Does Nativity Matter? Correlates of Health by Immigrant Generation in the Russian Federation

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Research findings highlight the importance of nativity in studies of population health, relying heavily upon experiences within the North American migration system and, to a lesser extent, Western Europe. While studies examining the effects of migration on health abound, to date very few focus on the link between migration and health in Eurasia generally, and even fewer on Russia specifically. The Russian Federation is second only to the United States in terms of the number of current residents born outside its borders. In the years following the collapse of the Soviet Union in 1991, Russia has emerged as a major destination for international migrants, experienced a dramatic decline in population health and seen rising reports of anti-immigrant violence and xenophobic sentiments. Existing scholarly work emphasizes the positive health selectivity of international migrants and a growing body of literature documents the disappearance, and in some cases a reversal, of the "healthy migrant effect" among the second generation foreign born. Generally, immigrants bring positive health habits to destination cultures, but lose the health-protective effect of these behaviors over time and across generations, with increased exposure to "toxic" destination cultures, which subject immigrants to social isolation and encourage higher rates of negative health behaviors. To what extent do present theories of migrant selectivity and second generation negative health assimilation apply to the Russian Federation?

In order to better understand the global influence of nativity on health, this paper examines two questions. First, do the foreign born in the Russian Federation experience

better overall health than the native born? Second, to the extent that the foreign born do display a health advantage, is the healthy migrant effect transferred to the second generation? Russia provides a valuable test case for the assessment of current theories linking migration and health. Recent reports stress the link between declining health, particularly among working aged men, and the widespread practice of negative health behaviors in Russia, especially drinking (Jurgen and Roon 2009). With poor health behaviors common, immigrants to Russia should be particularly likely to exhibit better health indicators than the native born population. This may be even more true for immigrants who are culturally and linguistically distant from ethnic Russians (non-Slavs). Any migrant health advantage may be lost among the second generation, who face anti-immigrant sentiment and rising ethnic hostilities, which may spur their assimilation into native negative health behaviors.

In addition to providing an important test case for theories of migrant health selectivity, investigations into issues of nativity and health can contribute to current policy debates over immigration in the Russian Federation. Like other destination states, the Russian Federation continues to struggle with balancing the need for immigrant labor with its persistent fear of immigrants. Media, policy makers and the press in Russia cast immigrants as criminals, and more recently, as carriers of a variety of infectious diseases (Zurabov 2007). Integrating the Russian experience into studies of nativity and health provides unique opportunities for both theory testing and for the injection of data-driven evidence into contentious policy debates.

The Healthy Migrant Effect

Research in the United States demonstrates a substantial initial health advantage for immigrants in comparison to the native born, which tends to diminish with longer residence in the U.S. This phenomenon is referred to as the "healthy migrant effect" (Antecol and Bedard 2006). Immigrants to the U.S. enjoy lower risks of mortality and better self-rated health than do their native-born counterparts (Cho, Frisbie, Hummer, and Rogers 2004; Markides and Coreil 1986; Uretsky and Mathiesen 2007). One explanation for the healthy migrant effect suggests that immigrants are culturally disposed to healthier behaviors than are native-born Americans. Immigrants are less likely to smoke or drink, and tend to weigh less than natives in the United States (Abraido-Lanza, Chao, and Florez 2005; Cho, Frisbie, Hummer, and Rogers 2004; Lopez-Gonzalez, Aravena, and Hummer 2005; Yang and Martinez 2006). Other studies point to the strong social support systems among immigrants to explain their health advantage (Marmot and Syme 1976; Vega and Amaro 1994). A third explanation focuses on selective migration. People who are willing and able to migrate are likely to be healthier than the average for their origin populations, possessing health advantages that continue after migration (Jasso, Massey, Rozenweig, and Smith 2004; Landale, Oporesa, and Gorman 2000).

To what extent does the research on the healthy migrant effect in the United States apply to other migrant-receiving countries? Sole-Aur and Crimmins (2008) find that immigrants over age 50 in 11 European countries are significantly less healthy than their native-born counterparts. Other studies focusing on Europe find that immigrant children to have poorer dietary practices and be at greater risk of obesity than native-born children (Kirchengast and Schober 2006; Skreblin and Sujoldzic 2003). In Israel, migrants from

the former Soviet Union display substantially higher risks of psychological distress, chronic health problems, and alcohol abuse than do the native born (Gross, Brammli-Greenberg, and Remennick 2001; Rahav, Hasin, and Paykin 1999).

While findings are somewhat contradictory, whether or not a healthy migrant effect is observed depends on both the selectivity of the migrants and average health levels in the receiving society. In the U.S., with extensive legal barriers to migration and a relatively unhealthy native population (in comparison with Europe), the healthy migrant effect is strong (Jasso, Massey, Rozenweig, and Smith 2004). In the U.S., the healthy migrant effect is strongest immediately after migration and then diminishes. The more immigrants are exposed to U.S. culture, the more likely they are to adopt typical American dietary and health habits, losing their behavioral advantage in health compared to the native born (Akresh 2007; Allen, Elliott, Morales, Diamant, Hambarsoomian, and Schuster 2007; Cho, Frisbie, Hummer, and Rogers 2004; Finch, Do, Frank, and Seeman 2009).

Given the deterioration in the healthy migrant effect with increased duration of residence, is there any health advantage observed among second generation immigrants? In the U.S., the social and economic experiences of children of immigrants differ, depending on their racial/ethnic background and the human capital of their parents. These variations in integration influence health. Health behaviors among Latinos tends to grow worse across generations (Allen et al. 2007; Eitle, Gonzalez, and Aranda 2009; Finch, Do, Frank, and Seeman 2009), while studies of Asian-Americans have found that Asian immigrants retain their health advantage or even improve across generations (Allen et al. 2007; Mutchler, Burr, and Prakash 2007).

Migration and Health in Russia

Immigrants to Russian Federation might be healthier, and have better health practices, than the native-born population. Russia has experienced marked declines in health over the past two decades, rapid population aging, and now has some of the worst health indicators, and lowest life expectancies, in the developed word. The most common explanation for poor health and high mortality in Russia are unhealthy lifestyles, at least partly driven by Russian culture (Cockerham 1997; Cockerham 2000). Russians, particularly men, tend to have an unhealthy diet and to smoke and drink heavily (Cockerham 1997; Jurgen and Roon 2009). While post-Soviet declines in life-expectancy occurred across the former USSR, Russia experienced the most serious declines, followed by the culturally similar countries of Ukraine and Belarus (Cockerham, Hinote, Cockerham, and Abbott 2006). In Russia, immigrants coming from more distant cultural contexts should be more likely to display better health behaviors and better overall health than the native born in Russia.

There are two possible reasons to expect that Russia will not exhibit a healthy migrant effect. First of all, a substantial proportion of immigrants to Russia are ethnic Russians, or Slavs (Ukrainians or Belarusians). Since the 1960s, ethnic Russians and other Slavic peoples have been leaving the non-Russian Soviet republics and migrating into Russia. This Russian and Slavic in-migration peaks in the early 1990s, after the collapse of the Soviet Union (Heleniak 2008). These migrants may exhibit behavioral lifestyles similar to the native population of the Russian Federation. Additionally, the health selectivity found among economic migrants may be dampened in this migration stream due to the political motivations driving many migration decisions and the large number moving as

back to Russia as migrants. For the first decade of the post-Soviet period, migration to Russia from the former Soviet Union was fairly open. All citizens of the Commonwealth of Independent States (CIS) could enter Russia without visas, and the 1991 law on Russian citizenship allowed any citizen of the former USSR to claim Russian citizenship and the associated social benefits. Migrants are expected to be most positively selected where migration is most difficult (Lee 1966), so migrants to Russia may not be positively selected on health. They may even be negatively selected, if elderly or disabled people in search of pensions and medical care had a greater propensity to migrate.

Secondly, the post-colonial nature of the Eurasian migration system provides another reason to believe that migrants to Russia may not be as highly selective as migrants to the U.S. or other destinations. The shared cultural space of the Soviet Union may have lessened the differences in social norms and health-related behaviors across the countries of the former Soviet Union. Previous studies of Soviet culture have highlighted the strong influence of Russian linguistic, religious and social norms, highlighting the privileged status of Russian and other Slavic ethnic groups within the Soviet Union (Anderson and Silver 1990). Educational uniformity during the Soviet era tended to homogenize economic activity into Soviet norms, at least in industry (Bollinger 1994). Kandiyoti (2002) argues that the extent to which regions such as Central Asia were deeply incorporated into a colonial culture remains under question, but warns of ignoring the long-term effects of the Soviet era on social norms, beliefs and behaviors. The shared Soviet past may mitigate the social distance between immigrants from the former Soviet Union and the native born in Russia, diminishing the likelihood of any health migrant effect.

If migrants to Russia do experience any health advantage, evidence from elsewhere suggests that the advantage is likely to diminish over time and unlikely to extend to the second generation. Immigrants into Russia experience exposure to high levels of alcohol consumption, poor diet, high rates of smoking and other unhealthy aspects of Russian society. To the extent migrants assimilate, they are likely to experience declines in health. The dangers of duration of residence may be magnified by the discrimination that many migrants face in the Russian Federation. Understanding the health status of the second generation is complicated by the fact that the adult children of foreign-born parents are all children of Soviet-era migrants, so their parents came to Russia in a very different social, economic, and political context, when migration was largely state-directed. Nevertheless, the importance of negative assimilation indicates that the second generation should experience worse health in Russia than the first generation.

Coloring discussions of migration and health in the Russian Federation, public discourse increasingly tends to portray migrants as less healthy than the native population. In a context of rising xenophobia and the growth of ultra-nationalist movements, particularly in Southern border regions and major cities, migrants are increasingly viewed as a health threat (Reuters 2009). Policymakers focus on a perceived lack of immunizations and high rates of infectious disease among migrants. A 2002 Federal Law (Number 115) required all foreigners seeking to remain in Russia for greater than three months be tested for HIV, STIs, and tuberculosis. The intense public debates over whether migrants benefit or harm the nation makes an understanding of the health status of migrants in Russia even more important.

Data and Methods

In order to assess the health selectivity of first and second generation migrants in the Russian Federation we rely upon the 2004 Russian Gender and Generations Survey (RGGS). The survey was conducted in the summer of 2004, financially supported by the Pension Fund of the Russian Federation and the Max-Planck Institute for Demographic Research, Rostock, Germany. The sample consists of 11,261 individuals between 18 and 79 years of age from 32 regions of Russia[1]. The questionnaire included 14 sections, reflecting core modules from the cross national Gender and Generations Program, and enhanced questions concerning pensions and family attitudes unique to the Russian study. Respondents were asked to report on all members of their households to augment cross generational coverage. Particularly important to this investigation, the survey gathered information on nativity, duration of residence, ethnic identity and language for respondents and their parents in addition to the standard questions regarding health status, socio-economic standing, social support and demographic characteristics of respondents.

Three questions concerning various aspects of health status are used as dependent variables. First, self-assessed health, as measured by a question on general overall health, measured on a scale of 1 (very good) to 5 (very bad). We compare those responding that their health is very good or good, to all others. Self-assessed health is strongly influenced by cultural norms and social expectations, and therefore we include two additional measures linked to more specific health issues. Respondents answering in the affirmative

[1] The 2004 GGS was designed, in part, to overlap with the Russian Longitudinal Monitoring Survey, a repeated panel study originally based upon the 1989 Soviet census for the Russian Federation. The weights calculated for the GGS are strongly reliant upon the 1989 census, with some updating for the results of the 1994 Russian Micro-Census. Given the high mobility of the population since 1994, and our desire to concentrate upon comparisons between groups of respondents (the native born, foreign born, and first generation), we elect to use non-weighted data.

to questions regarding the presence of a long standing illness or chronic condition, or any physical limitation, are compared to those selecting any other response (including "don't know").

The main explanatory variables are immigrant origin and generation. Respondents were split between first generation (those who reported that they were not born in Russia), second generation (those who were born in Russia, but had at least one parent who was born outside of Russia), and third or higher generation (those who were born in Russia and who reported both of their parents as born in Russia). For the purposes of descriptive analyses, we further split the second generation into those with two foreign-born parents, those with a foreign-born father, and those with a foreign-born mother. Due to cell size concerns we are unable to pursue detailed investigation of parental nativity and gender and instead use the basic category of at least one foreign-born parent in the multivariate analyses.

As we expected to see substantial variation across different regions of origin, we created three dummy variables to correspond with the major source countries for Russian immigration: the Slavic/Western region of the CIS (Ukraine, Belarus and Moldova); the non-Slavic countries of the CIS (Armenia, Azerbaijan, Georgia, Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan, and Uzbekistan) and all countries outside of the CIS. For first-generation immigrants, these variables correspond to the country of their birth. For second-generation migrants, these variables correspond to the country of birth of the foreign-born parent(s)[2]. These categories are intended to reflect variations in the cultural and political distance between the sending country and Russia (Slavic) and the

[2] In the 21 cases where an individual had two foreign-born parents from different regions, we considered only the country of birth of the mother.

importance of shared Soviet legacy (non-Slavic CIS), in comparison to migrants from other countries (non-CIS). By combining these variables, we created six origin-generation categories for the immigrant population.

In our first analyses, we looked at bivariate relationships between immigrant generation, origin-generation groups, and health. We then conduct logistic regression analyses to assess the effect of several control variables. To capture ethnic and linguistic differences, we created a dummy variable for whether the respondent's native language is Russian and whether the respondent lists their ethnicity as Russian. Income and social support are usually thought to influence the healthy migrant effect in other countries. Due to reporting issues linked to household incomes in the study, we rely upon a universal measure of the difficulty in "making ends meet" in the household as a measure of economic stability. Combining three indicators of social support (plenty of people to rely upon, people I can lean on completely, and enough people I feel close to), we identify those reporting very low to no social support. We also controlled for age and sex. We conducted separate logistic regression analyses for each of the three dependent variables. The models compare the odds of reporting good health, a chronic health condition, or a physical limitation among the six origin-generation groups with the odds experienced among the native population, net of the control variables.

Results

Tables 1 and 2 provide descriptive statistics for first and second generation immigrants in the Russian Gender and Generations Survey. In Table 1, of the total sample size of 11,261 respondents, first generation immigrants (the foreign born) comprise almost 10 percent. Second generation foreign born comprise 9 percent of the sample. Further

dividing the second generation into two categories we find relatively few with both parents foreign born (1.2% of the sample), compared to the 7.3% of the sample with one parent foreign-born. More than 80 percent of all respondents belong to the third or higher generation of immigrants, which for the purposes of this paper we classify as native born. Table 2, presenting immigrants by origin, highlights the large high proportion of immigrants from Slavic/western and non-Slavic CIS countries of origin (41 percent and 47 percent respectively) in the first generation. Second generation respondents are more likely to originate in the Slavic/Western region of the CIS (68 percent) than in other CIS countries (22 percent). Migrants from outside of the CIS comprise about 10 percent of both generations.

Table 1. Immigrant status by generation, RGGS 2004

Immigrant status	Freq.	Percent
1st generation	1,115	9.9
2nd generation (both parents foreign-born)	136	1.21
2nd generation (one parent foreign-born)	820	7.28
father foreign-born	*473*	*4.2*
mother foreign-born	*347*	*3.08*
3rd or higher generation (natives)	9,119	80.98
missing	71	0.63
Total	11,261	

Table 2. Immigrants by origin and generation, RGGS 2004

Region of Origin	First generation	Second Generation	All immigrants
Slavic/Western	462 (41.23%)	649 (67.89%)	1111 (53.65%)
Non-Slavic CIS states	521 (46.73%)	209 (21.86%)	730 (35.25%)
Outside the CIS	132 (11.84%)	98 (10.25%)	230 (11.11%)
Total	1115	956	2071

Table 3 describes the demographic, socioeconomic, and ethnic characteristics of the GGS sample, by immigrant origin and generation. With the exception of first generation

migrants from the Slavic/Western region of the CIS (who have a mean age of 51.54 years), all migrant groups are younger than the average for the native population (46.65 years) although the age difference is not statistically significant for second generation migrants from outside the CIS. Surprisingly, there are no significant differences between groups in terms of perceived poverty or social support, with both native and foreign born reporting similar subjective satisfaction.

Table 3. Descriptive statistics, RGGS 2004

Origin/generation group	Percent male	Mean age	Percent reporting very difficult to make ends meet	Percent with few sources of social support	Percent non-Russian Ethnicity*	Percent non-native speakers of Russian Language*	Total
Natives	37.35	46.65	26.26	15.15	11.32	8.19	9114
First generation immigrants	39.01	46.26	26.55	16.32	37.05	18.67	
Slavic/Western CIS origin	*36.36*	*51.54^*	*27.49*	*18.18*	*47.82*	*19.91*	*462*
Non-Slavic CIS origin	*41.46*	*42.88^*	*26.68*	*14.78*	*27.52*	*15*	*520*
Non-CIS origin	*38.64*	*41.14^*	*22.73*	*15.91*	*36.15*	*28.79*	*132*
Second generation immigrants	37.76	42.54^	25.42	16.11	10.01	2.41	
Slavic/Western CIS origin	*38.52*	*44.49^*	*26.16*	*16.49*	*9.41*	*1.08*	*649*
Non-Slavic CIS origin	*34.93*	*35.41^*	*22.97*	*14.35*	*8.04*	*3.35*	*209*
Non-CIS origin	*38.78*	*44.79*	*25.51*	*17.35*	*18.28*	*8.74*	*98*

N=11,184
^ Mean significantly different from mean for native population, p< .05
* Chi-square significant at p< .05

There are, however, significant ethnic and linguistic differences by migration status. First generation immigrant groups include the highest proportion of non-Russian ethnicity, at 37 percent, with non-Russians being most common in first generation immigrants from the Slavic CIS states (47.82%). The percentage of second-generation respondents reporting a non-Russian ethnicity is small only 10 percent, similar to the

percentage of non-Russians in the native population. There are even fewer non-native speakers of the Russian language than there are non-ethnic Russians in the RGGS, but the pattern across migrant generations is similar, with the highest numbers of other language speakers in the first generation groups, and the lowest in the second generation groups. The strong identification with Russian language and ethnicity in the second generation likely reflects the propensity of children of mixed marriages to adopt a Russian identity.

The next two tables explore the relationship between nativity and health in the RGGS. Table 4 shows the bivariate relationships between immigrant generation and our three measures of health status. There is little difference between first-generation immigrants and the native population in terms of any measure of health status, but interesting differences arise in the second generation. First, native-born individuals with two foreign-born parents are substantially more likely than any other group to report having a physical limitation (nearly 17 percent of this group reports a limitation, compared to just over 7 percent in the first generation and 8.5 percent in the native group). People with two foreign-born parents also experience slightly higher rates of chronic conditions than first generation migrants, indicating a possible decline in health across generations. Second, just over one third of native-born individuals with a foreign-born mother report a chronic health condition—the lowest level of any group. This indicates the potential importance of the gender of the foreign born parent in assessing how immigrant health advantages or disadvantages are passed into the second generation.

When we split the immigrant population by national origin, additional generational differences appear, particularly in terms of self-assessed health and chronic conditions. As Table 5 shows, first generation immigrants from Slavic/Western CIS states are less

likely than the native population to report good or very good health, and more likely to report a chronic health condition. This disadvantage decreases in the second generation. The results among migrants from the non-Slavic states of the CIS are particularly interesting. First generation migrants have a small advantage in self-assessed health and chronic conditions over the native population. Contrary to the common pattern of decline in migrant health across generations found in the United States, health advantages are even greater among second-generation migrants from non-Slavic CIS states. Among immigrants from outside of the CIS, findings are consistent with a healthy migrant effect. First generation migrants have better self-assessed health than natives, and lower rates of chronic conditions, but the second generation from outside of the CIS has self-assessed health similar to the native born, and higher rates of chronic conditions and physical limitations.

Table 4. Health Status by Immigrant Generation, Russian GGS 2004

Immigrant status	Percent reporting good or very good health	Percent reporting a chronic condition*	Percent reporting physical limitation*	N
1st generation	30.4	40.84	7.28	1113
2nd generation (both parents foreign-born)	29.41	44.85	16.91	136
2nd generation (father foreign-born)	30.44	42.92	6.57	472
2nd generation (mother foreign-born)	34.58	33.72	5.78	346
3rd or higher generation	29.14	41.89	8.51	9110
Total	29.50	41.61	8.32	11,177

* Chi-square significant at p< .05

Table 5. Health Outcomes by Origin-Generation Group, Russian GGS 2004

Origin/generation group	Percent reporting good or very good health*	Percent reporting a chronic condition*	Percent reporting physical limitation	N
Native population	29.14	41.98	8.51	9100
1st generation Slavic origin	23.18	47.62	9.31	462
2nd generation Slavic origin	28.81	40.83	7.57	647
1st generation non-Slavic CIS origin	33.01	37.12	5.97	519
2nd generation non-Slavic CIS origin	43.06	33.01	6.22	209
1st generation non-CIS	43.18	31.82	5.3	132
2nd generation non-CIS	27.55	47.96	12.24	98
Total	29.50	41.61	8.32	11,167

*Chi-square significant at p<.05

The findings in Table 5 support the existence of a healthy migrant effect in Russia. But, is the observed effect due to compositional differences between the foreign born and native born, or perhaps issues related to migrant status? We conduct multivariate logistic regression analyses for each of the three dependent variables, comparing each of the six origin-destination groups to the native-born sample while controlling for socio-demographic, economic and social factors. The results, presented in Table 6, demonstrate that socio-demographic characteristics are strong predictors of health status. Age is associated with lower odds of reporting good or very good health and higher odds of chronic conditions and physical limitations. Men are more than twice as likely as women to assess their health positively and almost half as likely to report a chronic condition, but they are 17 percent more likely to report a disability. Additionally, poverty and social support are significantly associated with health, with people who report difficulty making ends meet or little social support having lower odds of good or very good health and

higher odds of chronic condition or disability. Russian ethnicity is not significantly associated with any health measure, but Russian language is. Non-native Russian speakers are more than twice as likely to report good or very good health, and 40 percent less likely to report a chronic health condition.

Table 6. Logistic Regression Models Assessing the Link between Migration, Socio-demographic Characteristics, Resources and Health, Russian GGS 2004

	Model 1: Self-Assessed Health		Model 2: Chronic Conditions		Model 3: Physical Limitations	
	Odds Ratio	SE	Odds Ratio	SE	Odds Ratio	SE
1st generation Slavic migrants	1.01	0.13	1.02	0.11	0.87	0.16
2nd generation Slavic migrants	0.91	0.1	1.04	0.1	1.02	0.17
1st generation non-Slavic CIS migrants	0.93	0.11	1	0.1	0.95	0.19
2nd generation non-Slavic CIS migrants	1.04	0.17	1.14	0.19	1.6	0.49
1st generation non-CIS migrants	1.33	0.29	0.87	0.18	0.95	0.38
2nd generation non-CIS migrants	0.74	0.2	1.47	0.35	1.82*	0.61
Age	.92***	0	1.05***	0	1.06***	0
Male	2.11***	0.11	.58***	0.03	1.17**	0.09
Very difficult to make ends meet	.65**	0.04	1.12***	0.06	1.58***	0.12
Few sources of social support	.74***	0.06	1.19***	0.07	1.57***	0.13
Non-Russian ethnicity	1.02	0.12	1.09	0.11	1.01	0.18
Non-Russian mother tongue	2.21***	0.29	.60***	0.07	0.79	0.16
Pseudo-R2	0.25		0.14		0.14	
N	10,692		10,689		10,671	

*p< .10 ** p<.05 ***p< .01

After controlling for sociodemographic factors, the only effect of migrant group that remains significant is an 82 percent greater chance of reporting a disability among second generation migrants from outside the CIS. In the final version of this paper we will use stepwise regressions to demonstrate the effects of different control variables on the association between nativity and health. These results show that age, sex, economic resources, social support and language are all more important to understanding health outcomes in Russia than is nativity.

In the Russian context, the fact that we find no relationship between migration and health in multivariate analyses is notable. Our findings challenge the universality of existing studies on the health migrant effect, and highlight the importance of migrant regional origin in assessments of the healthy migrant effect. In the final version of the paper we will consider why, in a country that by all indicators should experience a healthy migrant effect, one is not found. Our lack of findings concerning nativity and health also provide a valuable contribution to present policy debates in Russia, as it challenges prevalent beliefs that migrants, particularly those from the Caucasus and Central Asia, are less healthy than the native population.

While our analyses are limited by the sample characteristics and structure of the 2004 Russian Gender and Generation Survey, our findings also point to several promising future avenues for cross cultural research in the study of health and nativity, such as the gender of the foreign born parent among the second generation and the importance of using subjective or objective measures of economic status and income. We intend to conclude our final version with a call for additional comparative research on the

processes of immigration and the status of second generation immigrants, in order to contribute to a more global appreciation of the relationship between nativity and health.

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