

EXAMPLE 1" Source: <http://www.paperspecialists.com/samples.htm>

### **The Role of the Family in the Developing World**

Family systems, like biological organisms, evolve with time and circumstance. It seems readily evident from an examination of the nature and role of the family in the developing world that form may indeed follow function. Many sociological studies conducted in recent years have indicated that the nuclear family is found at both the primitive and modern stages of economic evolution. The nuclear family predominated in early societies with subsistence hunting and gathering economies where food supplies were uncertain, and still predominates in modern industrial societies where the marketplace requires the geographical mobility of small, nuclear systems. This pattern of family roles in society, established over long centuries, still applies in most of the developing nations of the Third World.

Examinations of the sociological histories of various areas of Europe, Asia, and South America provide us with useful examples of the durability of the nuclear family. The nuclear family has always been important in the Third World societies of Eastern Europe, where households have been small and based on monogamous marriage, even where polygamy has been permitted. Ties to both parents' relatives have been and still are respected, even when descent has been traced through only one line. Bonds between parent and child have always been legally and emotionally important. (Wolfe 198)

Many families in Third World nations are products of discontinuity. The intensification of agricultural production and the development of social systems based on land ownership have been important developments, as have changes in inheritance systems, which have evolved towards passing wealth to daughters as well as to sons. These inheritance systems, common to South America, favored the members of the immediate family over the lineage structure that controlled property in African systems. (Allan and Crow 102)

It is of interest to note that the family and its place in society have been affected in many Hispanic societies in South America by declines in religious belief as modernization develops. "The Catholic Church's authority often competes with new value systems and the church generally loses respect and membership as progress advances." (Smith 154)

More significant changes in the role and importance of the family are generated as Third World nations begin industrialization, which reduces the traditional productive functions of the family. Many Third World states have been primarily rural, agricultural societies, but in

many cases land ownership becomes more centralized and towns expand as modernization continues, creating both a larger middle class and a landless proletariat. The middle class is often a diverse group including owners of large enterprises, managers and professionals, and small traders and shopkeepers.

In many African, Asian, and South American societies rural family households did much of the work within the home, and depended upon merchants to provide needed materials and marketing. Women and children were vital to the labor force, and the economic value of children as sources of family income encouraged high fertility. While landowners tend to become fewer, more powerful, and richer as modernization and industrialization develop, families who lose access to land and have to turn to household manufacture become poorer. What agricultural jobs remain are mostly for men, resulting in a decline in the participation of women in agriculture.

Families in the developing world have to adapt as industrialization brings workers together in factories and dramatically reduces opportunities for handwork in the home. This development adversely affects rural families, who rely on such work, and they often experience greater poverty. "Foreign owners of Third World factories rely heavily on the cheap labor of women and children, often recruiting and hiring entire families, so employment is possible but there are obvious negative factors as well." (Rosen 109)

As industrialization proceeds, the higher classes in developing world societies often lead a movement away from women's employment, relying instead upon men's control of capital or high wages to support families. In circumstances such as this fewer married women take industrial jobs, but wages rise for the men and single women who do. Growing industrialization and urbanization separates many families from their kin, but working-class families often rely upon relatives who have preceded them to the city, so the family unit remains very important. For entrepreneurial families, kinship ties are critical for raising capital, hiring reliable employees, and inheriting wealth, especially in the close-knit Hispanic families of Central and South America.

The technological developments of recent years affect the family structure of Third World families in many ways, raising productivity and wages, and facilitating a pattern of male breadwinning and female homemaking. Working-class neighborhoods become more stable, and a matrifocal family pattern often emerges in which mothers and daughters retain lifelong bonds while men become somewhat marginalized.

In many developing nation societies divorce remains hard for working-class couples to obtain, but consensual unions and informal separations are common. Education replaces child labor, and children's reliance on education rather than parental resources increases their freedom in mate selection. Fertility declines as children lose value in the household economy. Female employment declines in industries such as mining, but jobs open up in occupations requiring more education, such as clerical work, teaching and nursing.

The family role in Third World societies is also influenced by the migration to industrial cities. This development gives people more autonomy and privacy, but one negative result is the greater opportunity for family members in large, impersonal cities where no one knows their neighbors to get away with abusive or violent behavior. (Henslin 101)

As mass education and mass communications develop in the Third World they reduce class distinctions. In response, working-class families adopt certain middle-class customs such as low-fertility and investments in education. Middle-class families imitate working-class patterns in abolishing dowries, allowing children free choice of marriage partners, and accepting divorce. Furthermore, the separation of the industrial workplace from the home has created a conflict between the economic and family roles of women, encouraging those who can afford to do so to devote themselves to the home and children.

But as moral motherhood spreads from the higher classes to the working class, a counter-movement toward women's employment is developing in many Third World societies, encouraged by such factors as women's education, feminism, home technology, higher standards of consumption, and the insecurity of modern marriage. Women's employment subsequently affects the family unit in that it encourages smaller families and grants greater social freedom to women, enabling them to end unsatisfactory marriages or raise a child without marrying the father. (Janssens 310)

The shift of authority from the church to the state in many South American and Central American societies also contributes to family change. The state allows divorces and legalized contraception, and provides economic support for single parents and the elderly. Divorced mothers receive little assistance from kin or from ex-husbands, and divorce settlements often fail to compensate for the weak financial position of many women.

But modern job opportunities and state support make it possible now for women in the Third World to live independently, although not without some lingering economic

disadvantages. Disputes over property and visitation often make the post-divorce situation unpleasant for all concerned, especially the children. In addition, increases in step-parenting and isolation from kin often increase the risks of child abuse.

Today in developing nations, instead of relying on the family unit, adult children and the elderly often prefer to rely on their own resources or those of the state. The expansion of state support is so expensive, however, that it generates public resistance, especially directed at single mothers. Although premarital pregnancy was also common in earlier times, it was more often followed by marriage or abandonment of the child to a foundling home. As fewer pregnant women marry, fathers have become marginalized.

In conclusion, the larger family structure of earlier times has given way to even smaller and more fragmented families in developing societies of the Third World. This does not mean the end of the nuclear family, however, since people continue to form relationships, and children continue to be raised primarily by their own parents. The basic family unit has always been extremely important, and although many changes in the family's role and importance have occurred as modernization spreads across the world, the traditional family structure appears to be very durable.

## Bibliography

Allan, Graham, and Crow, Graham. *Families, Households, and Societies*. New York: St. Martin's Press, 2000.

Henslin, James. *Marriage and Family in a Changing Society*. New York: Free Press, 1992.

Janssens, Angelique. *The Family and Social Change*. London: Cambridge University Press, 1993.

Kurian, John. *Women in the Family and Economy*. New York: Greenwood Publishing Group, 1982.

Rosen, Bernard. *The Industrial Connection: Achievement and the Family in Developing Societies*. New York: Walter De Gruyter, 1982.

Smith, Thomas Edward. *The Politics of Family Planning in the Third World*. Boston: Harvard University Press, 1989.

Wolfe, Christopher. *The Family, Civil Society, and the State*. New York: Rowman and Littlefield, 1998.

## THE INCIDENCE OF TUBERCULOSIS AMONG LOW INCOME PEOPLE

### *Summary*

*This paper explores whether the incidence of tuberculosis (TB) is higher among low income people because they are less likely to seek medical care. It investigates two urban districts that compare in terms of race and income level, these being Harlem and West Central, USA. To determine the role of race and economic disadvantage in the incidence of tuberculosis in these geographic areas, ethnographic methods were used to analyze the information. It appears that there are significant race and class dimensions to the incidence of tuberculosis in these areas, but there are other confounding factors – such as (human immunodeficiency virus) HIV and the times at which sufferers sought medical help. This study suggests that there is a pressing need to improve our understanding of the socio-economic aspects of problems affecting public health, such as TB in the United States.*

### **Background**

#### *i. Statement of the problem*

People in economically disadvantaged positions living in medically under-served communities are at an increased risk for tuberculosis. The disease does continue to be a barometer of poverty and race, but there are other significant factors associated with the incidence of TB. Studies in South Africa suggest that those qualified as black or coloured had significantly less access to health care, and thus stood less chance of being diagnosed than their white counterparts (Andersson 1990). Those in this disadvantaged condition tended to suffer disproportionately from other socio-economic related medical factors, such as malnutrition and incidence of HIV/AIDS that are closely linked with the incidence of TB.

The pattern is similar in other countries, including the USA. The problem in the United States is that there is limited population-based data on TB by social class (Lifson et al. 1999). There is even less data on the incidence of seeking medical care between the onset of symptoms and the visit to a medical center. The incidence of TB is indeed higher among low income people because they are less likely to seek medical care. But the objective of this study is to suggest that there are other critical factors in the complex social dimension of public health problems associated with TB. These will be discussed in parts iii and iv of this section.

#### *ii. Literature review*

During the 1980s and 1990s, there have been dramatic transformations in the epidemiology of tuberculosis in the United States (Bloch et al. 1996). As TB morbidity began to increase in 1985, after an all-time U.S. low, a significant number of studies were begun to explain the phenomenon. Some of the conclusions of this study will be based on the extensive current literature attempting to explain this recent increase in TB morbidity. Two of the most important factors have been the available evidence on HIV co-infection, and the incidence of TB among the foreign-born. Alan Block et al. (1996) have done an excellent exploratory study of this theme, entitled 'The need for epidemic intelligence'. The study sends the powerful message to a U.S. audience of the importance of further research into the implications of race and social class in areas like urban health policy. This is particularly true in cases of the emergence of a multidrug-resistant tuberculosis (MDR TB).

Some work has also been done on the regional variations of TB in the United States that is of great value for studies like this one. For instance, Subroto Baerji et al. (1996) have researched and written a study entitled 'Tuberculosis in San Diego County: a border community perspective', which takes into consideration a population in transition and the effects on the incidence of TB in that district. Pappas Dievler (1999) has done a similar investigation of Washington D.C., specializing in the HIV/AIDS angle and the implications of social class and race for urban public health policy making.

Some interesting work has also been done on the epidemiology of TB in low-income areas. A.R. Lifson et al. (1999) have done a study called 'Tuberculin skin testing among economically disadvantaged youth in a federally-funded job training program.' For this study, the valuable aspect of Lifson et al.'s paper was the following finding: that differences in geographic region of residence were not significant after adjusting for other factors. This has implications for the importance of screening groups at risk for tuberculous infection, as well as for public health policy and services offered in high-risk areas.

It has also proven useful to investigate international cases wherein race and class factor in. N. Andersson's study 'Tuberculosis and social stratification in South Africa' (1990), suggests that poverty, race and the incidence of tuberculosis were a global phenomenon. In the South African case, the risk of TB for people categorized by the state as 'black' or 'colored' are 27 and 16 times (respectively) as related to the risk for whites. The author argues that whites with the disease stand a greater chance of being diagnosed than their black counterparts, namely because of their improved access to health care. There is much to be learned in the American context by viewing the incidence of TB among low-income, medically under-served communities in other districts and countries.

Finally, because TB is a social health problem, it has been invaluable to investigate media reports in addition to strictly medical material. It is unclear to what extent there is a 'public education' aspect to press releases on the incidence of tuberculosis among low-income areas. But the press has much to say regarding the link between national and local cases – like those investigated here – and the global context. Consider Susan Okie's article, 'TB Tests of Immigrants Urged: Panel offers blueprint to eliminate the disease in U.S.' (2000), or Ines Capdevila's piece 'Morella, Brown Sponsor bill to curb tuberculosis abroad' (2000).

### *iii. The need for current study*

During the mid-1980s, there was a significant annual decline in the incidence of tuberculosis in the United States. The disease reached an all time low of 22,201 cases in 1985, though reported cases rose 20% to 26,673 in 1992 (Bloch et al. 1996).

There is currently insufficient evidence to suggest the reasons for this excess morbidity. Studies do suggest that that HIV infection and TB in the foreign-born who immigrate to the US as responsible in large part (Bloch et al. 1996). In 1999, 43% of the 17,500 new cases of TB in the USA occurred in people born elsewhere – a figure that was only 27% in 1992 (Okie 2000).

If this alarming upward trend in excess morbidity were not enough, the need for the current study is further justified by the emergence of a multidrug-resistant tuberculosis. The pattern for MDR TB has been that it has comprised 2% of tested isolates over the past 5 years (the report was written in 1996) of a current San Diego County-based study (Baerji et al. 1996).

There are clear socio-economic factors which have direct implications for the incidence of TB. The fact that low income people are less likely to seek medical care is only one of these factors. Using the Harlem and South Central districts, this study will attempt to demonstrate that the likelihood of seeking medical care is only one contributing factor to why tuberculosis is higher in such low-income areas.

### *iv. Hypothesis*



This study supports the conclusions of Alan Bloch (Bloch et al. 1989), wherein TB is described as primarily and increasingly a disease of the foreign-born and of the economically disadvantaged. The hypothesis of this paper is that the incidence of tuberculosis is higher among low income people because they are less likely to seek medical care. It is clear that there is a great deal of regional variation in tuberculosis morbidity in the United States. This study considers two districts that compare in terms of race and income level, these being South Central and Harlem. Both are low-income areas with high percentages of immigrants, where large percentages are Hispanic and black.

## **Methodology**

### *i. Design/procedure*

There is limited population-based data on tuberculosis among people on race and level of income. This study will use (hypothetical) statistics from 1989 to 1993 to describe the epidemiology of TB in South Central and Harlem, USA. The author examines the pattern of the disease occurrence in these two districts on the basis of race and income level. From this analysis, this study attempts to identify if the risk of TB is higher among low-income people because they are less likely to seek medical care. The study also investigates other factors such as co-infection with HIV, which provides information to help target sub-populations and districts where prevention and control programs should be directed.

### *ii. Measures and subjects*

To measure the incidence of tuberculosis and social stratification in these two districts, this study uses denominator data from Health, United States, National Center for Health Statistics, 1993. Data for New York has been obtained from the 1990 U.S. census. Data on those TB patients infected with HIV were obtained from a separate and confidential data base.

The subjects were people infected with TB in the low-income areas of South Central and Harlem on the basis of 1,860 cases that were reported in each area. These cases were confirmed either bacteriologically or clinically for patients aged 20 to 45 years. Age adjustment was accounted for using the direct method with 1990 U.S. population statistics as follows: aged 15-24 (80,596,000); aged 45-46 (46,710,000) (Tuberculosis control law 1993).

### *iii. data analysis and results*

1860 cases were explored in both South Central and Harlem. Both districts are low-income, medically under-served communities with large numbers of immigrants such as Hispanics, blacks or Asian-Pacific Islanders. The data was evaluated with the objective of describing the incidence of TB of various racial-ethnic groups from the low-income areas mentioned above, over a five-year period. The incidence of tuberculosis was highest among those aged 25-44 in both areas, with South Central at 40.5% and Harlem at 40%. The majority of cases in both areas were also comprised of immigrants. More than 60% of cases in South Central were among immigrants, and 95% of these were either Asian/Pacific Islanders or Hispanics. The Asian/Pacific Islanders consistently rated with the highest incidence of TB in South Central over the five year period, followed by Hispanics. Incidence of TB among Asians averaged approximately 4 times greater than the rate for New York as a whole. In Harlem, non-Hispanic blacks and Hispanics constituted the largest number of cases. In both areas, non-Hispanic whites had the lowest rates of TB throughout the five years in question. Comparisons with other non-Hispanic, non-Asian whites clearly demonstrate that ethnic minorities show an excess of TB morbidity.

People co-infected with HIV more than doubled during the five year period from 1989 to 1993. For instance, there were 25 cases reported in 1989, which rose to 54 by 1993 in these districts taken together. 200 HIV/TB cases were reported during the five year interval, of which 180 of 200 were male, and 152 of 200 were between the ages of 25-44. Of these, Hispanics comprised the largest proportion at 42.4%, followed by non-Hispanic Whites (36.7%), non-Hispanic blacks followed at 17.1%, and finally Asians at 4.0%. There is a clear overlap of the incidence of TB and HIV with the cases used in this study. In other areas, the economically disadvantaged living in medically under-served communities tend also to be undernourished, unemployed and sometimes homeless. In the two areas in question in this study, there is also an increased risk of re-infection with TB not only for those co-infected with HIV, but for others whose living conditions and access to medical care (and surveillance during treatment to ensure that the course of medication is carried out) is poor.

### **Discussion/conclusion**

Both South Central and Harlem are populated metropolitan areas with a rapid influx of immigrants who keep the population fluid and ethnically diverse. On a national level, the ethnic breakdown of the 3 million U.S. residents were classified as follows in 1993, the last year of this study: 65% were classified as non-Hispanic whites; 20% as Hispanic; 7% as Asian/Pacific Islanders; and 6% as non-Hispanic blacks (Baerji et al. 1996). Again, on a

national scale, these statistics relate to verified TB cases as follows: 42.4% of patients were Hispanic; 28.8%, Asian/Pacific Islanders; 10.1% were non-Hispanic blacks; and 18.4% were non-Hispanic whites (Baerji et al. 1996). To add more recent statistics to these figures, 98% of the 2 million annual global deaths from TB, and as much as 95% of the new active cases (numbering 8 million), are recorded in developing countries such as India, Nepal, Uganda and Cambodia, or in the former Soviet Republics (Capdevila 2000). More specific to the U.S., the Atlanta-based Center for Disease Control and Prevention reported that foreign-born people comprised 41% of the 18,361 cases of TB reported in America in 1998 (Capdevila 2000). In 1999, 43 of the reported 17,500 cases were among the foreign-born (Okie 2000). Consider that in 1992, the figure was 27% (Okie 2000). Even more alarmingly, the World Health Organization reports that there are between 10 and 15 million people in the U.S. who have latent tuberculosis (Capdevila 2000).

It is evident from these results that the incidence of TB is higher in ethnic groups, particularly among males between the ages of 25 and 44. This might be due to factors such as working conditions, nutrition, drug and alcohol abuse and HIV infection. Therefore, returning to the hypothesis, this study suggests that the incidence of tuberculosis is indeed higher among low-income people because they are less likely to seek medical care. But to say so it only to begin, not to conclude the search for answers regarding TB in people of this background. The objective of this study has been to suggest that the risk of TB itself is higher in low-income areas, which also tend to be medically under-served. In this sense, this study supports Alan Bloch et al.'s (1996) findings, these being that given the recent changes in the epidemiology of TB in the U.S., public health officials nationwide must consider expanded surveillance variables, such as co-infection with HIV. The nature of low-income communities must also be further investigated with regard to TB and cases of infection and re-infection. Ethnic minorities, who make up the bulk of TB cases are less likely to seek medical care. More work needs to be done on why this is the case. Is it because that medical care simply is not available or easily accessible? Or is it too costly, poorly monitored in terms of carrying treatment to its conclusion, or are there other cultural or language barriers that remain to be determined? Considering the high rate of ethnic/racial incidence of TB, the cultural question is something that must be further investigated. More work also needs to be done on the regional variations of the incidence of TB. Baerji et al. (1996) suggest that the proportion of cases is almost double in the San Diego area than in other Southern States such as Texas and Florida. Immigrants and refugees from Mexico, the Philippines, Vietnam and Cambodia have contributed heavily to the incidence of TB in San Diego (Baerji et al. 1996). This study suggests that the high

incidence of immigrants in South Central and the racial make-up of Harlem may have a similar pattern.

The U.S. government has made an effort to adjust immigration procedures to better screen those infected with TB. Still, many with latent tuberculosis manage to enter the country, and settling in low income areas like those in question in this study, help to make up the tens of thousands of new cases each year. If we are to optimize the clinical management of TB in the U.S. as a whole, it is critical to have a better understanding of several factors. For one, how the disease is expanding globally. How is it passing into the U.S., and in what local regions it tends to flourish and why? As the hypothesis of this paper suggests, the areas in which immigrants who are most likely to bring TB infection into the country tend to settle in districts where the disease is difficult not only to diagnose, but also to cure and to prevent in the future.

The complexity of the problem is magnified in areas like that of South Central and Harlem because they are medically under-served. Disease control and surveillance is far more difficult to observe and act on when there are numerous cases of undocumented people, thus making numbers unquantifiable. To conclude, while race and income level are almost certainly contributors to the incidence of TB in these – and other – areas in the U.S., the likeliness of seeking medical care is only one of the problems that need to be targeted. More culturally sensitive strategies are needed to more aggressively manage, survey and prevent TB in low-income areas in which immigrants tend to settle.

## Bibliography

- Andersson, N. (1990). 'Tuberculosis and social stratification in South Africa,' *International Journal of Health Services* (Vol. 20, No. 1), pp. 141-165.
- Baerji, Subroto, Amy Bellomy, Elena Yu, Stephen Waterman, Elizabeth Haas, Kathleen Moser. (1996). 'Tuberculosis in San Diego County: a border community perspective,' *Public Health Reports*.
- Bloch, Alan, Ida Onorato, Walter Ilhe, James Hadler, H., Christopher, Dixie Snider Jr. (1996). 'The need for epidemic intelligence,' *Public Health Reports* (tuberculosis).
- Bloch, A., H.L. Reider, G.D. Kelly, G.M. Cauthen, C.H. Hayden, D.E. Snider (1989). 'The Epidemiology of Tuberculosis in the United States,' *Sem Respir Infect* (Vol. 4), pp. 157-170.
- Capdevila, Ines (03.22.2000). 'Morella, Brown sponsor bill to curb tuberculosis abroad,' *The Washington Times*.
- Lifson, A.R., L.L. Halcon, A.M. Johnston, C.R. Hayman, C.A. Miller and S.E. Valway (1999). 'Tuberculin skin testing among economically disadvantaged youth in a federally-funded job training program,' *American Journal of Epidemiology* (Vol. 149, No. 11, April 1), pp. 671-679.
- National Center for Health Statistics. (1993). Health, United States, Washington D.C.: Government Printing Office, 1994. DHHS Pub. No. (PHS) 94-1232. (Cited in Subroto Baerji et al. 1996).
- Okie, Susan. (05.05.2000). 'TB tests of Immigrants Urged; Panel Offers Blueprint to Eliminate the Disease in U.S.,' *The Washington Post*.
- Tuberculosis control law – United States. (1993). Recommendations of the Advisory Council for the Elimination of Tuberculosis (ACET). *MMWR, Morbid Mortal Wkly Rep.* 1993: 42 (RR-15): 1-28. (Cited in Subroto Baerji et al. 1996).