in tropical and subtropical countries than in temperate zones. These are not common and are not great public health importance, but may be of importance to the health of the individual. Most frequently seen is a group of conditions where an abnormal haemoglobin molecule causes anaemia as the presenting symptom. (65) Primary adult hypolactasia (lactose intolerance) is genetically determined, and is more common in some races than in others. (66)

The new environment. The immigrant may be at risk from various disorders in his new environment. A mild disease in one country may turn out to be severe in someone coming from an area where the disease is not epidemic and where there has been little or no opportunity to develop an appropriate immunity. 'New Commonwealth' immigrants in Britain, for instance, may be at a greater risk of developing rubella, whooping cough, and measles than they were 'at home', as well as from the tuberculosis and venereal diseases mentioned above. (67)

A number of diseases are characteristic of modern civilization, and are rare or unknown in communities whose way of life has not changed much. A rise in the frequency of these diseases occurs when Western customs are adopted. These include non-infectious diseases of the large bowel; diseases associated with cholesterol metabolism; venous disorders including pulmonary
embolism and CVA; obesity and diabetes, and others. It may be surmised that these diseases will appear and increase in an immigrant population as it changes its life style.

All this adds to the stress of adapting to new ways of meeting needs. In considering the health status of refugees rather than that of voluntary migrants, it must be remembered that they will probably have been uprooted by war, either civil or international, and that this will have a further effect on their health.

**THE EFFECT OF WAR ON HEALTH**

Extensive warfare in any part of the world has always had the side effect of severe impairment of public health facilities, and of disrupting normal life patterns for civilian population. It is impossible to impose any effective public health measures on the general population at that time, and the uprooting and relocation of large numbers of people increases the possibility that many may come into contact with disease against which they have no immunity, either genetic or acquired.

There is an increased risk of contact between animal reservoirs of disease, potential domestic animal carriers and humans. For instance, the plague cycle changed in Viet-Nam because the destruction of the forests by American bombing drove the 'wild' rats and their fleas - the reservoir of the disease -
out into contact with the 'domestic' rats who were in contact with humans, and the incidence of plague in the population increased. (70)

Because of the flight of civilian populations, refugee camps and cities become overcrowded. The combination of increased population densities, poor sanitation, and inadequate diet, increases the risk of epidemics. (71) The stress associated with relocation, lowered nutritional standards and changes in traditional life patterns, all lower resistance to common diseases that can therefore become serious health hazards to the population; for example measles, tuberculosis and pneumonia. The stress can also lead to breakdown of the psychological coping mechanisms, and to neurosis and perhaps psychosis. The increased risk produced in such groups may last long after a return to normal conditions. (72) These experiences of refugees are over and above the 'normal' stress of migration.

If, as seen above, the health of the migrant/refugee is at risk, then there is a need for supervision and treatment of the problems that may appear sooner or later in their new surroundings. Acceptance by the immigrant/refugee of the need for health surveillance and treatment will depend on his conception of health and sickness; on the health care system to which he was originally accustomed; and how he perceives the motives of the receiving country in demanding this surveillance.
BELIEFS ABOUT HEALTH AND SICKNESS

In all human groups, no matter their size or how technologically advanced they are, there exists a body of beliefs about the nature of disease, its cause, and its cure. There also exist therapeutic and preventative measures against disease.

Western medicine is based on the knowledge of human anatomy and physiology; the 'germ' theory and the concept of prevention of disease as well as cure; and sophisticated medical and surgical technology. Many other parts of the world have other concepts of health and sickness. Hughes describes five basic categories of events or situations which, in folk etiology, are believed responsible for illness: sorcery; breach of taboo; intrusion of a disease object; intrusion of a disease-causing spirit; and loss of soul. (73) These can be a single one or any combination. For example, "According to the Zulus any disease associated with laboured breathing, pains in the chest, loss of weight and coughing up blood-stained sputum is attributed to the machinations of an ill-wisher." (74) The Spanish-Americans attribute disease to an imbalance of hot and cold in the body, and that a cure must aim at restoring the balance." (75) In Sri Lanka and Mauritius the people believe that madness is "supernaturally caused and supernaturally cured." (76)

Yet in many instances modern medicine is accepted with or without the acceptance of the 'germ' theory if it demonstrates greater effectiveness in the treatment and prevention of disease.
It is usually applied to sickness introduced by the Europeans, such as tuberculosis, measles and the like. The diseases that are conceived to be unamenable to modern medical treatment are the traditionally endemic diseases, and especially those ailments that have a large component of psychological or psychophysiological involvement. (77)

In describing health behaviour in three cultures in Guatemala, Gonzalez observed that the way these groups utilized the medical services almost exactly paralleled the description in the literature of the behaviour of persons in non-western cultures elsewhere, and even that of members of the lower classes in England and the United States.

"These groups are not interested in preventative measures, but arrive in droves to be cured; that they wait too long to seek professional care and often arrive in the last stages of a serious disease; that they resist hospitalization and feel that this is a condemnation to death; that they do not follow prescriptions and advice given which involves diet, rest, exercise etc., but demand pills and injections to relieve symptoms; that they do not return for check-ups as needed ... and are often 'hard to reach' because of their indigenous beliefs concerning health and disease." (78)

Also in discussing health behaviour, Read describes the tendency among natives of Alaska to depend on their kin groups in what they considered as illness, which tendency was then transferred to a strong sense of dependence on government medical aid. (79)
If a migrant comes from an area with its own system of folk medicine that may or may not have been influenced by Western medicine, and if the traditionally endemic diseases in that area are the ones which health authorities in the receiving country are concerned about in their immigrants, then the migrant may perceive those authorities as being meddlesome busibodies, or their behaviour as being insulting. The success or failure of a health program is largely governed by the way it fits into the modes of thought and action of the recipient population. (80)

It has been seen that human beings have basic needs, as well as those associated with health and sickness. The ways of meeting these needs are culturally determined and are met within a specific and familiar environment. When people move, they take their conception of the 'right' way of doing things with them; but they must adapt to new ways if they are to survive in the new environment. This adaptation can be stressful. Two factors may add to the degree of stress experienced: when the move is between areas that are geographically and culturally different; and when the migration is involuntary. Besides stress, the migrant is 'at risk' in other aspects of health.

The changes in migration patterns mean that countries receiving these new migrants will be affected. Having been accustomed to immigrants who have not differed very much from their indigenous population and whose problems, including those of health, have been similar and familiar, what might be the effect of the changes?
CHAPTER 4

THE RECEIVING COUNTRIES AND THE
CHANGING PATTERNS OF MIGRATION

INTRODUCTION

The effect of the changing patterns of migration may be examined under three headings: economic stress; social stress; social and health problems, and the services to deal with them. Again, culture and custom, this time of the receiving country, can affect the outcomes of social and health services.

ECONOMIC STRESS

It was seen earlier in this thesis that since the Second World War voluntary migration has occurred generally during periods of economic expansion. The immigration policies of receiving countries have been described as a vital component of manpower policies by being able to provide "rather quickly and relatively easily, particular categories of workers to help overcome labour shortages." (81) However, Kubat sees immigration policies as "the responses of nations and countries faced with the consequences of steps taken only recently, to meet the needs of economic growth." (82) In other words, policies indicate a tighter control of immigration in what has been a rather laissez-faire attitude to economic planning.
In the sense that the numbers and 'mix' of skills and education of immigrants are geared to manpower requirements, the acceptance of perhaps thousands of refugees at comparatively short notice is unplanned and may cause economic, social and health problems for the country concerned. There will be a strain on the employment situation, housing and educational facilities, as well as on the social and health services. There may also be the need for direct financial assistance to the refugees until they are settled. It is not intended in this thesis to examine the economic costs of accepting a large group of refugees, but to look especially at the health problems arising in this situation.

**SOCIAL STRESS**

The relationship between a host population and its immigrant minorities will affect the adaptation per se, and the rate of adaptation of those immigrants.

Unfortunately, official policies may be contradictory to attitudes held in a country receiving immigrants. It may be that governments state that they protect the immigrant population but administrative measures taken at the same time endanger the adaptation and welfare of the immigrants. Governments may officially encourage immigration but do little to encourage acceptance of the newcomers by the indigenous population. (83) Jones concluded that the hostile reactions to the three major waves of immigrants into
Britain over the past 160 years were due to their being perceived as a threat to the "British way of life". (84) Discrimination against 'foreigners' is the outward manifestation of the resentment of the indigenous population towards those who are different, or who are perceived as being a threat. This dicotomy of official policy and public attitudes leaves the immigrant in an insecure and ambiguous situation, leading perhaps to social and/or health problems.

SOCIAL PROBLEMS AND SOCIAL SERVICES.

Social and health problems are closely linked, as should be social and health services. It is considered by several international organizations interested in migrant welfare, that they should be included in expanded services rather than have separate services developed especially for them. If necessary, special services should be available, but not in specialized agencies. In discussing this, Dumon also argues that social services for migrants have two functions; problem solving towards clients, and problem formulating towards the authorities. (85)

The increased demands on the social services caused by the immigration from different parts of the world will be for assistance in the meeting of needs: programs may be necessary to help the immigrant and his family adapt to new foods, new ways of food preparation and housekeeping, and to new clothing
and lifestyle because of the different climate. Housing is a particular problem for newcomers, and this will be aggravated by larger family size and different customs. (86) Overcrowding and unsanitary living conditions can lead to serious social and health problems.

Social workers can also help integrate the newcomers into the local community - to explain each to the other. (87) Language training for the whole family has already been seen as essential for the acceptance of the community and immigrant by each other. These services may have to be expanded as the characteristics of the immigrants change making adaptation more difficult than it has been for their predecessors. It may be that a sudden inflow of refugees will need a sudden but temporary expansion of services, including health care services.

HEALTH PROBLEMS AND HEALTH SERVICES

The health problems of immigrants have received little consideration apart from the medical examination required before the would-be migrant is allowed to enter the country. With the change in migration patterns, there is a possible risk to the indigenous population from imported diseases, as well as increased and different demands on the health services.
'Exotic' diseases. Maegraith defines an 'exotic' disease as one normally acquired outside the area in which the doctor works, be it in Europe, North America, or West Africa. With more and more travel in and out of the tropics, and with the speed of modern travel, "a person may be infected abroad with an exotic disease and return before the incubation period is completed so that the clinical event begins some time after his return and will have to be distinguished from local disease." (88) Because of this, many large urban centres already have hospital and medical facilities to deal with exotic diseases: for example, Toronto General Hospital Tropical Diseases Clinic, Canada; The School of Tropical Medicine in Liverpool, England; and the Tulane Medical Center, New Orleans, in the U.S.A. These must act as referral centres for other areas.

Medical practitioners. Unusual demands in both numbers and skills will be put on medical practitioners by an influx of people from a different country, and perhaps with very different problems from those usually seen. Apart from the 'exotic' diseases, atypical disease patterns may occur and the natural history of ailments may be modified by such factors as malnutrition or the presence of intestinal parasites. Both malaria and diphtheria can show atypical disease patterns. It has been noted in Britain that many people arrive from the tropics with sub-clinical scurvy, which is a lack of vitamin C, that later develops into clinical scurvy with the change of lifestyle. (89) There may also be a need
for an interpreter where there is a language barrier, and this can cause problems. (90)

**Hospitals.** The arrival of a few immigrants in a specific area presents no real problem in terms of numbers, but large concentrations will require modification of services to allow for such factors as the age, sex, and family composition of the immigrants, as well as their country of origin. A high birthrate among some immigrant groups will increase the demand for maternity beds (91), and large numbers of newly arrived and newly born children will create a greater demand for hospital beds especially if those children are prone to severe forms of what are normally mild childhood infections. (92) Mental health problems may increase the demand for both in-patient and out-patient services. (93)

**Public health services.** There will be an increase in the demand for, and scope of, public health services. Special arrangements may be required for the diagnosis and treatment of exotic diseases as well as for a possible increase in the incidence of tuberculosis and enteric diseases. (94) New immigrants often drift into food services, so supervision of food handlers becomes more important. (95) The rate of industrial accidents has been noted to be much higher among immigrants than in the work-force as a whole (96), and accidents happen more frequently in the home, especially with small children. (97) These will require supervision and education.
Maternal and child services will be stretched. Advice on nutrition is especially hard to give because of language barriers and different customs (98), as is teaching hygiene where new ways of waste disposal are not understood. (99) Increased efforts may be necessary to achieve and maintain a satisfactory level of immunization among both local and immigrant children. (100)

School health programs will be affected. Poor nutrition, with possible parasites, affects a child's performance in school; and the immigrant child is under a double strain as adjustment to a strange school environment may be complicated by stress in his home environment. (101) (102). It has been suggested that there may be a delayed or cumulative effect of the stresses associated with the child immigrant, which indicates a possible long-term problem. (103)

Some of these problems are common to all immigrants and are magnified by racial and cultural differences between them and the local population. As previously stated, it is only comparatively recently that much thought has been given to the help that can and should be given an immigrant to aid his adjustment to his new surroundings.
AID FOR IMMIGRANTS

The most important characteristic of help for immigrants seems to be that programs of assistance be planned. (104) (105) Dumon cites Rose's study of migrants in Europe in regard to problems of acceptance and adjustment (106), and the "amazing find" that "the variable that had most explanatory value, was not the degree of similarity or difference in culture between sending and receiving countries. The integration and adjustment was most clearly related to the openness of programs, policies and practices of immigrant countries." (107)

However, before programs are planned, it is necessary that the effect of culture and custom on both the recipients and providers of health care be considered.

THE EFFECT OF CULTURE AND CUSTOM OF HEALTH CARE

With the influx of a 'different' people, health care professionals will meet the effect of culture and custom on medical and health care. For example, pre-natal care is difficult if women cannot be examined because of strict purdah. (108) The abandonment of breast feeding by Pakistani women in Bradford, England was seen as part of their 'adaptation' to British customs, but which unfortunately had the effect of increasing the risk of gastro-enteritis among these babies as the process of mixing formulae was inadequately understood. (109) Advice on child care may be applied to the boys only in the family as the girls
are considered to be a lesser status. (l10) Intestinal parasites may be considered 'normal' and as already suggested, health surveillance seen as gross interference. As already seen, hospitals are seen as a place in which to die, and it may be very difficult to persuade an immigrant to go to hospital if this is needed. It can be seen that health program often fail, and for a multiplicity of reasons.

There are other reasons why programs fail. Patients many times misunderstand or ignore prescribed procedures, and this is universal. Others may choose not to use modern clinical services but rely instead on local remedies and curers. The way a treatment is offered will also affect its acceptance.

Leininger points out that the ethical and religious values of both client and health care professional impinge upon health care services and that "some health providers act as if religion plays no role with clients in health care practices." (l11) In tailoring health care to the needs of cultural groups, she notes that one way of 'reaching' these people would be the ability to converse in their language.

Bernard feels that there are far too many social workers and counsellors who know nothing about the cultures of other people nor do they speak their languages. He is concerned that there are counsellors "who do not know about other people well enough to be
able to interpret, and I don't mean just linguistically, to interpret their cultural behaviour and their social problems as accurately and profoundly as they should." (112) There is a great need for interpretation of culture on a 'two-way street'.

The culture and bureaucracy of scientific health care can present serious obstacles to effective delivery of care. (113) Jones observed that "professional status in general seems to be a frequent justification for the absence of any further training on the subject of New Commonwealth immigration into Britain." (114) Foster considers that "major barriers" to improved health programs are found in the cultures of bureaucracies, the assumptions of the medical profession, and in the psychological makeup of the professional in those programs. "This assumption, regretably, appears not to be widely accepted. In fact it is resisted by many." (115)

The attitudes and knowledge of both recipient and giver of health care will affect the outcome of the care given, the giver in this case being the health care system as well as the professional working in that system. If the cultural differences, i.e. attitudes, are different then the problem may not be perceived in the same manner, and indeed it may not be resolved unless the recipient and giver realise this. From the literature it can be seen that social and health care professionals have recognised that there are problems associated with the inflow of large numbers of
immigrants who are racially and culturally different. The social and health care policies, programs, and services of a country, as well as the immigration policies, are the product of the economic and cultural experience of that country. As background for examining the development of Canada's immigration policies and the possible effects of the arrival of comparatively large numbers of Vietnamese refugees on the country, it is of interest to look at the immigration experiences of selected countries, and to note the trends in immigration policies, and the problems caused by the changing world migration patterns.
CHAPTER 5

RECEIVING COUNTRIES: SOME EXPERIENCES WITH IMMIGRATION

INTRODUCTION

Countries receiving migrants may be classified according to the type of migrant they accept or prefer. Australia, the U.S.A. and Canada have traditionally received voluntary and permanent immigrants, while Israel has received permanent settlers in large numbers only since 1948. Since World War Two the industrial countries of Northwest Europe have recruited what they hoped were temporary migrant-workers as an answer to their chronic labour shortages. Along with Great Britain, they also gave citizenship to people from their former colonies, and the resulting inflow of these immigrants has caused complicated social problems. Many countries in Europe, Africa and Asia have had experience with refugees 'in transit' and have been helped with aid from governments and voluntary agencies as well as from UNHCR, but this will not be discussed here.

COUNTRIES OF PERMANENT SETTLEMENT

Immigration into Australia, the U.S.A. and Canada was virtually free until the series of 'gold-rushes' in those countries brought the Europeans face to face with the Chinese, who were promptly blamed for all the social ills of those new countries. (116)
In response to public agitation, governments enacted legislation restricting or excluding the in-flow of all races but the white: the U.S.A. in 1882, Canada in 1885, and Australia in 1888. In all three countries this discrimination on grounds of race continued until after World War Two. Also generally excluded were "those whose physical and mental capacities were believed to make them public charges or whose moral character was believed unwelcome." (117)

**Australia.** Responsibility for immigration rests with the central Australian government, and its purpose has been to promote economic development and security. In line with the 'White Australia' policy that started with the exclusion of the Chinese, the preferred classes of immigrants have been those from Britain and northern Europe; and the goal has been assimilation into the British-Australian society within one generation. To this end, there has been financially assisted passage for selected immigrants.

The attitudes of Australians towards immigrants in general has been ambivalent: while acknowledging the need to increase the population, they have felt their way of life threatened by imported 'cheap' labour. Since World War Two, a change in immigration policies has seen more and more immigrants from countries of southern and eastern Europe, and the Middle East. This increase in the numbers of "foreign elements" has caused a certain degree of tension and even fear for many Australians. (118)
Once in the country, immigrants have been expected to make their own way. Many of these new immigrants are illiterate and have substantially different cultural backgrounds. Night-school classes in the English language are a luxury for them as they struggle for financial survival doing the dirty, poorly paid jobs that no-one else wants. (119) Services for immigrants are the responsibility of States' governments and voluntary organisations and these seem to have worked well together. However, services have been seen as inadequate. "Until quite recently the Australian governments, despite their anxiety to attract immigrants from all over Europe, have done very little to help newcomers adapt to language, lifestyle, or workplace." (120)

In the past few years there has been both public criticism and critical discussion of the 'White Australia' policy, the size of the annual inflow of immigrants, and the amount and quality of the help offered them. (121) The tendency of immigrants to settle near their compatriots (for example there is a large Greek community in Melbourne) has enabled them to keep a sense of cultural identity and to develop political pressures for integration rather than assimilation into the Australian society, and to press for improvements in immigrant services. (122)

After the gradual easing of the total exclusion of non-whites since 1945, Australia abolished restriction based on race
or colour, and immigration policy is now based on a points system emphasizing skill, education, and family re-union. A point to remember here, is that Australia's foreign policy has recognised the need for good relations and trade with the countries of Southeast Asia and the Pacific community, all of whom are racially and culturally different from Australia, and from whom Australia is now accepting 'selected' immigrants.

The 1971 Policy Statement of the Australian Labor Party (123) sets out major developments in services for immigrants, including research into childmigrant education and language training. Multi-lingual welfare officers were being appointed to work in immigrant communities, and training courses were being developed for those working in the immigration field. Financial help was being considered for the Good Neighbour Councils who co-ordinate the voluntary agencies offering assistance to immigrants. (124) Since the change of government in 1974, however, these policies have been modified with a movement back to earlier attitudes and policies, with immigration 'preferred' from Britain and northern Europe.

Australia's policy regarding the admission of refugees has been criticised as being based largely on self-interest, (125) and illustrates their ambivalence about immigration. The acceptance of refugee/immigrants from war-torn Europe was seen as a humanitarian gesture, as was the acceptance of refugees from Hungary (1956-7).
and Czechoslovakia (1968); but it was only with much hesitation that Australia accepted 200 or so Indians expelled from Uganda in 1972. (126) Belately, 2500 Chileans were admitted in 1974, but through normal immigration procedures rather than through special arrangements for refugees. Families and voluntary agencies sponsoring refugees have been considered to be fully responsible for them. The criticism is that the majority of the refugees accepted would have been eligible for entry under the normal selection criteria based on health and skills. "Acceptance of Vietnamese refugees is an exception based perhaps on moral responsibility derived from Australia's involvement in the Vietnam war." (127)

Although it has been stated that Australians may feel threatened by immigrants who are racially or culturally different, there is evidence that immigrants of mixed race from Southeast Asia, including India, have settled successfully since the immigration policy was relaxed. (128) The feeling appears to be that if proceeded with slowly, integration of 'different' immigrants can be done, but that perhaps programs are still needed to integrate those 'different' immigrants already in the country.

The U.S.A. Like Australia, the trend in the U.S.A. has been to liberalize immigration policies in terms of selection by race or nationality, and to link them more to economic factors.

Until the First World War, the U.S.A. had an 'open door' policy for immigrants from Europe while excluding Asiatics.
Increasing public hostility towards 'foreigners' forced the enactment of more restrictive policies, and the quota system introduced in 1929 allowed immigration only in the proportions of the national groups already in the country. The reluctance to accept refugees from Nazi Germany in the late 1930s stemmed from these feelings and this legislation.

Changes came with World War Two. The Chinese Exclusion Act of 1882 was repealed in 1943, with the decision probably influenced by foreign policy; and special legislation allowed the in-migration of refugees from Europe after 1945.

Although reaffirming the quota system, the McCarran Walter Act of 1952 instituted a preference system based on skills and close family relationship. (129) Discrimination against Asiatics was officially abandoned, but the very small quota was an effective barrier against any increase in immigration from Asia. The Immigration Act of 1965 abolished the national origins quota system and linked immigration to the economic situation and the re-unification of families, (130) and the preference system was slightly revised in 1976. (131)

Since the legislation of 1965 there has been a striking global shift in the national origins of immigrants into the U.S.A. with a significant growth in the numbers from Asia, Latin America, and the Caribbean. With an eye to relationships with other
countries and with the abandonment of the policy of assimilation, "immigration policy is obviously directly tied into the image of the United States as a pluralistic society." (132) It has been recognised that the continuous infusion of different cultures has brought benefits to the country, but "it is by no means clear that the fear of non-Western cultures is a thing of the past or that the U.S.A. population will accept and integrate the new groups created by the 1965 Act." (133)

Under the American Constitution immigration is the responsibility of the Federal Government, and there has been a long tradition of the senior level of government's involvement with citizenship education including language training and the teaching of American history, with the goal of assimilating immigrants into the mainstream of American life. Practical help for immigrants has been provided by a network of voluntary organizations.

Between 1880 and 1920 the U.S. governments did very little to take care of the sick and unemployed. This led to the emergence of powerful mutual benefit societies amongst almost all ethnic groups which, besides helping to preserve language and culture, helped to form the present-day network of voluntary organizations. (134) These groups are now co-ordinated by two large 'umbrella' organizations, the American Immigration and Citizenship Conference and the American Council for Nationalities
Service, and these apparently have had good working relations with government officials and Congress. In this, they appear to function somewhat like the Good neighbour Councils in Australia, although their pattern of development has been different. In spite of some excellent work being done, the pattern of services and assistance offered to the immigrants in their adjustment to American society is under criticism as being inadequate. (135)

The traditional process whereby voluntary agencies helped immigrants to find homes and jobs was used in resettling the first wave of Vietnamese refugees to enter the U.S.A. in 1975-76. (136) Initially housed in former army camps, they were sponsored by groups and organisations across the country thus becoming isolated from one another. They have since been resettling themselves out of the original areas into places where there are other Vietnamese. (137) It appears that the need for the support of one's own people is very strong. They have also formed their own self-help organizations with the aims of mutual assistance, preserving their cultural heritage, and forming the basis for a Vietnamese-American culture of the future.

With the arrival of this large group of new immigrants came the opportunity to study the effects of migration, flight, and adaptation; and the effectiveness of services designed to help resettlement. There is a growing literature on the health and
adaptation problems of these refugees. Studies undertaken in the 'holding camps' have alerted the Public Health Services and the medical profession to possible health hazards as well as to diagnosis and treatment of 'exotic' diseases in immigrants from tropical countries. Others have been reported in the Morbidity and Mortality Weekly Reports from the Center for Disease Control in Atlanta. There have also been comments on the lack of co-ordination and co-operation of the voluntary agencies involved in the camps and camp life, and the resettlement process. (138) (139)

Development of immigration policies in Australia and the U.S.A. appear to have been a series of reactions to external events and internal social and economic pressures, and only comparatively recently has there been a perceived need for programs and services to help the immigrant adjust to his new environment. Both countries have attempted to assimilate rather than integrate the newcomers into their society. While the health of the immigrant on arrival is probably better than the average citizen because of the strict medical examination required, not much concern seems to have been shown for his health thereafter. Israel has the same 'melting pot' attitude towards her immigrants but has from the beginning planned programs to help the immigrant adjust.

Israel. Immigration is a fundamental tenet of Zionism: the policy is, and has been that every Jew has the right to
immigrate into the State of Israel. Only those who specifically act against the Jewish nation or who are considered a threat to the public health or state security may be denied entry. (140) The result of this policy has been to "flood the land and a society not equipped to receive them with masses of variegated, totally dissimilar newcomers from all corners of the earth - and predominately from the more underprivileged corners." (141)

Apart from the moral commitment of the Jewish homeland, the urgent need has been for manpower for defence as well as economic development. Because of this, immigrants are in a favoured position in Israeli society, receiving substantial financial and social assistance with settling, including free health insurance for six months and help with housing and employment. Until 1968, immigration and the absorption of immigrants was the exclusive responsibility of the Jewish Agency, a non-governmental organization. With the formation of the Ministry of Immigration and Absorption in 1968, the government became more involved with the co-ordination and operation of services. In spite of all this, there have been housing and employment difficulties, and resentment of the newcomers by the native-born citizens on account of the privileges they receive and the cultural differences between them.

There have been three 'waves' of immigrants into Israel: from Europe before 1948; from Asia and Africa from then until the 1960s; and from the Soviet Union in the 1970s. There has also
been a small but steady flow of immigrants from western Europe and North America. There are great differences between the way of life of European and Oriental Jews: family structure and roles, the level of education, the observance of the religious life, and language have all made adaptation difficult. The need to change accustomed work roles was particularly hard for Oriental Jews as their occupational "composition" was little suited to meet the manpower needs of the young state. (142) There have been special difficulties with the absorption of the Russian immigrants "who do not know what to expect from a free society." (143)

No other country has studied the adjustment of immigrants or records their progress as carefully as Israel. It is pointed out to prospective immigrants that settlement is not easy and in return for generous assistance the State requires an effort from the immigrant himself. The language is not an easy one to learn: however, in 1973 about 61% of immigrants were actively studying Hebrew during their first year in Israel, which is probably quite a high percentage when compared with other receiving countries. (144). Community organization are being encouraged to help with the social adjustment of immigrants, but in spite of great efforts to help them settle, there is considerable disappointment as measured by the rate of out-migration. (145)
With the acceptance of allcomers, not every immigrant into Israel has been in optimal health. It was observed very early on that "although it cannot be verified statistically, there is good reason to believe that abnormally low standards of health among some new immigrants greatly added to the difficulties of absorption. This applies to both physical and mental health and can be explained by the large percentage of the new arrivals who had gone through the ordeals of concentration camps and war, or who had come from backward countries where disease is widespread, notions of hygiene are primitive and standards of nutrition among the poor are extremely low." (146)

Health problems that would be a public health hazard, such as active tuberculosis, have been treated where feasible in the country of origin before the migrant has been allowed to travel to Israel. (147) Other problems such as poor nutrition and hygiene are dealt with in the process of settlement.

Israel is committed to immigration as a fundamental policy of populating the country, and has planned social and health services to assimilate the newcomers into the Israeli community. In spite of this, resettlement and adaptation have not been easy, with the process probably complicated by the internal economic situation and the external political situation in the Middle East.

The goals of these three major receiving countries have been the growth of population by immigration, and the assimilation of those immigrants into a 'dominant' culture. Until comparatively recently, Australia and the U.S.A. have not paid much attention to the effect of this policy on the health of the immigrants after
their arrival. They have now recognised that multi-cultural societies have happened in spite of their 'melting pot' attitudes, and that programs and services are indeed needed to help the integration of the newcomers into their societies. Israel has found that in spite of planning services to this end, the process of adaptation has not been easy for her new citizens. In all three countries, immigration policies have been affected by outside events as well as the internal situation.

Since the Second World War, countries of Northwest Europe have both recruited temporary labour from other countries, and admitted thousands of repatriates from their former colonies - all culturally, if not racially different. They have had similar problems with the integration and adaptation of these immigrants.

**NORTHWEST EUROPE.** France, Belgium, Luxemburg, and Germany disclaim having been areas of settlement in the past despite evidence to the contrary: all have depended on immigration for both population growth and labour for the last 100 years. Economic expansion in the 1950s and 1960s encouraged the recruitment of temporary labour from the countries bordering the Mediterranean, and in the case of France, from North Africa as well.

At first these workers were single males with comparatively low educational and skills levels, but in 1968 the European Economic Community asserted the right of families to migrate. (148)
The subsequent rejoining of families brought an increase in in-migration at the same time that pressure from the labour unions, welfare system officers, and politicians "hearing mumblings of discontent as to the visibility of the new minorities", (149) was forcing governments to restrict recruitment of foreign workers. Aided by a down-swing in the economy, these controls were enforced in Belgium 1967; The Netherlands 1970; and France 1974.

The countries of industrial northwest Europe had never promised permanent settlement for their migrant workers and there seems to have been a decided ambivalence about integrating them into the host communities. The migrants and their families have been eligible for the considerable health and welfare programs in their host countries; but otherwise the governments left the initiative for providing services to help their integration to voluntary agencies, and only later took over some of this responsibility themselves.

Schooling for the migrant children has been compulsory within the local school systems, with varying amounts of instruction in their mother tongues to maintain links with their own culture. At home the children may not find much encouragement for their schooling, and as result run the risk of becoming "illiterates in two languages". (150) This could lead to a lack of a sense of identity which in turn leads to delinquency; and will certainly
Pose a problem for the future in whichever country they will find themselves. France is already grappling with the problems of integrating the second generation of immigrants into the French community. (151)

A natural ghettoization of foreign workers has made it unnecessary for those with families to venture outside the circle of kin and friends. (152) The migrants themselves appear to be ambivalent about integrating into the larger community, (153) and opportunities for language training are poorly utilised. (154) Yet they show no signs of wanting to go home.

The issues raised by the situation of the migrant workers are complicated by the fact that France, Belgium, and The Netherlands have also absorbed large numbers of refugees and repatriates from their former colonies. Like the workers from southern Europe, they are conspicuous minorities by virtue of colour, race or culture. However, unlike the migrant workers, they immediately assumed all the rights and responsibilities of citizenship, and great efforts were made to assimilate them into the dominant culture - with varying degrees of success.

Little attention seems to have been paid to possible health problems among all these immigrants, although they must have brought their parasites and diseases with them. They had a medical examination before being allowed to migrate, but their
living conditions in the new environment are not conducive to
good health, either physical or mental. This could be expected to
contribute to an overloading of the social services; cause an
increase in the cost of welfare services; as well as adding to the
delinquency of the children.

There has been a general failure to integrate the workers
and their families into society; and the local population does not
discriminate between them and the repatriates. There is likely to
be social tension between 'foreigners' and 'natives' in periods of high
unemployment (155). The overall policy aims now, are to integrate
those already in the country (s) and at the same time discourage
any further in-migration.

GREAT BRITAIN

Britain also has a problem in that significant
minorities are not being integrated into British society. Although
only one in three migrants since the war has been 'coloured', one of
the remarkable features of the situation in Britain is the almost
universal equation of the term 'immigrant' with 'coloured person'.
(156) There is a considerable resentment against immigrants that
has forced the government to enact legislation for both the control
of immigration per se, and the rampant discrimination against them.

Until the early 1900s British immigration policy was
'laissez-faire' for "motives of both economic self-interest and
humanitarian concerns." (157) Around the turn of the century
there was political agitation against the presence of large numbers of Jewish refugees from eastern Europe, with the result that immigration was restricted by the Aliens Act (1905), further legislation in 1914 and 1919, and subsequent Orders in Council. Immigrants were not eligible for the old age pensions introduced in 1908, nor for unemployment and health insurance in 1911: in fact, popular sentiment was quite blatantly anti-immigrant (159), and racist (160). This antipathy towards foreigners certainly affected the treatment of refugees from Nazi Germany in the late 1930s.

Asylum was offered to Polish ex-servicemen who did not wish to go home at the end of the Second World War; and the Polish Resettlement Act of 1947 recognised that "resettlement had dimensions other than the economic and that it embraces not only housing but health, welfare and education as well." (161) However, the privileges of the Welfare State were not extended to the aliens admitted under work permits from Europe at the same time; and those workers were also refugees like the Poles.

In 1948, The British Nationality Act gave Commonwealth citizens the privilege of virtually free entry into Britain to work and settle; (162) and like the Poles, they were entitled to the full range of social security benefits. Because of political agitation and active discrimination against 'coloured' minorities,
the preferential status of Commonwealth immigrants has been steadily whittled away by a series of legislative and administrative measures culminating in the Immigration Act of 1971. (163) A permit is now required to enter Britain to work, except for patrials (those who have specific family ties with Britain) and nationals of E.E.C. countries. The Race Relations Act of 1976 (164) is the latest in a series of measures attempting to control racial discrimination in employment, housing, and in other services. In 1980, the White Paper on Immigration proposed more restrictions on immigration and on immigrants. (165)

It has been a feature of recent history that no co-ordinated attempt has been made to help new minorities integrate into British life, with the exception of the Poles and to lesser extent the evacuees from Uganda. The Local Government Act of 1966 (166) and The Urban Program of 1968 (167) were promulgated to give financial assistance to Local Authorities for extra services for immigrants, but use of the money made available has been uneven across the country. Community Relations Councils, voluntary committees controlled by voluntary executives on which elected local government representatives of the major political parties have been heavily represented, have attempted to involve ethnic minorities in community educational and welfare schemes. Activities and success have varied across the country, and with rare exceptions their impact on local political opinion about the real disadvantages
of the ethnic minorities appears to have been trivial. "In retrospect, the explanation of these deficiencies seems clearly political." (168)

The official diagnosis of the educational problems posed by immigration has been made principally in terms of problems for the host community rather than for the immigrants themselves. Rees comments that the proposal by the E.E.C. that children be taught their 'mother tongue' during school hours does not appear to have been seriously considered by the British Government, which is still thinking on the lines of rapid assimilation of immigrants into the British culture. (169) One result of this thinking is that the low educational attainment and high unemployment among young British-born Blacks are fueling racial tensions in the major cities. (170)

Problems with immigrant health have also been documented. The 1962 Commonwealth Immigrants Act (171) stipulates that immigrants from the Commonwealth are subject to a medical examination on arrival. Any medical procedure that however incidentally seems to single out 'New Commonwealth' immigrants could be interpreted as discriminatory; the checks for typhoid are an example. Other problems appear to be centred on the characteristics of the immigrants themselves; their attitude to the health service; the ignorance of both immigrants and health professionals of cultural
differences; and/or poor communication.

Some Local Authority Health Departments and hospitals have recruited staff from their local minorities in an attempt to overcome these intercultural and communication problems, but Jones found that only two hospital management committees were currently providing anything approximating race relations briefings for their staff, and such provisions were for nurses and not for the doctors or the 'lower ranks'. (173) There have been difficulties based on colour and cultural differences with patient/patient, patient/staff, and staff/staff relationships.

The traditional British 'laissez-faire' attitude to public policy has only occasionally been modified, and then in times of (in humanitarian terms) crisis such as with the Polish, Hungarian and Ugandan refugees. Only in recent years, and largely because of fears of racial tension, have any signs emerged of central government concern with the situation of minorities within a hostile British society. "The bitterness which results from the experience of racial discrimination does not disappear in a generation, and the situation may be beyond repair in Britain." (174)
Conclusion

The trend in immigration policies has been to remove the barriers based on race or nationality; partly in response to the changing international political realities and the changing world migration patterns, and partly because of the need to link immigration to economic needs. The exceptions being Britain, who by devious legislation is trying to restrict her 'coloured' immigration, and Israel who accepts all Jews who wish to migrate regardless of her internal economic situation and external pressures.

All have had problems with the integration of immigrants into their respective societies. Although the governments have officially encouraged immigration, with the exception of Israel they have not done much to prepare public opinion or provide programs and services to help the newcomers to adapt to their new environment. The result may have been to make it difficult for them to meet their basic needs. Employment and housing may have been unsatisfactory or even unavailable because of indifference or hostility on the part of the local population, and these attitudes certainly do nothing to help the immigrants feel that they 'belong'. When this indifference is extended to the needs of the immigrant children, then social unrest may be expected when these children grow up and find themselves to be a disadvantaged segment of the population because of a lack of educational opportunities.
These countries have set basic standards of health for their immigrants, but again with the exception of Israel, do not appear to have been too concerned with their health once they had settled. It has been seen earlier in this thesis that failure to meet basic human needs may adversely affect the health of immigrants; and if they are involuntary migrants, then this effect may be more detrimental as their health will have already been affected by their experiences.

With this in mind, it is intended to examine Canada's experience with immigration.
INTRODUCTION

Canada's experience with immigration has been somewhat similar to both that of the U.S.A. and Australia. Although there was no deliberate 'melting pot' policy, it was hoped to build a nation of people with similar customs and ideals by selective immigration. The 'fact' of a multicultural society was accepted earlier by Canada; but the need for programs and services to help the adjustment of immigrants has only recently been recognised.

1867-1918

Before 1867, immigration was the responsibility of the British government: with Confederation, and under Section 95 of the British North America Act of 1867 it became the joint responsibility the federal and provincial governments. The division of those responsibilities was set out in the Immigration Act of 1869, with the federal government being responsible for the selection of immigrants and their welfare from point-of-departure to destination, and the provinces for their settlement. Initially, this was all rather laissez-faire, but the quarantine stations set up by the federal authorities to prevent the importation of the infectious diseases were the forerunners of public health services for the whole population. The Immigration Aid
Societies Act of 1872 (176) was intended to regulate the functioning of the (voluntary) societies being set up across the country to aid the settlement of the newcomers. This Act is still in force.

The aim of immigration was the settlement of agricultural land, and the 'preferred classes' of immigrants were farmers, farm labourers, and domestic servants from Britain, selected European countries, and the U.S.A. When this failed to provide enough settlers for Canada's need, then large numbers were recruited from eastern Europe. The comparative isolation of the non-Anglo-Saxon communities that grew up on the prairies meant the retention of their language and culture: they were not assimilated. Clifford Sifton as Minister of the Interior from 1896-1905 was responsible for immigration, and is credited with the foundation of the concept of selective immigration that remains the cornerstone of immigration policy today.(177) He was responsible for the 1902 amendment to the Immigration Act that excluded "diseased persons" as a measure of protection of the public health.(178) Already excluded were those deemed undesirable on physical, mental, or moral grounds. A revision of the Immigration Act in 1910 gave the Canadian government power to make regulations rather than changing the Act itself in response to external and internal events and situations that affect the recruitment and settlement of immigrants. (179).
In spite of the government's enthusiasm there was not unanimous public approval of large scale immigration. The Province of Quebec feared the submersion of its culture; the trade unions campaigned against the arrival of non-agricultural workers in the cities of the eastern provinces as it caused unemployment; and public agitation in British Columbia led to increasing (legislated) discrimination against Chinese immigrants by the imposition of a larger and larger head tax. There was already a head tax on immigrants to insure against their becoming a charge on the public purse in the event of illness or disability. This discrimination on racial grounds was extended to the Japanese and the Indians; although the problem was dealt with by an agreement with the Japanese government to restrict the emigration of its citizens, and by the 'direct passage' legislation affecting the travelling route of the Indians.

Services for immigrants were seen as perhaps necessary before and during migration and were designed as much for the protection of Canada by excluding the undesirables as for the encouragement of the immigrant. There were voluntary societies to aid the settlement of the immigrants, but neither provincial or federal governments appeared to take much interest in their welfare once they had arrived at their destination.
By the end of this period land for settlement was becoming scarce, the public were anti-immigrant, and legislation was becoming more restrictive. Immigration was practically stopped by the First World War.

1919-1945

The hostility towards certain nationalities and categories of people that was generated by the First World War, and the return of ex-servicemen to an economic recession with heavy unemployment, caused a slowdown in the rate of immigration in the 1920s. The decision to exclude immigrants from India was upheld by the Imperial Conference of 1919 thus setting a precedence for future policy regarding non-white British subjects; and the Chinese were totally excluded in 1923. This xenophobic attitude paralleled that in the U.S.A. at that time, and continued until after the Second World War.

As economic prosperity improved in the middle 1920s so immigration policies became more active, with land settlement still the major objective. 1926 saw the beginning of a sponsorship scheme allowing the re-unification of families in Canada. At the same time services for immigrants were expanded: more offices were opened in Britain and Europe; passage assistance was generous; immigrants were welcomed at point-of-entry and helped with the evaluation and exploitation of (land) opportunities; and medical
examinations prior to departure were instituted first in Britain and then in Europe. It appears that once here, immigrants were expected to manage by themselves.

Again, outside forces affected Canada's immigration program. The Stock Market crash of 1929 followed by the Depression of the 1930s, brought immigration to a virtual standstill that lasted until 1945.

1946-1960

With the end of the World War Two, Canadian immigration policy evolved rapidly, reflecting the swift pace of national development and the profound changes on the international scene. In his statement to the House of Commons on May 1, 1947 Mr. MacKenzie King acknowledged that "the problem of immigration must be viewed in the light of the world situation as a whole" and that policy should be related to the social, political and economic circumstances resulting from the war, and to the problem of the resettlement of displaced, homeless people, as well as to the future economic and population growth of the country. (181)

Many of the immigrants accepted after the war were refugees from Europe, and many had tuberculosis. In 1946 the federal government accepted responsibility for the medical care of indigent immigrants, and chest X-rays became compulsory. Later, these
arrangements were further developed with cost-sharing arrangements with the provinces who, under the British North American Act of 1867 are responsible for the health and welfare of their citizens. Apart from this, immigrant services were still confined to the recruitment, screening, and transportation of immigrants.

Between 1952 and 1960 the immigration flow was continually being adjusted to the country's labour requirements. However, the policy adopted with the 1952 Immigration Act did not give equal chances to all potential newcomers. (181) The Chinese Exclusion Act of 1923 had been repealed in 1947 (182), but there was still explicit discrimination against immigrants from Africa, Asia and the Caribbean. The ideal was still a nation of one culture ... one race. At the same time there was a new emphasis on social and humanitarian considerations with sponsored immigration becoming a major phenomenon. This had the effect of bringing in large numbers of unskilled relatives, especially from the countries of southern Europe. There seems to have been an increasing willingness on the part of the government to make exceptions to the rules in favour of individuals and groups.

1961 to the present

The problem in the 1960s was to find a way to end the discriminatory features of immigration policy while bearing in
the mind the economic situation and the changes in labour requirements. Canada was fast becoming an industrial country and needed highly skilled immigrants, and the formation in 1966 of the Department of Manpower and Immigration recognized the relationship between economic needs and immigration.

A new policy in 1962 made unsponsored immigrants from anywhere in the world admissible on the same criteria - the education, training, skills and other qualifications necessary to obtain employment or to set up their own enterprises. At the same time the sponsorship rules were changed to allow residents of Canada to sponsor certain classes of relatives regardless of nationality, while sponsorship of other classes of relatives was restricted to certain countries of origin. (183) The regulations regarding sponsored immigrants were tightened in 1967, although the discriminatory clause on country of origin was removed. (184)

This amendment to the Immigration Act also introduced a points system for independent and nominated immigrants based on education, knowledge of French and/or English, occupational skills and demand for those skills, age, and a personal assessment score. Although overt discrimination on nationality was finally removed, the requirements of the points system tend to weigh against would-be immigrants from the poorer parts of the world who are more likely to be poorly educated, unskilled, and speak
neither English nor French. The removal of the last pieces of racial discrimination from Canada's immigration policy in 1967 may be compared with that in the U.S.A. - 1965, and Australia - 1973.

Hawkins comments on the fact that this Canadian policy change was not in response to public pressure as in the U.S.A. and later to some extent in Australia; in fact the Canadian public was hardly aware that immigration policy was discriminatory. The policy had become "distasteful and impracticable to the ruling groups in both major political parties" and was out-of-line with the role that Canada then wished to play in the international community and Commonwealth, and with her role as a trading country especially with the Caribbean and Asia. (185)

The 1966 White Paper on Canadian Immigration Policy recognised the importance of services to help the adjustment of immigrants to Canadian life.(186) In the same year, responsibility for immigrant services at the federal level, previously borne entirely by the Department of Citizenship and Immigration, was divided between the new Department of Manpower and Immigration and the Department of the Secretary of State. The former took responsibility for the initial needs of the immigrant - selection, counselling, job placement; and the latter for the longer-term needs of adaptation to a new way of life with emphasis on
programs rather than on individual assistance. Social assistance services are the responsibility of the provinces, and in this respect may be seen as the logical successors of the Department of Manpower and Immigration after the latter has facilitated the immigrants' initial settlement. (187) Health insurance and health services fit into this category.

Hawkins has observed that there had been almost no consultation with the provinces in this area of common jurisdiction and concern, and that little thought seems to have been given to serious planning or to the development of adequate services beyond the basic welfare and medical needs of the immigrants for the first year after arrival. (188) Richmond made the comment that when compared with services in Australia, and in Britain which has not encouraged immigration, "the quantity and quality of services to assist immigrants in Canada has been low." (189) It has already been seen that in the last decade those countries have considered their respective programs and services to be inadequate.

There are voluntary agencies that have been interested in the welfare of immigrants after their arrival in Canada, and these usually have cultural, religious or ethnic affiliations. Being community based they should be well placed to assist individuals as well as encouraging and educating the community to understand and accept the needs of newcomers, and all levels of
governments maintain a liaison service with them.

It has been commented that their programs do not reach enough immigrants and that no-one is doing any planning, co-ordination and development in this field. "The voluntary sector in immigration is, in fact, very difficult to classify and to describe because it is a scene of great diversity, very unequal performance and constant change and fluctuation." (190) It is plain that these agencies have given considerable, and largely unpaid, service to the government in the reception, welfare and adjustment of immigrants; but the consequences of the diversity and lack of planning mean very unequal treatment for the immigrants, and that there is no way of knowing how many have benefited.

CANADA'S REFUGEE POLICIES

There has been frequent co-incidence between Canada's immigration requirements and the need of certain groups of people for asylum. Doukhobors and Mennonites were admitted in 1899 as immigrants by Order-in-Council, rather than as the political-religious refugees they actually were. At the same time, more than a thousand Mormon families settled in what is now southern Alberta as 'preferred' immigrants in spite of the fact that they had fled from the U.S.A. for fear of persecution.
Mennonites and Doukhobors were denied entry in the early 1920s during Canada's early xenophobic period, but this regulation was rescinded in time to allow many thousands to leave Russia before the Russians 'closed the door' in 1926. Canada also accepted thousands of Roumanian Jews on humanitarian grounds in the 1920s.

No modification of policy was made during the 1930s when "even refugees were rejected on economic grounds." (191) Some individual refugees with capital or industrial expertise were admitted by Order-in-Council just prior to the war; otherwise refugees from Europe were interned as aliens during the war just as they were in Australia and Britain. "Overall, the Canadian public has time after time failed to differentiate between the immigrant and the refugee." (192)

There was considerable pressure from the international community on the traditional receiving countries to relax their immigration laws and give asylum to some of the millions in Europe who had been uprooted by the war. Some of these refugees were admitted to Canada under special government authority; and many of them were basically healthy and had qualifications which would have made them eligible under immigration standards. Canada's early efforts concentrated on the admission of large numbers of those who could, with assisted transportation, be
Quickly resettled. (193) In other words, they had skills that Canada needed. Eventually, Canada admitted several thousand refugees from Europe, including the unskilled, the sick, and the physically and socially handicapped. Canada's desired image abroad, and her foreign-born political constituents dictated the admission of immigrants not directly destined for the workforce. (194)

Other refugee groups have been admitted under special programs in response to major international crises: 38,000 Hungarians, 1956-57; 12,000 Czechs, 1968; 228 Tibetans, 1970—whom the Province of British Columbia refused to accept; and 1200 Chileans, 1973-74.

In spite of the government contention that "the chief motive behind Canada's contribution to refugee resettlement has been the desire of the Canadian people to help" (195), Howard has commented that even as "genuinely humanitarian motives exist among many legislators and civil servants... (they) nevertheless find themselves obligated to respond to a public opinion which is not uniformly in favour of admitting refugees." (196) Attitudes towards minority groups appear to be improving but "it cannot be assumed that these latent antipathies have altogether disappeared." (197)
Canada does not have a policy of political asylum, and suspicions have been voiced that there may be ideological factors in refugee policy. (198) (199). It may be noted that the majority of the refugees admitted since the 1950s have fled communist regimes. While taking credit for the admission of Chileans fleeing persecution from their right-wing government, the Canadian government has not facilitated their migration.

There appears to be further discrimination. "It is important that whatever numbers Canada allows...refugees be selected according to their ability to adapt to Canadian life." (200)

The 1976 Immigration Act states, with regard to the selection of immigrants:

"Sec. 6(1). Subject to this Act and the regulations, any immigrant including a Convention refugee, a member of the family class, and an independent immigrant, may be granted landing if he is able to establish to the satisfaction of an immigration officer that he meets the selection standards established by the regulations for the purpose of determining whether or not an immigrant will be able to become successfully established in Canada.

(2) Any Convention refugee and any person who is a member of a class designated by the Governor in Council as a class, the admission of members of which would be in accordance with Canada's humanitarian tradition with respect to the displaced and the persecuted, may be granted admission subject to such regulation as may be established thereto and notwithstanding any other regulations made under this Act." (201)

The individual most in need of asylum may be the one who has suffered severe physical and/or psychological trauma, and who may well need extended medical care. Those disabled by torture have not
been admitted to Canada; and unless privately sponsored, illiterate, unskilled peasants who speak neither French nor English have also had difficulty entering this country. (202)

The Vietnamese in Canada

There were several thousand Vietnamese already in Canada when the 'Boat people' sailed over the horizon. They had been admitted as landed immigrants rather than as "refugees on parole, as their compatriots in the U.S. were."(203) The criteria used to grant interviews/visas were good health, and relatives in Canada or skills that Canada needed. As such, it may be assumed that those accepted would have a good chance of adjusting to a new environment.

From the point of view of the government it is sound sense to admit only the most economically adaptable refugees to Canada - it lessens public hostility if it is seen that they are not a public charge. Low refugee costs are also attractive to the provinces who must bear the cost of social services such as education and health care. At the same time the government can take credit for its 'humanitarian' attitudes. The legislation to admit 'the poor, the halt, and the lame' exists: it remains to be seen if it is used for the 'Boat-people'.

CHAPTER 7

THE 'BOAT PEOPLE'

INTRODUCTION

The 'Boat people' are only part of the vast population movements in present-day Southeast Asia; there are thousands of refugees from Kampuchea in Thailand, and from The People's Republic of China in Hong Kong. Wherever they are, in camps or otherwise, their needs must be met within an alien environment. In addition, there is the stress of an uncertain future; and once accepted for resettlement in another country the refugees are faced with making further adjustments. As a prelude to considering the health problems that may arise with the resettlement in Canada of some of the 'Boat people' it is necessary to look at the way needs are met within the Vietnamese culture; at the effect of the war and their subsequent flight; and from this to identify possible health problems associated with their resettlement.

HUMAN NEEDS

As previously discussed, human needs are normally met within a specific cultural setting, and in moving from one culture to another an individual has to learn other ways of meeting his needs. In other words, he attempts to adapt.
Figure 2. Map of Viet-Nam and part of Southeast Asia
A basic human need is for food, and diet and food preferences are partly governed by geography. Viet-Nam has been described as "two bags of rice on a pole"(204), as the tropical monsoon ensures the 'wet' cultivation of rice on the two major river deltas, the Songkoi (Black River) in the north and the Mekong in the south. The people do not consider that they have eaten if there has not been rice at the meal, to which vegetables and fish, or occasionally pork or chicken are added.

Most ingredients for their accustomed diet will be found in Canada, especially in areas that have large concentrations of Chinese people such as Vancouver, Toronto, and Montreal.

Safety and security are supplied by familiar surroundings. The Vietnamese people will be used to a flat delta landscape where the majority of the population live, and to a hot and humid climate which allows a great deal of out-door activity. The highlands are occupied by several hill tribes collectively known as the Montagnards and whose way of life is more primitive than that of the lowland Vietnamese. The change in climate alone will mean that the 'Boat-people' will have to adapt to heavier clothing, and in many parts of Canada will have to change to a life-style spent mostly indoors during the winter.

Housing in Viet-Nam ranges from the well-built masonry walls and tiled roofs of the wealthy to the wooden walls, thatched
roofs and earthen floors of the peasants. If possible, the furniture will include the highly polished hardwood slabs used as beds. The most important room on the house contains the 'altar of the ancestors' in Buddhist homes or a 'shrine' in Catholic homes, and this is where the family's religious observances take place and rites honouring the ancestors are performed, especially at the festival of Tet.

The family is the basic unit of Vietnamese society and provides the chief source of identity, 'belongingness' and 'self-worth' for the individual. The family takes precedence over the wishes or inclinations of the individual and as this family solidarity is not the 'norm' in North America where emphasis is placed more on individuality, it is possible that conflict may arise within Vietnamese families as the children become exposed to western values at school. Authority in the family rests with the senior male, and descent is patrilineal. Until recently, women have been considered inferior with more duties than rights, however the economic changes caused by the war have meant that women have had to contribute more financially to the family by working outside the home.

There is a strong sense of continuity of the family, past, present and future, and of its association with the land.
"ancestor worshippers, the Vietnamese saw themselves as more than separate egos, (but) as part of this continuum of life. To leave the land and the family forever was therefore to lose their place in the universe and to suffer a permanent, collective death."

It may be speculated that having to leave the land associated with the ancestors is then a major psychological shock; although this may be a delayed reaction.

The family functions within a society, and in Viet-Nam the traditional society, built up over the past one thousand years, was based on the village as a social unit. It was an agrarian, rather static society, stratified according to wealth in land; ruled by an emperor and his royal family; and governed by an intellectual elite organized in a civil bureaucracy. This social structure was more or less patterned on that of ancient China with whom the Vietnamese are ethnically linked. The teachings of the moral philosopher Confucius still influence values and attitudes. As late as 1945, rural communities still embraced more than ninety percent of the total population of the country, and this preponderance of the total population with its static way of life explains the existence in Vietnam of many old beliefs, traditions and superstitions. (206)
TRADITIONAL HEALTH AND SICKNESS BELIEFS AND PRACTICES.

In Viet-Nam the traditional beliefs and practices regarding health and sickness are widespread not only among the rural society but also among the educated urban families. These beliefs are related to and adapted from Chinese medicine with its concept of harmony with the universe.

"There are three souls and nine vital spirits which collectively sustain the living body. When all souls and spirits are present the individual experiences a sense of well being, but if one or all should depart, sickness, insanity or death could result." (207)

Popular beliefs attributing the cause of disease to the entry of evil spirits into the body are common, especially among the Montagnards. Some believe that the spirit can be induced to depart by sorcerers employing traditional rites, and others hope to keep the spirit away by wearing charms or offering sacrifices and petitions. Another set of beliefs is that illness can be caused by a sorcerer who possesses something belonging to the victim, a piece of clothing or a lock of hair for instance.

Popular beliefs can often interfere with diagnostic and preventative procedures. A person who is afraid that he will become ill if someone, possibly a sorcerer, acquires something belonging to him is likely to refuse to allow a blood sample to be
taken. Attempts to introduce public health measures such as improved sanitation and personal hygiene have met with little success when it is believed that sickness may be prevented by the appropriate rituals requesting protection from or propitiating an evil or errant spirit. The healers, therefore in traditional Vietnamese health practices are those who have the power to meet and exorcise evil spirits. (208).

However, popular beliefs have not interfered with acceptance of modern medical treatment. This acceptance is based mostly on the effective performance of Western drugs, especially the antibiotics, and striking surgical results. Reliance on Western medicine has been greatest in the cities, but was increasing in rural areas where people tended to see it as an additional curative aid rather than a substitute for traditional remedies. It is often believed that Western medicine is unsuitable for the Vietnamese constitution since Western drugs are 'hot' and have a dehydrating effect on the humor and blood. It seems probable that the younger refugees at least will accept Western medicine, especially if they have come from the cities of Viet-Nam. Sensitive and knowledgeable health services personnel will assist and ease this adaptation.

Overlying this traditional society are the effects of the French colonization.
THE EFFECTS OF COLONIZATION

The French imposed some changes on the traditional structures of the country: political subjugation; the introduction of French education; the beginnings of industrialization in the north and of commercial agriculture in the south; the growth of urban areas. These all made their impact on the social structure of Viet-Nam.

In the cities there developed a new élite consisting of senior government officials, military officers, professional people and families engaged in commerce; all of whom spoke French and were at least partly French educated. The new urban middle class consisted of civil servants, school teachers, small merchants who, while not employing large amounts of labour did not themselves work with their hands - an activity they considered degrading. The urban lower class was made up of mainly unskilled, largely uneducated labourers and petty tradesmen.

An important factor in the political and cultural history of Viet-Nam has been the gradual inflow of Chinese people for permanent settlement as 'middlemen', traders, and business men. (209) They controlled banks, transport companies, insurance agencies, and the marketing of many basic foodstuffs. Most importantly, they established a monopoly on the rice trade causing suffering and resentment on the part of the Vietnamese peasant.
They came originally from southern China and "because of history, the proximity of China, their clannishness, entrepreneurial talents and opportunism, the 'Hoa' (as the Chinese living outside China were known) in Viet-Nam were to be inextricably caught up in the events of 1978-79 that caused the exodus." (210).

THE EFFECTS OF THE WAR

Because of the prolonged warfare it is difficult to separate culture and beliefs from the experiences of the population during that time.

The safety and security of both rural and urban family and class relationships in all of Viet-Nam were destroyed by the continuous warfare from the late 1930s until the Americans withdrew in 1975. It was not always possible to keep the large extended families together when resettling the refugees from the north in South Viet-Nam after the partition of the country in 1954; and later, the absence of physical security in the rural areas of the south forced the mass migration of peasants in the cities and 'safe areas'.

The huge labour surpluses caused by this migration were largely absorbed by the needs of the Americans; in fact, the cities became dependent for their economic survival on the prolongation of the war. (211) The social upheaval contributed to the breakdown of the traditional family life, with widespread prostitution, an increase in juvenile delinquency, increased opium smoking, and an
increase in venereal disease. Family roles were reversed: farmers became unemployed because of relocation "while the wives and daughters could find work as prostitutes, bar girls, laundresses and maids ... all war-created work, much of which ... was related to the American presence." (212)

Food was in short supply in both rural and urban areas. It has been stated that malnutrition was endemic in South Viet-Nam, and probably in North Viet-Nam as well, even before the destruction of crops, i.e. starvation, as a military weapon by the Americans. (213) (214)

The effect of all this on the Vietnamese people was malnutrition; an increased susceptibility to disease; and to the breakdown of psychological coping mechanisms. "I have never seen people so depressed, so totally lacking in motivation ... a terrible sense of fatigue ... enormous amounts of opium smoking ..." (215). As Maslow points out "... the threat of chaos ... produces a regression from higher needs." (216)

HEALTH PROBLEMS IN VIET-NAM

Attempts were made during the ten year truce, 1955-64, to improve the public health services in the Democratic Republic of Viet-Nam (North Viet-Nam).

"Having got rid of many superstitions and bad habits, each family now has a double septic tank and a bathroom, and three or four families share a well. Bodily hygiene
... is being improved. People take especial care to eat clean food and live in clean dwellings." (217)

This led to claims by the government of North Viet-Nam that malaria had been eradicated in several regions, as well as having improved the living conditions of the peasants: however all this must have been destroyed by the saturation bombing later in the war.

Conditions in the South did not improve during this time. A malaria eradication program, which had begun to produce results, was halted by the Viet Cong terrorist attacks against the government teams working in the villages, and malaria is again endemic in Viet-Nam. (218) Plague was rampant with South Viet-Nam being the only country in the world with a plague problem. South Viet-Nam also had the highest rate of tuberculosis in any under-developed country; polio, leprosy and trachoma were common, and "everyone had intestinal parasites." (219)

POST WAR

On April 30th 1975 the war in Viet-Nam ended with total victory for Hanoi. With the reconstruction of Vietnamese society by the new government, private property was abolished, a new currency destroyed private holdings and hoarding, and the press was suppressed and books burned. The loss of private property and private holdings of money hit the Chinese-dominated business
community especially hard, as did the deterioriating political situation between Viet-Nam and China. There was also persecution of Buddhists, Catholics, and the Cao Dai and Hoa Hao - two smaller religious groups. (220)

There had been a continuous 'trickle' of people leaving Viet-Nam by boat since the American evacuation of Saigon in 1975, but by early 1979 this had become a 'torrent'. An investigation of this phenomenon by the Australian newspaper, the Melbourne 'Age', documents the reasons for this outflow, and the experiences of the refugees and the countries of first asylum - Hong Kong, Thailand, Malaysia, Singapore, and Indonesia and the Phillipines. They estimate that 65% of the main exodus of 163,000 people who left between March 1978 and mid-1979 were from Viet-Nam's Chinese minority, and that in the same period about 250,000 Chinese left for China. (221)

The 'Age' investigation quotes a study made by the Hong Kong government in June 1979 on the ages of nearly 20,000 'boat people' that concluded that on an average boat about half the passengers were children, women and old folk. "Of the 292,315 people who left by boat from Viet-Nam, about 77,000 got to Hong Kong. Most of the rest - just over 200,000 - choose the sea-route leading southwest from Viet-Nam." (222)

As Lord Carrington, Britain's Secretary of State for Foreign and Commonwealth Affairs is reported as saying to the
UNHCR Geneva Conference on July 20, 1979, "One can only conclude that they have left because the policies of the Vietnamese government made it impossible for them to remain." (223)

EXPERIENCES DURING FLIGHT

Apart from shortages of water, food and fuel on their overcrowded, slow-moving, defenceless, and often unseaworthy boats, the refugees leaving southern Viet-Nam were liable to attacks by pirates operating from ports in southern Thailand. U.S. refugee officials interviewing victims of these attacks often wrote 'RPM' in their notes, meaning rape, pillage and murder. An American official estimated in June 1979 that 30% of all refugee boats leaving southern Viet-Nam had been 'hit' by pirates; of these about a third suffered 'RPM'. (224)

LIFE IN THE REFUGEE CAMPS

From all the countries of first asylum the 'Age' investigation documented some depressing common factors about the refugee camps. They were congested, facilities were rudimentary, and above all, they were haunted by uncertainty. How long would the refugees have to wait for resettlement?

Each camp had its own characteristics. From the description of one camp, Bidong in Malaysia, one gets the impression of a "dangerously congested slum" with rubbish rotting
on the beach, and an overpowering stench of human-excrement. There was an acute shortage of water; the diet, UNHCR's standard ration pack, was inadequate; and there was a thriving black market in everything including food. There was widespread malnutrition among the children, and many cases of tuberculosis for which they had an inadequate supply of drugs. There had been an outbreak of hepatitis in early 1979, and some isolated cases of typhoid and meningitis. In a population of 42,000 living in an area of less than one square kilometre, there were 28 cases of mental illness "most of them 'RPM' victims." There was a hospital, built and staffed by the refugees: and in spite of this tragedy, the camp was described as an "indestructibly resilient world." (225)

An eye-witness account of a refugee camp for Khmer (Cambodian) refugees described how the empty field designated as the camp was inundated with sick and starving refugees before any shelter could be raised. Many were too weak to move when it rained, and drowned. However, this camp soon "got itself organized." (226)

At the other end of the spectrum, the 'Age' investigation describes the most humane administration of camp life as being in Hong Kong where the government had progressively allowed the UNHCR to take over the running of most of the refugee centres. Most residents of the camps were allowed to come and go freely except when they were about to fly abroad for resettlement. Also, because of a labour shortage in the Territory they were encouraged, and helped,
to find employment. (227).

This is the world from which will come the approximately 50,000 refugees to be resettled in Canada. It is difficult to separate the 'normal' stresses of migration and adaptation from the 'abnormal' stress of deprivation and flight. In any case, their health will have been affected by their experiences and their resistance to disease will have been lowered.

These will include infectious diseases that threaten the health of Canadians; and may include those indigenous to Southeast Asia that pose no threat to Canadians, as well as those common in their new environment against which they have no immunity. These will be considered in the next chapter. The mental health aspects of the adaptation process will be examined in the following chapter.
CHAPTER 8

HEALTH PROBLEMS EXPECTED WITH THE REFUGEES

INTRODUCTION

Before considering the diseases that may be a threat to Canadians and/or the refugees themselves with the resettlement of the 'boat-people' in Canada, it is necessary to define concepts and terms used in describing the health of a community.

INDICES OF COMMUNITY HEALTH

The usual measurement of the health of a community is the frequency of disease, disability, or death in that community. It may be simply measured by the number of people affected at a given time. However, most indicators currently employed are based on the calculation of rates that take into consideration the size of the population; either the total number, or the parts that are susceptible or 'at risk' to certain diseases or conditions. For example, the mortality rate indicates the number of deaths per 1000 population over a specific period of time. This crude rate is limited in its usefulness as an indicator of community health as it merely states the number of deaths without reference to the composition of the population in terms of the age groups, or to a specific cause of death. It may be refined as 'age-specific'
and 'cause specific', but these rates still refer to deaths or diseases that cause death. Among the best indices of community health are the maternal and infant death rates because of their direct relation to social and environmental factors and to community services. (228).

The morbidity rate indicates the amount of a specific disease per 1000 population over a given period of time. Again this is a crude measurement; and although often unreliable because of incomplete reporting, is useful in alerting the community to local outbreaks of infectious diseases. The following are more accurate indices of health/sickness, and will be used in this thesis.

The incidence rate indicates the number of new cases of a specified disease or condition occurring in a given period of time and is expressed as N:100,000 total population. The prevalence rate indicates the number of existing cases on a given date and may be expressed as N:100,000 population or as a percentage of the population. The case fatality rate is the number of deaths from a specified disease divided by the number of cases of that disease expressed as N:100 population.
THE COLLECTION OF INTERNATIONAL EPIDEMIOLOGICAL DATA

The problems of the reliability and comparability of data on the international distribution of disease are considerable. The more developed countries with their technology and extensive health care systems are able to collect more data, both qualitatively and quantitatively, than are the more under-developed countries. The World Health Organization has made great strides towards solving this problem by achieving recognition of the importance of uniform rules for processing health data and the use of a standard classification of disease, injury, and causes of death. (229) The problem of reliability remains: the World Health Organization routinely collects data from individual countries, and those judged relatively reliable are published periodically. (230) (231). However, caution is required in interpreting differences between countries in publishing disease rates.

There are no accurate and current epidemiological data about disease in Viet-Nam. The neglect of health care during the French colonial period was followed by prolonged warfare with the complete breakdown of social order. Sources of information on the possible health status of the Vietnamese refugees are the Centre for Disease Control, Atlanta, U.S.A.; the literature on the health problems of military personnel after service in
Viet-Nam; and the growing literature on the health of the Vietnamese refugees admitted to the U.S.A. since 1975.

**FACTORS IN THE SPREAD OF DISEASE**

The reservoir of most diseases of man is man himself, although he may become incidentally infected with diseases where the reservoir is in animals, such as Jungle Yellow Fever. The human reservoir consists of persons with both active and inactive (quiescent) disease. A 'carrier' is defined as a person who is not suffering from clinical symptoms of a disease but "who is excreting, or may from time to time excret, the agent to contaminate his environment or infect his associates." (232)

The spread of disease may be by direct transmission from man to man, as in coughing and sneezing; or indirect, when the organism can remain viable outside the body and enter the body at a later time. Some diseases require a 'vector' for transmission, of which malaria is an example as it needs a mosquito to transmit the parasite causing the disease from man to man. Other diseases have an intermediate stage outside the human host in order to complete the developmental cycle, e.g. hookworm.

Certain climatic conditions are necessary for the spread of some diseases, for instance malaria requires an average temperature
about 70°F for 10 consecutive days to enable the parasite to
develop. the mosquito before it can be transmitted to another person.
In this sense the global distribution of malaria can be said to
be geographically determined whereas measles knows no climatic
or geographical boundaries.

Improvements in living standards especially in sanitation,
immunization, and treatment of communicable diseases, have lowered
the incidence of many of the infectious diseases of the past in
countries of the 'First World'. Travellers today are subject to
national and international regulations aimed at preventing the
spread of disease. (233) However, many of these diseases still
persist in the under-developed countries where reservoirs of
infection, the presence of specific vectors, and unsanitary
conditions allow infection to spread.

A low prevalence of an infectious disease in a given area
means that much of the population there will not have had the chance
to acquire the appropriate immunity by contact with the
disease-causing organism. Thus the movement of relatively large
numbers of people from areas with a high prevalence of a specific
infectious disease to areas where the prevalence is low increases
the size of the reservoir and subsequently the chances of the
local population acquiring the disease. It can be seen that there
may be a risk of introducing diseases into Canada from Viet-Nam
with the resettlement of large numbers of refugees in this country.

Bearing in mind that imported diseases can threaten the health of Canadian as well as that of the individual refugee, these will be considered under the following headings:

1. Infectious diseases that may be transmitted to Canadians. These may be caused by bacteria, viruses, or parasites; and their transmission may be direct or indirect, by a vector, or through an intermediate host.*

2. Infectious diseases that are unlikely to be transmitted to Canadians, but remain a threat to the health of the individual refugee.

3. Infectious disease prevalent in Viet-Nam, but unlikely to be a problem for either Canadians or refugees.

4. Non-infectious diseases and conditions that may be seen in the refugees but are unfamiliar to Canadian health professionals.

INFECTIOUS DISEASES THAT MAY BE TRANSMITTED TO CANADIANS

Bacterial Diseases

Bacterial enteric diseases. Enteric diseases caused by bacteria are a serious medical problem in Viet-Nam. Two studies in the Vietnamese population found Shigella to be the most often cultured. (234) (235) A study of Vietnamese refugee children found enteropathogens in 49% of 367 stools cultured, including E coli, Shigella, and Salmonella. (236) Some resistance of these organisms to chloramphenicol, tetracycline, and streptomycin was noted.

Typhoid fever is endemic in Viet-Nam and from 2 - 5% of cases become carriers. Typhoid bacilli that are presumed to have come from that country may also be chloramphenicol resistant. (237)

These diseases can be spread through food and water. Given the high standards of sanitation in Canada it is unlikely that they will be spread through the water supply system; but as carriers are asymptomatic, poor personal hygiene could spread the disease through the handling of food. As noted previously, newly arrived immigrants tend to find employment in the poorer paid jobs of which food services is an example. As no records are kept by the Department of Employment and Immigration on the jobs that new immigrants take, the degree of risk to the public health from these diseases through food handlers cannot be estimated.

Approximately 6000 Vietnamese refugee/immigrants had (officially) settled in Vancouver by the end of 1980, although the real number may be much greater. Vancouver has a large oriental population, and it has been estimated by S.U.C.C.E.S.S. (a voluntary agency originally set up to aid the resettlement of Chinese immigrants) that there may be as many as 10,000 Vietnamese in Vancouver as they move from the places of original settlement into an area of familiar faces, language, and culture.

In Vancouver, a special clinic was set up by the
provincial government in 'China-town', with staff fluent in more than one oriental language, Cantonese, Vietnamese, Mandarin, to look after the health needs of the Vietnamese immigrants. A spokesperson for that clinic stated that as far as he knew, no cases of bacterial enteric disease had been reported among the new immigrants. However, it must be remembered that these diseases could become a public health hazard.

Gonorrhea. For convenience, this discussion will include all sexually transmitted diseases.

It has been reported that preliminary results of special studies that screened refugee groups in the U.S.A. for the presence of sexually transmitted diseases indicated that the prevalence in these groups was low. The report also noted that isolates of Neisseria gonorrhoeae from Southeast Asia may be relatively resistant to a variety of antibiotics. (238)

The refugees accepted for resettlement in Canada will have been screened for syphilis during their pre-immigration medical examination. As they are also mainly in family groups (239) it is not expected that they will add much to the problem of control of sexually transmitted diseases in this country apart from the recognition and treatment of disease already present. This could well include the more exotic varieties such as chancroid,
Lymphopathia venerum, Granuloma venerum, and soft sore.

A program screening adult Vietnamese immigrants in Vancouver has found no new cases of syphilis although it identified 6 of 14 cases already known to have been treated prior to immigration.

**Tuberculosis.** The reservoir of tuberculosis is primarily man, and in some areas diseased cattle. Infection with *Mycobacterium bovis* (bovine tuberculosis) is now rare in countries where dairy cows are regularly tested for the presence of the disease. It is probably rare among the Vietnamese as there is no tradition of drinking milk after weaning in that country. (240)

The main source of infection from *M tuberculosis* is sputum containing bacilli, and transmission is by direct contact; droplet nuclei, which is a true airborne infection; or by indirect droplet infection where large particles drop to the floor and after drying become resuspended in the air. This bacillus causes pulmonary tuberculosis and extra-pulmonary disease such as the tuberculosis of the lymph glands known as scrofula.

The re-activation of old pulmonary disease is known to be a health problem among people with an already low resistance exacerbated by poor nutrition and living conditions. (241) Re-activation may also be triggered by stress, and it has been recognised that rates of both new and re-activated tuberculosis
are higher in immigrants than in the Canadian-born population. (242)

The Center for Disease Control, U.S.A., considers tuberculosis to be the most serious public health problem with the present wave of Indochinese refugees. They report a survey in mid-1980 that showed a prevalence of 926 per 100,000 refugees based on the number of cases (activity unspecified) added to the tuberculosis registers in the participating areas. Of the 920 reported cases 47% had been recognised overseas on the basis of X-ray abnormalities; 18% were known not to have been "certified as having active or inactive disease, and 35% were of unknown certification status. (243) This means that 53% were diagnosed after their arrival in the U.S.A. A similar pattern could possibly develop with the refugees in Canada.

The prevalence rate for tuberculosis in Canada in 1976 was 31.6/100,000 based on the number of patients under treatment on December 31st of that year. (244) This is considerably lower than the rate for the Vietnamese population. Continual sensitization by contact with the tubercle bacillus gives some resistance to the disease, and a decrease in exposure because of the declining number of active cases in the community means that more of the population become susceptible to that bacillus. This has happened in Canada. The risk to the Canadian public health is from the increase in the size of the reservoir of tuberculosis in the community with the inflow of relatively large number of Vietnamese refugees, with the accompanying increase in exposure to the tubercle bacillus. It is worth considering here some facts about tuberculosis in Viet-nam
and in the Vietnamese people.

The major procedures for the diagnosis of tuberculosis are the tuberculin skin test; chest X-rays; and microscopic examination of sputum and gastric washings, with culture of these to confirm the diagnosis and reveal bacilli that did not show up with the staining used in the examination of direct smears. Certain products of M tuberculosis or of culture extracts (tuberculins), when injected into the skin, produce a specific sensitivity reaction. This skin test is an important screening device for the individual suspected of having the disease, as well as being a safe and reasonably inexpensive tool for the epidemiological surveillance of tuberculosis patterns in the community. The World Health Organization has established an international standard for the tuberculin used, PPD-S (Purified Protein Derivative - Standard) (245), which should allow for accurate comparison of the results of screening in different areas if this standardized tuberculin is used.

If the children in a community show a high percentage of positive reactions when skin tested, this indicates that there are sources of infection in that community, i.e. persons who are or have been excreting bacilli in their sputum. Regular screening of the children in a community 'at risk' is thus a valuable tool in the surveillance of tuberculosis; but it is used in Canada only in Native Indian and Inuit communities where the prevalence of
tuberculosis is much higher than in the general population. Table 1 shows surveys of children in Viet-Nam and in selected groups of Indochinese refugee children in the U.S.A. Although the numbers examined in the 1979 samples are small, the percentage of children with positive reactions in these is larger than in the earlier groups. This could mean that overcrowding and under-nutrition in the camps in Southeast Asia have helped to spread the disease.

Attempts were made in the 1950s, 1960s, and early 1970s, in both North and South Viet-Nam, to prevent the spread of this disease, but they were neither consistent nor universal. (246) (247). In South Viet-Nam immunization of the children was attempted with the BCG (Bacillus Calmette Guerin): as this often leaves no scar it is impossible to know how many children were vaccinated. This procedure can affect the results of the skin tests, although indurations of over 10 mm are considered evidence of infection rather than immunization.
### Table 1

Studies showing the number (%) of Indochinese children tested who were tuberculin positive. \( \geq 10 \text{mm} \).

<table>
<thead>
<tr>
<th>Study</th>
<th>Ages</th>
<th>Number examined</th>
<th>Number (%) Positive. ( \geq 10 \text{mm} )</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Viet-Nam 1967</td>
<td>0-14</td>
<td>12,980</td>
<td>1,647 (18.2) ( \geq 10 \text{mm} )</td>
</tr>
<tr>
<td>2. Guam 1975 Refugees.</td>
<td>0-14</td>
<td>24,351</td>
<td>3,022 (12.4)</td>
</tr>
<tr>
<td>3. Washington 1979.</td>
<td>0-18</td>
<td>45</td>
<td>10 (22.0)</td>
</tr>
<tr>
<td>4. Utah 1979 Refugees</td>
<td>0-14</td>
<td>136</td>
<td>40 (29.4)</td>
</tr>
<tr>
<td>5. San Francisco 1979</td>
<td>0-18</td>
<td>333</td>
<td>136 (41.0)</td>
</tr>
</tbody>
</table>

Sources:

4. Ibid. p.10.

A study in the U. S. navy showed that the risk of breakdown of old tubercular disease is higher among Southeast Asians than in other population groups (248); and they may be more likely to have extra-pulmonary disease. (249). It must be
remembered that these immigrant/refugees will also be 'at risk' from
the breakdown of old tubercular disease and of having extra-pulmonary
disease.

Treatment of tuberculosis today is with specific drugs
used in various combinations for periods of one to two years.
Drugs may also be used prophylactically where former treatment is
considered to have been inadequate, and with people who have been in
close contact with an active case of tuberculosis and whose skin-tests
have subsequently changed from negative to positive. In Southeast
Asia all primary and secondary anti-tubercular drugs are sold without
prescription. (250) A survey in Viet-Nam showed that 71% of M
tuberculosis were resistant to streptomycin, 64% to INH, 27% to PAS,
and 19% to all three drugs. (251) These are the drugs of first choice
in the treatment of tuberculosis and the resistance of the organism
is evidence of indiscriminate use of drugs without supervision. Drugs
sensitivity will be an important fact in the treatment of tuberculosis
originating from Viet-Nam.

A major factor with tuberculosis in Canada due to this
immigration is the increased in the size of the reservoir with the attendant
increased risk to the Canadian population. This is complicated by the
drug resistance of the organism, and the tendency of inactive disease
to breakdown under stress. It was seen earlier in this thesis that migration can be stressful, and that involuntary migration more so. This is definitely a public health hazard.

As the Southeast Asian refugees are being admitted to Canada as landed immigrants, they have been subject to the standard pre-immigration medical examination that includes a chest X-ray. Persons with tuberculosis that has been inactive for one year may enter Canada on a Minister's Permit that is conditional on continuing surveillance (follow-up) and possible further treatment. There are 27 Vietnamese in British Columbia under this Permit, and these are not considered to be a risk to Canadians because they are known. It is the unknown cases of the disease that are the problem.

Because of the increased risk to the public health inherent in the influx of large numbers of immigrants from an area with a high prevalence of tuberculosis, measures have been taken by the British Columbia provincial government to monitor the situation. As mentioned earlier, there is a special clinic for these immigrants in Vancouver. A spokesperson for this clinic indicated that three cases of active tuberculosis have been discovered among approximately 6000 Vietnamese refugee/immigrants. One was a case of a 'wrong' chest X-ray film at the medical examination in Hong Kong; and the others were two children in a
family with no other evidence of tuberculosis in the family members. These were found through a skin-test screening program. This gives an incidence rate of new disease of 50/100,000 Vietnamese immigrants compared with a rate of 11.8/100,000 for Canada as a whole, and indicates that tuberculosis among these refugees could become a public health hazard.

Some 300-400 Vietnamese in Vancouver, with a tuberculin reaction (skin test) of diameter greater than 15mm, have been placed on prophylactic drug therapy. However, there is much discussion about the effectiveness of this. Against the obvious benefit of preventing the breakdown of quiescent disease, its presence indicated by the tuberculin reaction, must be weighed the possibility that intermittent treatment resulting from non-compliance with the drug regimen and/or poor supervision, will produce a strain of bacteria resistant to one or more of the treatment drugs. There is no question that there must be long-term surveillance, for five years at least; the question is what is the best way to accomplish this?

Viral diseases

Hepatitis B. A recent study has shown that the prevalence of asymptomatic Hepatitis B antigenemia among the Vietnamese refugees is estimated at 13% while the prevalence of this antigen among
Canadians is approximately 0.6% (252) The presence of this antigen HBsAg means that the individual is a possible source of infection. Man, and possibly chimpanzees, are the only known reservoirs, and the incubation period is from 50-180 days. The mode of transmission is by parenteral inoculation with infected human blood and blood products either by contamination of wounds and lacerations, or by contaminated needles and syringes. There is some evidence of non-parenteral spread with the antigen found in several body secretions and fluids. (253) (254) (255). The people who are 'at risk' from this infection are dentists, doctors, and health care personnel who give direct care to patients.

The Department of Health and Welfare Canada pointed out on January 26, 1980 that over 300,000 immigrants from countries with unusually high prevalence of Hepatitis B had entered Canada since 1972 "without causing an obvious resultant increase in morbidity." (256) Statistics issued by the same Department on November 8 1980 show an accumulated 840 cases of Hepatitis B for 1980 compared with 690 on the same date in 1979, (257) an increase of 22%. No reason for this is suggested; however, the above inflow of immigrants must have increased the reservoir of the disease in this country and so increased the risk to the Canadian public.

Screening of the Vietnamese refugees in order to identify those carrying the antigen was started in December 1979 after some lobbying by the dental profession. (258) It was intended that
information on the carriers would be available at the provincial
departments of health; however, there have been negative reactions
from the provinces because of the need to process and store this
information.

Other groups in the Canadian population who have a high rate
of infection with Hepatitis B are doctors and dentists, and any
singling out of Vietnamese refugees per se, as being a risk to health
personnel could be construed as discrimination on racial grounds.

Preliminary results of a screening project in Vancouver
show that many of the Vietnamese who previously demonstrated the
antigen HB$_S$Ag in their body have now produced their own antibodies,
and are no longer a potential source of infection. It may be
that the prevalence of Hepatitis B antigenemia in the Vietnamese
will eventually fall to that of Canada as a whole. However,
precautions against the spread of the disease must be continued.

Parasitic diseases

Parasitic infections are almost universal in the people
of Southeast Asia, with 75% of rural and 56% of urban Vietnamese
found to harbour one or more. (259) In countries of similar problems
of sanitation over 50% of the population are infected. (260) The transmission of most parasites is favoured by either poor sanitation methods with promiscous defaecation and lack of personal hygiene, or a taste for uncooked foods. Many parasites are already present in Canada, and there are relatively few that could be transported from Viet-Nam and become established here. However, Giardia lamblia and Entamoeba histolytica could be a public health problems.

Infection with E histolytica (amoebic dysentry) is cosmopolitan but the prevalence rates vary from area to area. Epidemic spread is usually by water contaminated with E histolytica cysts; and endemic spread is by flies, vegetables contaminated with faeces containing cysts, and the soiled hands of food handlers. The reservoir is usually an asymptomatic person who can excrete the cysts for years; and the incubation period is from 2-4 weeks. The person with acute amoebiasis is not highly infectious due to the fragility of the trophozoites excrete at that time. Possible complications of infection with E histolytica are amoebic liver abscess, and more rarely amoebic pericarditis. (261)

Giardiasis, infection with G lamblia, is often asymptomatic although it can produce gastro-enteric symptoms. There is a higher incidence in children than in adults, and a higher prevalence in areas of poor sanitation. The diagnosis may be confused with many
others; and untreated, it is a debilitating condition.

There are endemic foci of amoebiasis and giardiasis in parts of Canada (262), which means that new foci could start in other areas. It was also found that immigrants tend to keep their parasites (263) which could be due to the familiarity and acceptance of parasitemia as a fact of life in their homeland; or to embarrassment; or to resentment of perceived persecution by authorities in this country.

It can be seen from Table 2 that the prevalence rates for E histolytica in selected groups of Vietnamese are similar to those in the U.S.A.; while the rates for G lamblia are higher. Assuming that the Canadian prevalence rates for these infections are similar to those in the U.S.A., then there may be a slight risk to Canadians from the increase in the size of the reservoir with the inflow of the refugees. The risk to the public health can come from infected and unhygienic food-handlers, and in institutions such as daycare centres and schools where children are in close proximity. These conditions will need accurate diagnosis and treatment because of their debilitating effects on the individual rather than the risk of spreading the diseases. There has been one case of G lamblia reported among the Vietnamese refugees in Vancouver and no cases of E histolytica, according to the spokesperson for Vancouver Health Department.
# TABLE 2

<table>
<thead>
<tr>
<th>Group</th>
<th>Number examined</th>
<th>E. histolytica number (%)</th>
<th>G. lamblia number (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. All ages. U.S.A. Refugees. Sept. 1975</td>
<td>1077</td>
<td>-- (2.2)</td>
<td>-- (8.2)</td>
</tr>
<tr>
<td>2. All ages. Canada Refugees (volunteers) 1976-77.</td>
<td>75</td>
<td>7 (9.3)</td>
<td>10 (13.5)</td>
</tr>
<tr>
<td>3. All ages. U.S.A. Refugees. Feb. 1979</td>
<td>165</td>
<td>3 (2.0)</td>
<td>29 (18.0)</td>
</tr>
<tr>
<td>4. All ages. U.S.A. Refugees. 1979.</td>
<td>356</td>
<td>3 (1.0)</td>
<td>16 (4.0)</td>
</tr>
<tr>
<td>6. U.S.A. (estimated)</td>
<td></td>
<td>(1.5-9.5)</td>
<td>(5.0)</td>
</tr>
</tbody>
</table>

* There are no national data for Canada: a National Data Bank for Parasitic Diseases is in the process of being built.

Sources:


5. Ibid. p.9.

INFECTIOUS DISEASES THAT ARE A THREAT TO THE INDIVIDUAL REFUGEE

Bacterial.

Hanson's Disease. Leprosy is a chronic and only mildly communicable disease with a long incubation period probably averaging 3-5 years. Man is the only known reservoir, and the mode of transmission has not been definitely established. Reliable data about the prevalence of this disease in the world are lacking, but its prevalence in Viet-Nam has been estimated at 300-500/100,000 (0.3-0.5%). (264). This may be compared with 0.37/100,000 in the U.S.A. in 1975. (265). Reported by WHO, with no data given but presumably in the mid-1970s, there were 64 registered cases in Canada (266) giving a prevalence rate of 0.3/100,000. (267)

39 definite cases were found in 27,057 Vietnamese refugees examined in the U.S.A. in July 1976, with a prevalence rate of 144/100,000 (0.14%). (268) Three cases have been found in 10,000 Vietnamese refugees in British Columbia in 1980, and more may be expected during the next decade because of the long incubation period.

Leprosy is greatly feared, and refugees may deny symptoms or that there is a family history of the disease for fear of deportation. It is only mildly contagious to close family contacts, and is not considered to be a public health hazard. However, the more active and contagious type, Lepromatous leprosy, needs treatment
to prevent disability and disfigurement. The public as well as health professionals need to be reminded that leprosy is not highly contagious, as fear could provoke violent reactions against the Vietnamese in Canada.

Melioidosis. Endemic in Viet-Nam and extremely rare in the western hemisphere, this is a disease whose symptoms may simulate those of tuberculosis and which should be kept in mind "in any unexplained suppurative disease, especially cavitating pulmonary disease, in a patient living or recently returned from Southeast Asia." (269) In some parts of Southeast Asia the prevalence of active and inactive disease is estimated to be as high as 30%.(270) The reservoir is in animals, and infection probably comes from contact with contaminated water and soil. The incubation period can be months or even years; and untreated, the mortality rate is high. Because secondary cases, i.e. direct transmission from man to man, are exceedingly rare this would be a problem of diagnosis and treatment. It appears that no cases have yet been seen among the Vietnamese refugee/immigrants in British Columbia.

Yaws. Also caused by a spirochete, this chronic relapsing disease is unevenly distributed in the rural tropics and subtropics where there are low standards of hygiene. It is present in Southeast Asia in spite of attempts at eradication, and "as the infection rapidly returns to high endemicity if surveillance fails" (27) it may be assumed that the war has
encouraged its return. The reservoir is man, and transmission is chiefly by direct contact with exudates of early skin lesions of infected persons. The incubation period is from two weeks to three months, and the period of communicability may extend intermittently over several years while moist lesions are present. Yaws is usually acquired in childhood, and thus cases could be seen among the refugees. This is not a public health hazard, and is easily cured once diagnosed: apparently no cases have been recognised among the refugees in British Columbia.

Parasitic Diseases.

Helminths. Some intestinal worms for example Strongyloides stercorealis, complete their life-cycle in man. Because of the capacity for auto-infection, this condition should be treated as soon as diagnosed as the worms can spread throughout the body causing acute as well as chronic illness.

Other helminths, such as Ascaris lumbricoides, Trichuris trichuria, and hookworm (Necator americanus and Ancylostoma duodenale in Southeast Asia) require a minimum of one to two weeks of incubation in the soil before entering the human body through the skin to complete their life-cycle. Man is the reservoir, and these parasites need the appropriate climatic conditions with low standards of sanitation and hygiene to facilitate their spread. Only hookworm is known to spread in temperate climates. (272)
The incubation periods of these vary, but carriers can excrete eggs or cysts in their faeces for years; and although not usually fatal these conditions can cause chronic ill-health in areas where re-infection is possible.

Studies in selected groups of Vietnamese refugees show that rates of infection vary (see table 3). According to a spokesperson for the Vancouver Health Department, approximately 50% of the Vietnamese immigrants in Vancouver have helminth infections; with Ascaris lumbricoides and trichuris trichuria being most common, and with some hookworm diagnosed. With high standards of sanitation in this country, the climate, and the fact that Canadians do not usually go barefoot, there is little risk to Canadians from hookworm. As the developmental cycle for the other helminths cannot be completed in Canada, there is no chance of re-infection and parasitemia will eventually die out among the Vietnamese. However, there is the need to treat this condition when diagnosed.

Protozoa. Leishmaniasis (Kala azar) is a protozoal disease widely spread in the tropical and subtropical areas of the world. The known reservoirs include man, canines, cats, and wild rodents; the transmission is by the bite of an infective sandfly. Direct transmission from person to person by blood transfusion and sexual contact has been reported. The incubation period is usually from 2-4 months but may range from 10 days to two years; and untreated, this chronic and communicable disease is usually highly fatal. The treatment drug is highly toxic, and must be
<table>
<thead>
<tr>
<th>Group</th>
<th>Number examined</th>
<th>Ascaris lumbricoides</th>
<th>Hookworm</th>
<th>Chlorocercis sinensis</th>
<th>Trichuris trichiura</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. All ages. 1975</td>
<td>1077</td>
<td>328 (30.5)</td>
<td>44 (4.1)</td>
<td>---</td>
<td>97 (9.0)</td>
</tr>
<tr>
<td>2. All ages. 1979</td>
<td>165</td>
<td>14 (9.0)</td>
<td>106 (64.0)</td>
<td>---</td>
<td>20 (12.0)</td>
</tr>
<tr>
<td>3. All ages. 1979</td>
<td>356</td>
<td>44 (12.0)</td>
<td>25 (7.0)</td>
<td>6 (2.0)</td>
<td>31 (9.0)</td>
</tr>
<tr>
<td>4. Children 0-18 1979</td>
<td>31</td>
<td>14 (45.0)</td>
<td>---</td>
<td>1 (3.0)</td>
<td>3 (10.0)</td>
</tr>
</tbody>
</table>

Source:
4. Ibid. p.9.
obtained from the Center for Disease Control, Atlanta, U.S.A. With the absence of both a large reservoir of the parasites and the specific vector in Canada this will not be a public health hazard but a problem of diagnosis and treatment. It has not been seen to date among the Vietnamese in British Columbia. Cutaneous Leishmaniasis (Oriental sore) does not occur in Southeast Asia.

**Flukes.** Schistosomiasis (Bilharziasis) in Southeast Asia is infection with Schistosoma japonicum, a blood fluke with both male and female worms living in the veins of the host. Animals as well as men are epidemiologically important hosts, a vector snail is required, and transmission is by contact with water contaminated with larval forms (cercariae) that penetrate the skin. S japonicum should not be confused with other schistosomes of birds and rodents in North America that may penetrate the human skin but do not mature in man - known as 'swimmer's itch'. S japonicum is not a public health hazard in Canada as there are no vector snails here for the species affecting man. This will be a problem of diagnosis and treatment, and this fluke has not been seen to date among the Vietnamese in British Columbia.

**Paragonimiasis.** The lung fluke, Paragonimus westermani, requires an intermediate host and ingestion of raw or partly cooked freshwater crabs or crayfish containing encysted larvae for its spread. The reservoir is man, and the parasite cannot be transmitted
directly from man to man. It is endemic throughout Southeast Asia, and the problem in Canada will be the difficulty of a definitive diagnosis as this may be confused with tuberculosis. The specific treatment drug is Bithionol which must be obtained from the Parasitic Drug Service in Atlanta, U.S.A. It has not been recognised to date among the Vietnamese refugees in British Columbia.

Clonorchiasis. This liver fluke, Clonorchis sinesis, is endemic in Viet-Nam and requires the ingestion of contaminated fish for its spread. It cannot be transmitted directly from man to man, and the developmental cycle cannot be completed in Canada in the absence of the intermediate host snail and the appropriate fish. This parasite will not be a public health hazard, but a problem of diagnosis. It has not been diagnosed among the Vietnamese in British Columbia.

Malaria. This is also a parasitic disease: it is no longer endemic in temperate zone countries but is a major cause of ill health in the tropics and subtropics. However, there is concern in North America at the increasing number of cases appearing here.

There are four types of this disease in humans: vivax or benign tertian malaria (Plasmodium vivax); quartain malaria (P malariae); falciparum or malignant tertian malaria (P falciparum); and the less common ovale malaria (P ovale) seen only in West Africa. Mixed infection may occur in endemic areas and as the symptoms are
similar for all types a differential diagnosis is difficult without laboratory facilities. Prompt diagnosis and treatment is essential as fatal complications may occur with P falciparum due to the rapid destruction of the red blood cells as the gametocytes develop and spread. The case fatality rate for falciparum malaria among untreated children and non-immune adults exceeds 10%.

This is complicated by the world-wide resistance of P falciparum to chloroquine which has been the treatment drug of first choice. Other drugs are being tried. The reservoir is man and possibly the higher apes; and transmission requires a female vector mosquito. The mosquito becomes infective by ingesting human blood containing plasmodia in the gametocyte stage of development. The female and male gametocytes unite in the mosquito's stomach and sporozoites develop there within 8-35 days depending on the species of parasite and the temperature to which the vector is exposed. These sporozoites concentrate in the salivary gland and are injected into man as the mosquito takes another blood meal. The incubation period varies from 12 to 30 days, again depending on the species of parasite, but with P vivax this may be 8-10 months. In the susceptible host, the gametocytes usually appear in the blood within 3-14 days after the on-set of symptoms, according to the species of parasite. The mosquito remains infective for the rest of her life - a few days or a month or so - and man is infective indefinitely with P malariae, one to three years with P vivax,
and approximately one year with P. falciparum.

There are appropriate mosquito vectors and climatic conditions for the spread of malaria in parts of North America. The last definite case of indigenous malaria in the U.S.A. was reported in 1957, (253) but there have been cases of malaria imported from the Punjab into parts of southern California in the 1970's, when it was suspected that the local mosquitoes became infective and spread the disease. (274) (275) Malaria has been diagnosed in servicemen returning from Viet-Nam, (276) (277) as well as in increasing numbers in travellers returning from the tropics and subtropics.

Malaria was endemic in parts of Ontario from about 1820-1880 but not above the summer isotherm of 70°F, and was apparently reported at one time in certain (unstated) parts of the western provinces. (278) Given a large enough reservoir of the disease and the right climatic conditions, malaria could possibly become re-established where there is an appropriate vector.

Malaria may also be spread through injection or transfusion of blood from an infected person, or by sharing needles during illicit drug use. (279) It has been reported from a Saigon prison that P. falciparum was transmitted by the common use of needles and syringes among drug addicts who had not been in malarial areas. (280) P. malariae is a relatively uncommon disease which may become
chronic with a latency period of more than 30 years, and is thus more likely to be transmitted through a transfusion of blood from an infected person than are the species with a shorter life-span. These, with \textit{P vivax}, were cited in a discussion of transfusion-induced malaria. (281)

The areas of Viet-Nam that are most heavily infected with malaria are the Central Highlands. The prevalence of malaria in the Vietnamese refugees in the U.S.A. was been found to be low, 0.09\% in 1975 (282) and this may have been due to the fact that the majority of those refugees had come from the urban areas that are not infected. If this is the case with 'the Boat-people' it means that the new reservoir of the disease in Canada will be small; and further more, it will be diluted by the spreading of the refugees across the country. The chances of a mosquito becoming infective are further reduced by the fact that the areas of Canada that are plagued with mosquitoes have screened doors and windows which again reduce the opportunity for mosquitoes to take a blood meal from an infected person.

There has been a slight increase in the incidence of malaria in Canada that is thought to be due to Canadians travelling in infected areas without taking the prophylatic drugs. The threat to the public health is more likely to come from the inadvertant transmission of the disease through contaminated blood
products and needles and syringes than from its re-establishment by vectors. Anyone with a history of malaria is never accepted as a blood donor by the Blood Transfusion Service of the Canadian Red Cross Society; and people who have come from or have lived in areas where malaria is endemic, and who may or may not have taken anti-malarial drugs and have never had malaria, are deferred from three years as donors and then only the plasma is used. With the proper sterilization of needles and syringes there should be no risk to the public from this source.

The problem will be the need for fast and accurate diagnosis of the species of parasite causing the symptoms in order to initiate the appropriate treatment.

DISEASES ENDEMIC IN VIET-NAM THAT ARE UNLIKELY TO BE A TREAT TO EITHER CANADIANS OR REFUGEES.

The following are included in this chapter because of the publicity given them.

Cholera. This an acute diarrheal disease with a fatality rate in untreated cases of over 50%. The reservoir is man, and the mode of transmission is through ingestion of water contaminated with faeces or vomitus of infected persons, and to a lesser extent through contaminated food, soiled hands, and flies. It is widespread in Southeast Asia. The incubation
period is from a few hours to five days, and it has been reported in a refugee 'in transit' between Southeast Asia and California. (283) However, this has been an isolated occurrence, and cholera is unlikely to become a problem with the refugees.

Plague. Sylvatic, or wild rodent plague, is known to exist in the western third of the U.S.A. as well as in large areas of the world including Southeast Asia. In the U.S.A. plague in man is limited and sporadic following exposure to the rodents or their fleas. It occurs in three clinical forms, with untreated bubonic plague having a case fatality rate of about 50% and untreated septocemic and pneumonic plague being usually fatal. Wild rodents are the natural reservoir of this disease. Bubonic plague is transmitted by the bite of an infective (rat) flea, and pneumonic plague by the airborne route. The incubation period is from 2-6 days. Since 1962 Southern Viet-Nam has experienced a marked increase in the incidence of plague. (284)

International regulations require that prior to their departure from an area where there is an epidemic of pulmonary plague, travellers shall be placed in quarantine for six days after last exposure, and may be kept under surveillance for not more than six days after arrival at their destination. The refugees are coming from camps in Malaysia, Hong Kong, and Indonesia after some months residence there. (285) No mention of plague in these areas has been found. Given these factors and the short incubation period, it is seen as unlikely that plague will be a
problem with the refugees.

**Certain 'exotic' diseases.** It is possible that their incubation period of 5-15 days may allow certain 'exotic' viral diseases to produce symptoms after the arrival of the refugees although this is unlikely. They are Dengue; Japanese B encephalitis which infects man only incidentally but which is associated with a mortality rate of over 80%; scrub typhus; and Chikungunya (haemorrhagic disease).

**Filiariasis** is the infection with the nematode worm and microfilariae of Wucheria bancrofti or Brugea malayi in Southeast Asia. A long exposure and heavy parasitism are required to produce symptoms. An epidemiological study of the prevalence of filariasis in South Viet-Nam failed to find infection in residents of Saigon or in a district of the Mekong Delta. (286) As the refugees are apparently coming from the urban areas of the lowlands this disease should not be a problem among them.

**Leptospirosis.** Endemic in Southeast Asia, this spirochete only incidentally infects man through his contact with water, soil, or vegetation contaminated with the urine of infected animals. The reservoir includes many farm animals,
rodents and other wild animals. The incubation period is 4-19 days so symptoms could manifest themselves after the arrival of the refugees. Direct transmission from man to man is negligible, and untreated the mortality rate is 20%. This would be a problem of diagnosis and treatment, and no cases have been found among the refugees in British Columbia.

OTHER INFECTIOUS DISEASES

It has been pointed out that in the consideration of the 'exotic' the 'ordinary' infectious disease should not be overlooked. (287) Because of the malnutrition and stress, and the effects of war and flight, the refugees may be more susceptible to infectious diseases common in Canada. Measles can be particularly devastating in a population with little or no immunity to the disease; and diphtheria carriers have been found among the refugees in the U.S.A. (288)

It was found that of 45 refugee children screened within 10 days of their arrival in Washington, D.C., less than half (44%) had any previous history of medical care, and immunization against the 'common' infectious diseases was minimal. (289) Besides giving them protection, immunization of the refugee children will reduce
the pool of susceptible children in Canada where the rate of immunization is less than optimal, and thus help prevent the spread of these diseases.

Overcrowding in the refugee camps in Southeast Asia will have increased the spread of lice, scabies, and fungal skin infestations. (290) (291) These will likely have been cleared up before children go to school here, but this could become a problem where children are in close contact.

NON-INFECTIONIOUS DISEASES AND CONDITIONS

Malnutrition. Malnutrition was noted among Vietnamese children by Vennema in 1968 (292); and was observed in children evacuated to Australia (27%), (293) and the U.S.A. (11%). (294) It may be assumed that it is widespread still in Viet-Nam as a result of the social upheaval since the war. Children are most susceptible to protein-energy malnutrition which causes stunted growth and anemia. Other forms of malnutrition may be vitamin deficiencies causing scurvy due to lack of vitamin C; beri beri due to lack of vitamin B; and rickets due to lack of vitamin D.

A survey of the nutritional status of selected groups of Southeast Asian refugee children in the U.S.A. has revealed anemia
and stunted growth to be the major nutrition-related problems. (295) The report suggested that there is a need for awareness of the problems of acute under-nutrition and anemia by health care workers, but comments that the initial high prevalence of these conditions may reflect the impact of a difficult adjustment period for these children on American diets for the first time.

Some of the Vietnamese children arriving in Vancouver during 1979-80 were observed to be rather thin, but soon gained weight. No screening program was initiated. The babies born in this country are "a good size" according to a spokesperson for the Vancouver Health Department.

**Genetically determined conditions.** More than 90% of Southeast Asians cannot digest lactose (milk sugar). (296) Gastro-enteric symptoms after drinking milk are inevitable in subjects over nine years of age, with 50% of lactose-intolerant children under that age developing diarrhea. Six of 114 Vietnamese children evacuated to Australia in 1975 and between the ages of one week and six years, were intolerant of lactose. (297) Awareness of this apparently culturally determined condition is essential for health personnel, especially those concerned with nutrition and health education.
There has been no evidence of severe lactose intolerance among the refugees in Vancouver although the problem is known. Advice is given to families on the gradual introduction of milk into their diets.

The distribution of genetically determined red-cell defects is possibly linked to the distribution of malaria in the world. The prevalence of Thalassaemia in Viet-Nam is estimated as 1-5%; of Haemoglobin E 2-8%; and Glucose-6-phosphate dehydrogenase deficiency (G6PD. def) as 2-6%. (298) These are not important per se, but people with G6PD deficiency may experience mild to severe hemolysis during primaquine therapy for malaria. (299) Haemolytic anaemia following administration of trimethoprim-sulfamethoxazole (Bactrin and Septra) has been noted in some Asians with G6PD deficiency. (300) This knowledge appears to be essential for physicians who are or will be treating Vietnamese refugees, but information on the prevalence of these conditions is not available.

Tropical Sprue. This is a primary mal-absorption syndrome of unknown and possibly multiple aetiology that is not indigenous to North America but which has been seen in military personnel returning from Viet-Nam. (301) Spontaneous cure is common, but if
untreated the mortality rate may be as high as 30%. (302) This appears to be a problem of diagnosis and treatment.

Malignancies. A tumour that is rare in North America but is "surprisingly prevalent" among people of Southeast Asia is a primary liver cancer, hepatoma. (303) Lung cancer may be more common in the Vietnamese and may manifest itself early due to the pre-adolescent onset of cigarette smoking and a high prevalence of smoking in general. (304) No good data are available on the above and it remains to be seen what the actual incidence rates of these malignancies will be. It also remains to be seen if the use of the defoliant "Agent Orange" during the war will have increased the risk of malignancies and deformed babies (305) among the Vietnamese people, of whom the refugees are a sample.

Miscellaneous. It is reported that Southeast Asians have more rheumatic heart disease and more systemic lupus erythematosus than North Americans, although classical rheumatoid arthritis is rare. (306) Otherwise it may be assumed that there will be a rise in the incidence of the so-called 'diseases of Western civilization' such as ischemic cardiac disease and diabetes, as these non-Western people change their life-style to that of North America. A culturally determined condition that may be seen is 'linear bruising'
that resembles trauma. The Vietnamese have a lay practice of coin-rubbing of several symptoms including fever and headaches - which could raise the spectre of child battering in western minds.

(307)

This chapter may be summarized as follows:
Public health threat | Little or no public health threat | Threat to the individual refugee

**Infectious diseases endemic in Viet-Nam**
* bacterial enteric disease
* cholera
* plague
* STD
* tuberculosis
* hepatitis B
* giardiasis
* amoebiasis
* malaria (transfusion induced)
* lice, scabies, fungal skin infections

**Non-infectious diseases and conditions**
* blood and tissue parasites
* lice, scabies, fungal skin infections
* 'common' infections
* melioidosis
* yaws

* major threats.

**Figure 3** Summary of diseases that may be a problem with the resettlement of the Vietnamese refugees in Canada
DISCUSSION

Even before the arrival of these refugee/immigrants it had been observed that there are special problems in Canada associated with the changing patterns of world migration (208) and these problems have been discussed in this thesis. Apart from the fact that strained relations between a host population and an immigrant minority can cause stress that ultimately affects health, it is the various aspects of the physical health problems that are of concern in this chapter.

Because they are coming from an area of the world with different disease patterns, the arrival of the Southeast Asians will increase the size of the reservoir of tuberculosis, hepatitis B, and bacterial enteric disease in the total Canadian population and thus increase the risk of Canadians acquiring these diseases. Other diseases that are little known in Canada and no threat to Canadians will also be encountered among these refugees. Both infectious and 'exotic' diseases will put a strain on existing health care facilities by increasing the demand for public health surveillance services, and for diagnostic skills and laboratory facilities. The federal Department of immigration is responsible for the initial health of immigrants, but the provinces are responsible for their health once settled, and there are problems arising from this split responsibility.

Normally the prospective immigrant is medically examined in his country of origin, and any outstanding health problems are treated
there before an immigration visa is granted. The examination includes chest X-ray for those over the age of eleven, and examination of blood, urine and stool. The policy of family re-unification means that on occasion a would-be immigrant is admitted to Canada on a 'Minister's Permit' where landed immigrant status is deferred and dependent on treatment and/or surveillance for a specific disease. The aim of the medical examination as part of the immigration process is to keep infectious diseases out of Canada and to ensure that immigrants do not become a burden on the social and health programs and services of this country.

Because of the unusual and emergency situation in Southeast Asia the pre-immigration medical examination of the refugees was considered to be incomplete and was finished at the point-of-entry to this country. The health documents were then processed in the usual way with a copy going to the Department of Health and Welfare in Ottawa.

Under the British North America Act of 1867 the provinces are responsible for the health of immigrants as part of their total population. It is the responsibility of the federal Department of Health and Welfare to inform the appropriate provincial departments of any health problems associated with a particular immigrant, and this process is known to be slow. Because the objective of the immigration medical examination is to (only) keep infectious diseases out of Canada, information on the presence of inactive disease that could be
a future source of infection to the Canadian public is not recorded or passed on to the provincial health departments. It is because of this, that the provincial health authorities have instituted programs to re-screen all the refugee-immigrants from Southeast Asia in order to obtain baseline data for the continuing surveillance for infectious diseases. This process is complicated by the fact that the sponsorship program has scattered these refugee/immigrants across the country, and that they are likely to subsequently relocate themselves into areas where there are other Vietnamese. In large metropolitan areas such as Vancouver, it is comparatively easy to set up special programs for the surveillance and health needs of these immigrants with staff who are familiar with their language and culture. It was found in this thesis that the culture of the 'giver' as well as that of the 'recipient' of health care will affect the outcome of any health care program. One wonders how surveillance for infectious diseases is accomplished in more remote areas where there are cultural and language barriers between health care personnel and the new immigrants?

It has also been found in this thesis that there is a lack of knowledge about tropical diseases on the part of health care professionals in countries with more temperate climates. In Canada this is deemed to be the result of insufficient attention being given in medical schools to the epidemiology and prevention of 'exotic' as well as other diseases of the tropics. (309) It could
also be a result of the fact that parasitic disease has never been an important problem in Canada. A discussion with a member of the Faculty of Medicine at the University of British Columbia brought the observation that work and travel in the tropics by medical students has increased their awareness of tropical diseases, and this has caused a (welcome?) increase in their interest in parasitology.

The problems seen to be associated with the arrival of these refugee/immigrants are the continuing surveillance of infectious diseases such as tuberculosis, hepatitis, and bacterial enteric disease, for the protection of the public health; the need for knowledge on the part of health professionals of diseases and conditions that could cause symptoms and perhaps chronic ill-health in these new immigrants; and the need for knowledge of the effect of culture on the delivery of health care. Factors seen to affect the resolution of these problems are the different objectives of the federal immigration policies and the provincial Departments of Health, with a lack of inter-governmental co-ordination of health services for immigrants; and curricula for educating health care professionals that contain little or no teaching on tropical diseases or the effect of culture on the delivery of health care.

If indeed the present pattern of world migration continues then the need for both of the above is a truly long-term prospect, and not just necessary to deal with the immediate phenomenon of 50,000 refugees from Southeast Asia.
CHAPTER 9

PROBLEMS OF ADJUSTMENT AND MENTAL HEALTH

INTRODUCTION

Adaptation to a new environment has been seen to be stressful in one way or another for all migrants, and this 'normal' stress may be aggravated for the Vietnamese refugees by their experiences of war and flight. There is a growing literature on the adaptation and mental health of the first wave of refugees into the U.S.A. in 1975-76; but it must be remembered that Canada has admitted the refugees from Southeast Asia as landed immigrants rather than as "refugees on parole, as their compatriots in the U.S. were." (310) This factor may have an effect on the adaptation problems of the Vietnamese in Canada.


In her observations of the absorption of the first wave of refugees from Viet-Nam into American society in 1975-76, Kelly noted that most of them had apparently thought little about the social or cultural consequences of leaving their homeland. (311) Housed initially in ex-army camps, they had time on their hands to think, and while being 'processed' into America were still surrounded by Vietnamese culture: all of which probably
caused ambivalent feelings, and contributed to depression, and anxiety about the future.

Suicidal attempts and psychotic depressive reactions were reported among some refugees in U.S. camps (312); and psychosomatic complaints such as headaches, stomach pains and insomnia were reported in another study.(313) Children expressed their distress by somatic complaints, feeding disorders, sleep disturbances, developmental arrest, tantrums, violent anti-social behaviour and marked withdrawal; and the depth of their depression was illustrated by their refusal to learn English.(314) This is the observable 'tip of the iceberg' indicating the presence of varying degrees of unhappiness with their situation: however, no absolute figures appear to be available.

These initial reactions may have been avoided in Canada by the policy of a brief period only at the Reception Centres set up for the Indochinese refugees in Edmonton and Montreal. Uncertainty about the future at this stage is also avoided as the immigrants do not leave Southeast Asia until they have a definite destination in Canada, and are only "in transit" at the Reception Centres.

Successful adaptation to a new environment appears to depend at least partly on how well needs are met. The availability of shelter (housing), employment and financial stability are dependent on the economic situation, and North America has been in
an economic downswing for several years with high levels of unemployment. These are factors beyond the control of health services and personnel involved with the mental health of these new immigrants, but must be remembered as possibly contributing to maladjustment and unhappiness.

It was found that the Vietnamese refugees in the U.S.A. in 1975-76 found jobs and housing difficult to find, and they were often under-employed in the sense that they were not able to use the skills and qualifications they had. In addition, the U.S. government policy was to scatter them across the country in an attempt to avoid concentration of Vietnamese in specific areas such as California. There was considerable public opposition to resettling the refugees in the U.S.A.; which was probably due to the overwhelming need to forget the Vietnam War, and the fear of unemployment due to the influx of thousands of new immigrants. There is still anti-Oriental feelings in parts of the U.S.A.

Even if there was enough to eat and a roof over their heads, fulfillment of the need 'to belong' and for 'self esteem' would be denied the Vietnamese refugees in this situation. The sense of alienation, of feeling not being wanted by the American people, combined with socially unacceptable employment (by Vietnamese standards) could lead to depression, anxiety, and may be psychotic reactions to this stress.
The results of a two-year study of 'first wave' refugees in the U.S.A. based on the Cornell Medical Index, indicated a high and continuing level of physical and mental dysfunction persisting into the second year. This was attributed to their refugee status rather than to cultural factors. (315) The second part of this study of continuing changes in life events gives some indication of the areas in which the refugees found instability: work, finances, spouse relations and life-style.(316) This could be restated as instability in the process of meeting human needs.

It has been observed that the new habits and customs challenge Vietnamese traditions in painful ways beginning at the basis of Vietnamese life - the family. The elderly have become a burden rather than to be venerated; their wisdom is no longer applicable, and their ability to adapt is negligible. The role of the children is changing as adults become dependent on them for guides and interpreters. They are at the same time a source of pride and anxiety as they learn new ways, customs, and values that conflict with those of their parents.(317) It was seen earlier in this thesis that the lack of a sense of identity in immigrant children could lead to social problems as they grow up and try to resolve their conflicts.

The Vietnamese are a persevering people, but to maintain this in the face of unemployment, under-employment, and low pay, is not easy.
The policy of scattering them across the U.S.A. made their social and cultural losses even harder to replace. It has been found that after one year in America, the refugees still had difficulty in accepting American values such as the dispersal of the extended family; numerical limits on home occupancy; indifference and disrespect towards old people; absence of friendly people with whom to socialize in the daytime; the hectic pace with few breaks in the workday; the distances that require vehicular traffic, rather than work, family and sociability being in one easily accessible location; and value put on work and achievement rather than on interpersonal ties. (318)

The full impact of the break-up of the extended family, the westernization of the children, the widening of the generation gap, and the tug between traditional and western values may only be felt after some years, but the studies mentioned above have shown that there may be conflict much earlier. This would indicate both immediate and long-term problems of adaptation, and the mental health problems that accompany this.

THE VIETNAMESE IN CANADA

As mentioned earlier, the Vietnamese already in Canada were admitted in 1975-76 as landed immigrants having met immigration criteria that would hopefully have enhanced their chances of adapting successfully. However, it has been observed
that they had problems similar to those of their compatriots in U.S.A.; unemployment, cultural adjustment, loneliness, the language barrier, all compounded by the weather. (319)

Canada's policy regarding the resettlement of this second wave of refugees from Southeast Asia has been to admit them as landed immigrants sponsored by community groups or organizations, with a matching formula by which the federal government sponsors an equal number to a total of 50,000. The immigration criteria are good health, and the motivation and skills to settle successfully in Canada. This is a selective process in that those with obvious health defects, either physical or mental, will have been 'screened out'.

The Canadian sponsors agree to provide food shelter and financial support as needed, until the immigrants become self-supporting, or for one year. They are also expected to help the adjustment of the newcomers to the new life-style, and to orientate them to community and government services. This is a continuation of the unwritten policy of involving local communities and voluntary agencies in immigrant settlement; and with this scheme, the government has delegated moral and financial responsibility for meeting the needs of these refugee/immigrants to the sponsors.

There are officially about 6000 Vietnamese refugee/immigrants in Vancouver, British Columbia. In an attempt to
assess what is being done to help their adaptation to the new environment, interviews were conducted with several community (voluntary) agencies and individuals involved in this process.

As stated earlier, the sponsors accepted responsibility for a family until they were settled or for one year. One problem has been the acute shortage of housing in Vancouver, but this seems to have been overcome with several sponsors sharing their homes until an apartment was found for their guests. There have been some humorous and not so humorous misunderstandings about food and its preparation, the use of western style beds, and the different western and oriental concepts of time and the keeping of appointments. In western eyes being 45 minutes late means a cancelled appointment: in Vietnamese eyes it is polite to arrive 45 minutes after the appointment time. Another point of possible misunderstanding is the different styles of conversation: westerners find it very difficult to accept the periods of silence, and deep thought that the Vietnamese give to their answers. The concept of Sao You (scratch the wind) or coin-rubbing for various health problems has been met by health professionals and has raised the spectre of child-abuse in their minds. These seemingly small incidents are the everyday facts of cross-cultural interaction; and one wonders how much preparation was given the sponsors, and others working with the refugee/immigrants, in order to minimise the
irritation and misunderstandings that can arise on both sides in this situation.

There are voluntary agencies with the expertise to help sort out misunderstandings but no data to indicate who asks for what or in what quantities. This supports the contention noted earlier in this thesis that it is difficult to evaluate the part that voluntary agencies play in the resettlement of immigrants. Unfortunately, the co-ordinating body for the resettlement of the refugees in Vancouver, "The City of Vancouver Task Force on Vietnamese Refugees", was disbanded in November 1980, so it has not been possible to obtain either an overview of the situation or more specific data from this source.

Lack of knowledge of the English language has certainly been a barrier to employment, and those who can speak English appear to be settling down and obtaining employment much faster than those who do not know the language. Many are under-employed because of the language problem and/or because their professional and technical skills are not recognised in this country. One comment heard was that professional and technical organizations could do more towards helping with this problem. There is misunderstanding on the part of some employers of the immigrants' comparative slowness at completing tasks, in spite of their general willingness to work. All this does not help the 'self-esteem' of these new immigrants.
Being able to communicate helps fill the need to 'belong' and English language classes are conducted by voluntary agencies as well as by the federal Department of Employment and Immigration - although there is a two month waiting list for the latter. There is a weekly newspaper in three languages, English, Vietnamese and Chinese, supported by S.U.C.C.E.S.S. (United Chinese Community Enrichment Services Society), which facilitates communication between community, sponsors and new immigrants. This is the only multi-language newspaper in Canada for the Southeast Asian Refugees, and is mailed across the country. One issue contained articles on nutrition, child development, and health; legal matters such as housing regulations; understanding Canada; and a letter from a sponsor expressing his/her feelings on refugees!

A major factor in the 'sense of belonging' in any culture is the 'social network' of familiar faces, language, and activities. In the U.S.A the firstwave Vietnamese soon 'resettled' themselves into areas where there were other Vietnamese. This would help them support each other in adjusting to the American way-of-life, and in forming a Vietnamese-American subculture. It has shown again that the policy of direct assimilation into the dominant culture does not work, and it is of interest that it was tried in spite of the American recognition of the multicultural society.
The large Chinese-Canadian community in Vancouver provides a 'social network' for Chinese and Vietnamese immigrants, and this is attracting the Vietnamese to 'resettle' themselves here out of their original areas of settlement. S.U.C.C.E.S.S. estimates that their number in Vancouver alone is now around 10,000. This 'network' with the special health clinic in the area of 'Chinatown', will help the adaptation of the Vietnamese to Canadian life; in fact, they themselves have asked for specific programs at the clinic, such as family planning. However, all this raises the question of what and how much help (if any) has been offered both sponsors and immigrants in the more remote areas of the country to aid the adjustment process?

The overall feeling from the interviews and the news media is that this resettlement scheme has been a success. But is this an Occidental view of a situation where Oriental feelings are not expressed? It is of interest to note here that nothing has been heard of possible reaction to RPM (Rape, Pillage and Murder) or other experiences during the flight of the boat-people. Four of a possible 10,000 refugee/immigrants in the Greater Vancouver area have been admitted to psychiatric in-patient facilities. Is this the 'tip of the iceberg'? What does it mean for mental health programs - and professionals?
Prevention of the breakdown of coping mechanisms should be the objective of mental health programs, and recommendations on the creative aspects of this are beyond the scope of this thesis.

Economic factors such as the high rate of unemployment and lack of housing are beyond the control of health services personnel, although the effect of these on health must be remembered. Knowledge of Canada's official policy of multiculturism is important for health care workers as this implies the acceptance and understanding of 'different ways of doing things'. Planning and execution of programs for preventing the breakdown of coping mechanisms (mental health) is difficult if the intended recipients perceive mental illness as caused by hostile agents outside the body. Understanding the effect of culture (ways of doing things) and life experiences on the immigrant adaptation process will increase the sensitivity of mental health workers when dealing with the psychological signs of maladaptation and stress.

It was observed earlier in this thesis that social welfare personnel have a dual role; helping the client(s), and acting as an advocate for them to planners of social welfare programs. This could be applied equally well to all health care personnel, but implies an understanding of the effect that culture
and life experiences including migration, have on health and on the giving and receiving of health care. With perhaps 10,000 Vietnamese in Vancouver, this appears to be an ideal situation for a study of the factors affecting the adaptation process of immigrants; especially when it is remembered that patterns of world migration are changing, and Canada is likely to receive more immigrants who are racially and culturally different from the majority. Such research is sadly lacking in Canada, and planning programs and services for immigrants per se is pointless without the information that this research would generate.
CHAPTER 10

RECOMMENDATIONS AND CONCLUSION

INTRODUCTION

The question posed in this thesis is what effect, if any, the health status of the Southeast Asian refugee/immigrants will have on 1) the health of Canadians, and 2) the future health of the refugees themselves. It was postulated that the factors underlying both the problem and its resolution would be the characteristics of the new immigrants and the country receiving them - Canada. This is conceptualized in figure 1. (page 7)

It has been found that the health status of the new immigrants is determined by two factors: the immigration policies of the Canadian government, and the cultural background and life experiences of the refugee/immigrants themselves. The problems arising from this are seen to be 1) the increased risk to Canadians from certain infectious diseases, namely tuberculosis, hepatitis, and bacterial enteric disease; 2) the importation of 'exotic' diseases that are not a great risk to Canadians but which may pose problems of diagnosis and treatment; and 3) mental health problems in the new immigrants arising from culture shock and possible difficulty in adapting to a new environment.

The resolution of these problems is seen to be affected by the cultural background and life experiences of the new immigrants,
and by certain Canadian characteristics. Besides the personal attitudes of Canadians towards these immigrants, the latter includes a system in which responsibility for various aspects of Canadian life is shared by different levels of government, and where policies may be formulated at one level and programs and services provided at another. A factor found to contribute to the success or failure of programs and services designed for the resettlement and health care of these immigrants is the knowledge of health care professionals about the effect of culture on health and health care, and about the etiology and epidemiology of tropical diseases.

The Characteristics of the 'Boat people'.

The 'Boat people' are a group representative of the large and continuing involuntary movement of people in Southeast Asia today. They appear to be mainly 'ethnic' Chinese fleeing Viet-Nam because of intolerable living conditions, and have been living for various periods of time in refugee camps in Thailand, Malaysia, and Hong Kong. The uncertainty of their refugee status has added to the accumulated stress of prolonged social upheaval and warfare and their experiences during flight.

The process by which 50,000 of these refugees were selected for resettlement in Canada means that overall they have met the criteria for immigrants per se. However, the environment
from which they have come means that there are some long-term health problems associated with their resettlement in this country. Their cultural background, especially their beliefs and customs about health and sickness, will affect the way in which these problems are solved.

THE CANADIAN CHARACTERISTICS

Under the British North American Act of 1867, immigration was to be the joint responsibility of the federal and provincial levels of government. The evolution of the system has brought about the situation whereby today the federal government alone makes immigration policy. This is aimed at preventing the spread of infectious disease, as well as admitting immigrants who are healthy and who will quickly settle and become productive citizens. Settlement services such as language training and employment counselling are offered at the community level by the federal Departments of the Secretary of State and Employment and Immigration respectively. These are supplemented through services offered by interested voluntary agencies and which are encouraged by the unwritten federal government policy of involving the community in immigrant settlement. The provinces are not involved in this process per se; but they are involved in immigrant health problems in other ways, and it appears that there is a need for greater co-operation and co-ordination between levels of government in this matter.
It has been seen that immigrants may, through no fault of their own, make unusual demands on social and health programs. Again under the British North America Act of 1867, these are the responsibility of the provinces - although the federal government can and does influence the formulation of health and welfare policies at this level. The provincial governments delegate some of the planning and delivery of programs and services to the local level, i.e. community Boards of Health and Health Units. The division of responsibility for immigration and the welfare of landed immigrants across various levels and departments of government and the voluntary sector, is seen as leading to possible fragmentation of services and a lack of planning and co-ordination between official and voluntary agencies.

Other factors seen to contribute to the success or failure of programs and services offered in the context of the resettlement of these 50,000 refugees are the attitudes and knowledge of Canadian health care professionals. Attitudes towards immigrants may be representative of societal values; but until comparatively recently immigrants passed unnoticed into the mainstream of Canadian life and their health and adaptation problems were not seen by the majority. This of course is changing as immigrants are becoming more conspicuous by virtue of their race, colour and culture. The previously homogeneous society means that Canadian health care professionals have not been educated in
the cross-cultural aspects of health and sickness and the influence of this on the delivery of health care.

Taking the health problems associated with the resettlement of the 'Boat people' one by one, recommendations will be made on factors seen to affect their resolution.

THE PROBLEMS

The Risk of the Spread of Infectious Diseases

One objective of Canadian immigration policy is the prevention of the spread of infectious diseases, and as these new immigrants have had to pass a pre-immigration medical examination it could be assumed that there would be no health problems associated with their resettlement in this country. Obvious disease will have been 'screened out' by this examination; however, it is known that tuberculosis, hepatitis and bacterial enteric disease can lie dormant, perhaps for years, and become active again at a latter date. Because of this environment from which they come, and their experiences of war and flight, it is considered that the Vietnamese are susceptible to the breakdown of inactive disease that had been acquired earlier, and can thus become a public health hazard.

Short-term programs were instituted by both federal and provincial governments to deal with this problem as the immigrants arrived, but these programs are now being 'phased out.' In future,
all immigrants from Southeast Asia will enter Canada through regular immigration channels; and their health care once they have arrived will be the responsibility of the provincial governments and local health units. The health problems of these future immigrants are expected to be similar to those of the Vietnamese refugees.

Programs and services for the protection of the public health are already in place. However, it has been seen that the success of any health program is at least partly dependent on how it is perceived by the 'recipient', and his/her interaction with the 'giver' of health care who may see the problem from a different perspective. These perceptions are culturally determined, and the greater the distance between those of the 'recipient' and 'giver' the greater the risk of program failure. In this instance, it could mean the increased risk of the spread of infectious diseases.

It would appear that both those responsible for planning programs and the health care professionals carrying them out should be aware of the effect of culture on the giving of health care. In the context of the prevention of the spread of infectious diseases this is seen to be primarily a responsibility of the service level; although the need for such knowledge should be acknowledged at the policy making level.
The professionals both planning and delivering health care are seen to be physicians and public health nurses; and the problem of acquiring knowledge of the effect of culture on health and sickness is both immediate and long-term. The following recommendation is made in order to solve the immediate problem.

Recommendation.

1. That health care agencies, especially those in the public health field, provide material on the cross-cultural aspects of working with the Vietnamese immigrants for their staff.

The arrival of the Vietnamese refugee/immigrants has only highlighted the fact that world migration patterns are changing and, that unless policies are drastically changed, Canada will be admitting more immigrants from countries with different patterns of disease and different concepts of health and sickness. It is suggested that the need for understanding the effect of culture on the delivery of health care will continue, if not grow, and that courses on this subject should be included in the education of physicians and public health nurses.

These health care professionals are educated at university. Professional licencing bodies ensure that basic standards are met in order to protect the public; but apart from this function can only suggest that courses on certain topics be
included in the university curricula. However, it is felt that it is a professional responsibility to acknowledge the changes taking place in Canadian society and the effect of this on the delivery of health care, and hence on the education of its members.

Universities, as educational establishments, and the professional licencing bodies come under provincial jurisdiction. Separately, they have national associations that interact with each other and government at the national level. With this in mind, the following recommendations are made.

Recommendation.

2. That the medical and nursing professional associations, in conjunction with the appropriate university departments, explore ways of including courses on the effect of culture on health and sickness and the cross-cultural aspects of the delivery of health care, in the basic education of physicians and public health nurses. It is further recommended that the disciplines of sociology and anthropology be involved in this process.

Continuing education is also a professional responsibility, and it appears that these courses are initiated by interested professional individuals.

Recommendation

3. That the above professional associations encourage their members and the appropriate university departments (or community colleges) to plan continuing education courses in the cross-cultural aspects of the delivery of health care.
The Problem of 'Exotic' Diseases.

Apart from the risk to the public health from imported infectious diseases such as tuberculosis, there is the problem of diseases that are a threat to the health of the individual refugee/immigrant and which are perhaps little or unknown in Canada. The recognition and treatment of these diseases, which include intestinal parasites, malaria, and Hansen's Disease, requires a level of knowledge about tropical disease that is not common in Canada, and which has not been widely taught in medical schools here. There appears to be an increasing interest in tropical diseases among medical students who are aware of the effect of social change on the distribution of these diseases in the world: but again, this aspect of medical education is seen as a professional responsibility.

Recommendation.

4. That the medical profession, in conjunction with the University Schools of Medicine, ensure that teaching of the etiology and epidemiology of tropical diseases be expanded in the basic education of physicians.

Again, continuing education is seen as a collective as well as an individual responsibility of health care professionals. It was somewhat disturbing to find a time-lapse of two years between the announced arrival of the Vietnamese refugees in Vancouver and a 'possible' course on tropical medicine for practicing physicians at the University of British Columbia. It is therefore recommended:
Recommendation.

5. That continuing education courses in tropical medicine for physicians be initiated by the medical associations as well as by individual practitioners.

Adaptation, and the Mental Health of Immigrants

The other component of the health status of the 'Boat people' is the mental stress caused by the process of adapting to a new environment. This is not a threat to the health of Canadians, but has ramifications for mental health programs and services. Those with obvious psychological distress will have been 'screened out' by the pre-immigration medical examination; however, loss of mental health can be an insidious process occurring over many years. Cultural beliefs and customs affect the perception of this problem and its prevention and treatment, by both the Vietnamese and the western health care professionals.

Adaptation is the learning of new ways of meeting needs, and it is the inability to deal with this that can lead to depression, anxiety, and desperation. It has been seen that immigrants tend to have higher hospitalization rates for mental disorders than the locally-born populations, so it would appear that ways of preventing this should be explored.

The federal government, with its responsibility for immigration policies, programs and services, has relied heavily on the response of community groups and organizations for the operation
and success of their program for the resettlement of these refugees.
This is in line with their unwritten policy of involving the community in the immigrant resettlement process per se; and it appears that by doing this voluntary agencies and groups have given a great deal of unpaid help to the government.

Many of the problems of adaptation can be handled by voluntary agencies with the interest and resources to do this. Highly trained, and highly paid, professionals are not needed; although there is a need for social workers to be aware of the special problems of immigrants and the effects of culture on the adaptation process, social welfare, and mental health. Therefore the following recommendation is made.

Recommendation.

6. That the professional associations of social workers, in conjunction with the appropriate university department explore ways of including courses on the effect of culture on health and social welfare, and on the cross-cultural aspects of the delivery of care in these areas, in the education of their members.

If the coping mechanisms of the new immigrants do fail, then the knowledge of, and sensitivity to, the peculiar stresses of migration and adaptation by psychiatrists, psychologists, psychiatric nurses, and social workers will facilitate treatment and recovery. The actual numbers of immigrants requiring help will probably be small, so special programs may not be needed. There is a need to sensitize health care workers, including the bureaucracy, to the
effect of culture on mental health and to the eastern and western perceptions of a health problem and its resolution. Again, this is seen as a professional responsibility and attention is drawn to recommendations 1 and 2.

It has been observed that the evaluation of immigrant resettlement services is difficult because of the autonomy of the voluntary agencies involved in this process, and an overall lack of planning, co-ordination and accountability. The need for the services has certainly been recognised by the federal government with their funding of the voluntary programs. It would appear that the government has a responsibility to the community i.e. the taxpayers, the agencies, and the immigrants themselves, in evaluating the way the money is spent in terms of the type and quantity of services offered, and to whom.

Recommendation.

7. That all programs designed for the resettlement of the Vietnamese refugees be evaluated by the Department of Employment and Immigration. This is to include the sponsorship program, and the role of the voluntary agencies as well as that of the more formal social and health programs.

In view of the probability that immigration from countries that are significantly different from Canada will continue, the following recommendation is made.
Recommendation

8. That these programs, redesigned if necessary, and with an evaluation process built in, be offered to all immigrants.

It is disturbing to note that in spite of the evidence that the resettlement problems of these new immigrants may continue for years, both senior levels of government appear to have reverted to their former 'laissez-faire' attitude to immigrants. The federal government has phased out the extra services that they supplied for the refugees; and the legislation passed by the provincial government of British Columbia to provide the mechanism for funding services for the resettlement of refugees per se* does not seem to have been activated. The 'City of Vancouver Task Force on Vietnamese Refugees' has been disbanded, leaving the efforts of voluntary agencies and sponsoring groups unco-ordinated. This 'Task Force' could have been used in an evaluating role for the programs and services offered to the refugees. Both voluntary and government programs and services are seen as contributing to the successful adaptation of all immigrants, not just to that of the Vietnamese; and the prevention of mental breakdown reduces the future cost to the community of immigrant ill-health.

With all this in mind, a final recommendation is made.

Recommendation

9. That both levels of senior government facilitate research into the factors that affect the immigrant adaptation process, and into immigrant health problems in general.

CONCLUSION

Man has been migrating through time immemorial and although his motives have remained constant, the patterns of movement across the globe have changed and quickened. World-wide social change means that there will be more voluntary migration from areas that 'have not' to areas that 'have'; and that the latter, for whatever reasons, will feel obliged to give asylum to those uprooted by war, natural disaster, or political persecution.

This has brought about new Canadian immigration policies, with the result that more and more Canadians will be coming into everyday contact with people who are 'different'. It has been seen that the meeting of different races and cultures can produce some social stress.

Immigrants in the future are likely to have health problems that will bring them into early contact with the health care system and its professionals. Planners of health care services should be aware of the fact that sensitive and informed professionals can ensure successful outcomes to these cross-cultural contacts in the health care field, and ultimately contribute to making the concept of a multicultural Canada a reality.
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