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‘HEALTH PARADOX’ AND FORMER SOVIET UNION IMMIGRANTS: TOWARDS AN INTEGRATED THEORETICAL FRAMEWORK

This study examines the critical mechanisms explaining the health outcomes of such understudied social group as immigrants from the former Soviet Union (FSU), including Ukraine, Russia, and Belarus, among other countries. Literature on the ‘health paradox’ suggests that immigrants from various countries enjoy better health than their native-born counterparts. Importantly, however, this trend does not seem to exist among FSU immigrants, especially those residing in the United States. In addition, while research studies find that socioeconomic status (SES) is the fundamental cause of health and illness among native-born individuals, higher SES does not appear to be the health-protective factor among the FSU group, likely due to their unique experiences and beliefs. Consequently, a new model is necessary to provide a more nuanced explanation of health outcomes of immigrants from FSU countries. Drawing on medical sociology and epidemiology literature, first, this paper outlines unique factors that explain health of FSU immigrants and argues that particular attention should be paid to acculturation, its sources, and the mechanisms through which it affects health. Specifically, differential levels of acculturation shape the degree to which FSU immigrants engage in risky behaviours, hold unique beliefs, access health care, and cope with stressors, which, in turn, influences their physical and mental health. Second, hypotheses are proposed based on the new model to be tested by future studies and third, unique interactive effects on health outcomes are discussed including such factors as SES, gender, country of origin, and other social structural factors. Overall, this paper contributes theoretically to medical sociology, epidemiology, social psychology, and global studies by outlining the novel model conceptualizing immigration and health relationships among one of the fastest-growing immigrant groups in contemporary society.

Keywords*: health, medical sociology, health paradox, former Soviet Union immigrants.*

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“ПАРАДОКС ЗДОРОВ’Я” ТА ІММІГРАНТИ З КОЛИШНЬОГО СРСР: ІНТЕГРОВАНА ТЕОРЕТИЧНА МОДЕЛЬ

Метою цього дослідження є вивчення важливих механізмів, що пояснюють наслідки для здоров'я такої недостатньо вивченої соціальної групи, як іммігранти з колишнього СРСР, зокрема, України, Росії, Білорусі тощо. Дослідження про “парадокс здоров'я” свідчать про те, що іммігранти з різних країн у цілому мають краще здоров'я, ніж корінні жителі країн. Проте ця тенденція в більшості відсутня серед іммігрантів з країн колишнього СРСР, особливо тих, які проживають у США. Хоча соціально-економічний статус (СЕС) є одним з головних факторів, що впливають на здоров’я та захворювання серед корінних жителів, високий СЕС у

цілому не виявляється як фактор, що позитивно впливає на здоров'я серед іммігрантів з колишнього СРСР, скоріше, завдяки їх унікальному досвіду та переконанням. Отже, нова модель необхідна для кращого розуміння та аналізу здоров'я іммігрантів з країн колишнього СРСР. Посилаючись на літературу з медичної соціології та епідеміології, виявлено унікальні фактори, що впливають на здоров'я іммігрантів з країн колишнього СРСР. Особливу увагу слід приділити акультурації, її джерелам і механізмам, за допомогою яких вона впливає на здоров'я. Зокрема, різні рівні акультурації впливають на ризиковану поведінку, унікальні переконання, використання медичної допомоги та вміння виходити зі стресових ситуацій серед іммігрантів колишнього СРСР, що впливає на їх фізичне та психічне здоров'я. Запропоновано гіпотези, засновані на новій моделі, які можуть бути використані у подальших дослідженнях. Зазначено унікальні інтерактивні ефекти, що впливають на концепт здоров'я, зокрема, СЕС, гендер, країна походження та інші соціально-структурні фактори. Стаття робить теоретичний внесок у галузь медичної соціології, епідеміології, соціальної психології та наук про глобальні проблеми, пропонуючи нову модель, що концептуалізує взаємозв'язок імміграції та здоров'я серед однієї з швидкозростаючих груп іммігрантів у сучасному суспільстві.

Ключові слова: *здоров'я, медична соціологія, парадокс здоров'я, іммігранти з колишнього СРСР.*

The former Soviet Union (FSU) immigrant group, including Ukraine, Russia, and Belarus,[1] has been one of the fastest-growing immigrant groups in the U.S. and other countries. For example, between 1991 and 2005, more than 1.3 million individuals from FSU immigrated to the United States [1]. High levels of immigration from all over Eastern Europe have continued in recent years. In 2016, immigrants from different Eastern European countries accounted for the most significant portion of European immigrants in the U.S. [2]. However, research has been scarce on essential life outcomes of FSU immigrants because they were mainly classified as white and merged with the U.S. white population in immigration studies.

It is crucial to address the health outcomes of this group. The so-called 'health paradox' indicates patterns of morbidity or mortality of a specific group at odds with what we would expect, considering this group's socioeconomic status [3, p. 108]. Empirical evidence illustrates that foreign-born people generally show better health and lower mortality than the U.S. born whites [3; 4, 5], with this health advantage becoming reduced over time as immigrants assimilate [4; 6; 7]. Better health outcomes of immigrants are likely a result of less risky behaviours and more protective resources such as cultural capital and social support [3, p. 114; 8; 9].

Interestingly, however, the FSU immigrant group is characterized by unique experiences, health behaviours, and social status. For example, many Eastern Europeans are known to have high educational attainment [10]. However, in many cases, they experience high socioeconomic strain, lead unhealthy lives, distrust medicine, and hold unique ideologies affecting their health [10–14]. As such, it is unclear whether the 'health paradox' holds among FSU immigrants.

[1] FSU countries: Russia, Ukraine, Georgia, Belarus, Uzbekistan, Armenia, Azerbaijan, Kazakhstan, Kyrgyzstan, Moldova, Turkmenistan, Tajikistan, Latvia, Lithuania, and Estonia.

There is overall limited literature on the health differences of FSU immigrants and U.S. born whites, and research findings are generally mixed. For example, studies illustrate concerning risks for hypertension [15; 16], diabetes [17], and obesity [18] among immigrants from former FSU countries who moved to North America. Levels of cardiac risk-factors and disability among FSU immigrants are also higher when comparing this group to their U.S. counterparts [15; 19; 20]. On the other hand, one study finds FSU immigrants to be more disadvantaged based on self-rated health; yet display slightly better health than U.S. born whites in terms of functional limitation [21]. Also, immigrant women from Russia and Ukraine have a lower risk of preterm birth, but not of delivering a term small for gestational age than women from the U.S. [22]. Taken together, prior research shows mixed results regarding the 'health paradox' and FSU immigrants. As such, this paper aims to provide a new comprehensive theoretical framework outlining predictors of health of FSU immigrants, which, in turn, will provide the foundation for future empirical studies.

SES as the Fundamental Cause of Health and Illness. Socioeconomic status (SES) is one of the fundamental structural factors found to affect health. Link and Phelan [23] argue that SES involves a range of resources such as money, knowledge, prestige, power, and beneficial networks that protect the health of a high SES group no matter which other mechanisms are relevant at any time. Research shows that SES is a fundamental predictor of health for the U.S. population as it is related to multiple health outcomes over time and through the replacement of intervening mechanisms [24].

However, it is unclear if these factors can explain the health of FSU immigrants. In general, Eastern European immigrants in the U.S. have relatively low incomes [25]. However, a national health study has revealed that differential poverty levels between FSU and U.S. born individuals do not explain differences in health-related outcomes [20]. Research suggests that FSU immigrants tend to be highly educated [20; 25] and, by some accounts, are about twice as likely to hold a college degree than the U.S. born whites [20, p. 440]. However, as FSU immigrants often show poor health despite their high education [20]. Education also does not seem to be a factor that contributes to health differences among FSU and U.S. groups. It is possible that the education of FSU immigrants does not translate into a higher income and occupational status in the U.S. due to various barriers, including discounting of credentials, labour market issues, and lack of social networks [20; 25].

Given that the "SES as the fundamental cause of health" parsimonious argument does not appear to apply to FSU immigrants, there is the need for a more nuanced understanding of what drives the health status of this group. The following sections discuss the factors and links that contribute to FSU immigrants' health, focusing on acculturation as the main mechanism (Figure 1). Then, I discuss the proposed hypotheses based on the figure and the potential interactive (i.e., moderating) effects of SES and other important social structural factors in the immigration-health relationship.

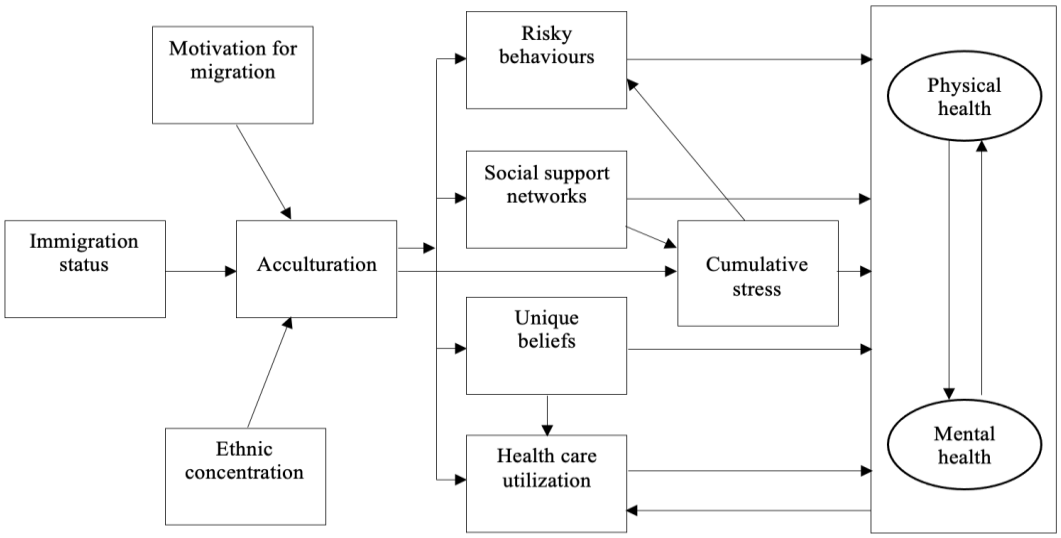

Figure 1. An Integrated Model of the Predictors and Mechanisms of Health among FSU immigrants

FSU Immigrants' Health Model. ***Motivations for migration*****.** Figure 1 shows that the first important source/predictor of acculturation is the motivation for migration because acculturation may be different based on individuals' 'positive' and 'negative' motivations to immigrate. This thought is aligned with the 'push and pull' framework, which suggests that there may be unfavourable conditions for people as they get 'pushed' from their place of origin (e.g., economic instability), and favourable conditions for people as they get 'pulled' to their destination (e.g., economic prosperity) [26]. More positive motivations for migration (e.g., favourable pull factors) are likely to contribute to more successful acculturation than more negative ones. Importantly, to conceptualize and measure this concept, respondents must be asked about a wide range of their motivations to immigrate, including the economic situation, conflict in the home country, violence, religious prosecution, and environmental contamination, among other motivations [26].

Immigration status**.** The second possible source of acculturation is immigration status. The 'positive selectivity' argument states that immigrants are in a way selected on their favourable health [27, p. 228–235], with FSU immigrants experiencing high selectivity by the U.S. when applying for immigration status [21, p. 316]. However, some FSU immigrants may not be positively selected on health (e.g., when they are unauthorized and do not undergo mandatory health checks). This suggests that the link between immigration status and health is likely complex, and thus, to provide a better understanding of FSU immigrants' health, it is crucial to study how immigration status (legal vs illegal) shapes such essential process as acculturation. Specifically, immigration status can influence the degree of integration into society and receptiveness of the destination country [28]. For example, holding an illegal status may preclude proper acculturation due to the lack of connection of

unauthorized immigrants to important social institutions (e.g,. employment, health care etc.) as sources of social and cultural exchange.

Ethnic concentration. The third source of acculturation to consider is ethnic concentration. Living in a community with high levels of ethnic concentration (a percentage of a particular ethnicity/group in the area) helps immigrants properly acculturate as they can benefit from local opportunities and resources [29, p. 1648]. Although there is a gap in the literature addressing the settlement of FSU immigrants in the U.S., one study found that FSU immigrants who live in ethnic clusters of public housing showed better acculturation and more social networks with both people from their country of origin and the U.S. as well as experienced more social support and lower cultural alienation [30]. Thus, ethnic concentration must be considered a factor contributing to increased acculturation within U.S. society among FSU immigrants.

Acculturation. Acculturation should be understood as a fundamental factor that links multiple processes related to the health of FSU immigrants and differentiates them from their U.S. born counterparts. It is a multidimensional concept that reflects different aspects of change and adaptation to new cultural characteristics and domains because of interactions with another population [3, p. 112]. Prior research notes that language proficiency, age at migration, and length of time in the destination could be proxies/measures of acculturation [3, p. 115; 31, p. 94]. Given the multidimensionality of this concept [3, pp. 112–113], I argue that the acculturation measure should reflect these factors along with other dimensions such as understanding and levels of adoption of American (i.e., U.S.) identity and behaviours (e.g., socializing with American friends, going to American restaurants etc.), degrees of residential assimilation, and adoption of biculturalism among others. Cultural adaptation is important for the health status of FSU immigrants [32]; however, many immigrants experience adverse conditions precluding them from successful adjustment [33]. It is important to note that proper acculturation does not mean that FSU immigrants must adopt American values to improve their health; acculturation should rather be understood as a complex and long-lasting process of adjustment, which allows immigrants to benefit from important social institutions, support networks, and other resources in the destination country while maintaining and reflecting on their own cultural beliefs and values. Overall, to better understand the processes through which acculturation shapes health, there is a need to assess the intervening mechanisms that link those factors (outlined below).

Risky behaviours. One such intervening factor between acculturation and health is adopting "risky behaviours", including problematic alcohol and drug use, poor diet, inadequate exercise, etc. The lifestyle explanation argues that, in post-Soviet countries, the socio-economic and political contexts constrain people into unhealthy lifestyles causing poor health [11; 34, p. 124–126] and, as compared to other immigrant groups, FSU immigrants come from countries that are characterized by high alcohol consumption, smoking, cardiovascular diseases, and accidents [34, p. 120]. Also, FSU immigrants are at a high risk of drug use [35], are often ill-informed about preventative health measures, and tend to engage in alternative medicine [13, p. 870; 36, p. 205]. This suggests that certain segments of the FSU population can bring riskier behaviours to the U.S., likely due to their exposure to adverse social and structural conditions. Many individuals from FSU countries have

experienced disasters, wars, genocides, and extremely unstable economies, which are known to be major stressors causing risky behaviours. Thus, it is plausible that acculturation accompanied by having access to better institutional infrastructure in the U.S., getting more information on proper diet and exercise, and benefiting from improved resources related to navigating care can help those FSU immigrants reduce their risky behaviours and engage in more preventative health measures.

Social support networks. The second important intervening factor between acculturation and health is social support networks (i.e., the level of perceived support from relationships). In post-Soviet countries, social networks have often been used for private advantage through a so-called 'blat' or to take advantage of social institutions [14]. The U.S. has distinct norms. Thus, acculturation is necessary for FSU immigrants to adopt new norms regarding networks and support. In addition, low levels of acculturation, including the lack of English language skills, likely causes isolation from U.S. institutions such as education and health care [3, p. 115], which are important sources of social support networks. In turn, these social support networks are important for managing stress [9, p. 414, 420] and subsequently maintaining good physical and mental health. Therefore, I propose that greater FSU acculturation will lead to the adoption of social support networks [37] and, thus, reduce stress and better health-related outcomes [9; 38].

Unique beliefs. The third intervening factor shaping the link between acculturation and health is the 'unique' beliefs of FSU immigrants, mainly about medicine and health (e.g., the degree to which FSU individuals distrust Western medicine, adopt alternative medicine etc.). Research suggests that FSU immigrants are often perplexed by Western medical care [13, p. 869], distrust information and approaches of U.S. doctors [39, p. 25–26], and engage in self-medicine such as using herbs, external treatments, and their home country pharmaceuticals [39, p. 25; 40], which are not always effective and can even be damaging to health. These unique beliefs about medicine can also result in the lack of basic health screening measures and low health care utilization [39, p. 25–26; 41, p. 9]. Thus, I propose that proper acculturation will allow FSU immigrants to learn more about other views on health and develop a more comprehensive evidence-based approach to medical care, which, in turn, will improve health care utilization and health outcomes of the FSU immigrant group.

Health care utilization. The fourth intervening factor between acculturation and health is health care utilization (i.e., whether FSU immigrants access health care in the U.S. and the frequency of health care utilization). Evidence suggests that FSU immigrants tend to navigate the U.S. health care system similarly to how they did in their home countries, which often results in them being labelled as aggressive when getting medical attention [40, p. 18], with such acculturation factor as lack of English proficiency further reducing and exacerbating issues with health care use [42]. Holding an illegal status can cause even more barriers, making immigrants avoid hospitals overall [43]. All these issues together can cause the proliferation of untreated chronic conditions and major health problems. Higher levels of acculturation will increase and promote adequate understanding and utilization of U.S. health care, further improving health.

Cumulative stress. Finally, it is important to consider cumulative stress (the frequency of experiencing various straining (negative) life conditions) as the link between acculturation

and health. Research illustrates that high unemployment rates, loss of jobs, and financial difficulties are some of the issues causing high levels of everyday stress in FSU countries [44]. Further, immigrants tend to experience the stress-inducing factors associated with migration (e.g., not being sponsored for a visa, leaving relatives behind), which is especially pronounced among women [45]. Finally, the adaptation problems, English language difficulties, academic issues, reception policies, and discrimination [3, p. 111–116; 9] are all likely to further contribute to the stress levels of immigrants resulting in a so-called 'cumulative stress'. The accumulation or combination of various stressors negatively affects health and risky behaviours [3, p. 111; 44, p. 14; 46]. Thus, I argue that proper acculturation is critical in reducing and preventing accumulated stress, including providing the support networks in the destination country known to be important sources of stress management [9, p. 419–420] and further health improvement.

Health outcomes. Consistent with the stress process paradigm [47], the stressors discussed above, especially when they accumulate, are likely to exacerbate the health of FSU immigrants. Focusing on the mental health of this group is particularly urgent, given that they experience high levels of depression [48]. Further, as indicated in Figure 1, the mental health and physical health of FSU immigrants are interrelated and tend to influence one another (e.g., lower self-rated health influences higher depression) [49]. Given that FSU immigrants are a population with unique views on health and health care [50, p. 12–13], I argue that proper acculturation will improve their health through the mechanisms mentioned earlier. In addition, as illustrated in Figure 1, improved health status further reduces health care use, which is consistent with the behavioural model of health care access [51]. Considering the cultural uniqueness and resistance to answer certain questions among this group [52], it is essential to use more objective measure of health such as physicians' diagnoses and engage in more qualitative data collection to understand better the meaning FSU immigrants attach to health. In sum, hypotheses based on Figure 1 and the relationships discussed above are presented in Table 1.

Table 1

Suggested hypotheses based on Figure 1

Block 1	Block 2
If there is low ethnic concentration in the destination area, the status of FSU immigrants is illegal, and the motivations to immigrate are characterized by more negative conditions, then FSU immigrants will be less likely to acculturate	If there is high ethnic concentration in the destination area, the status of FSU immigrants is legal, and the motivations to immigrate are characterized by more favourable conditions, then FSU immigrants will be more likely to acculturate
If FSU immigrants experience difficulties with acculturation, this will lead to more risky behaviours, less social support networks, the perpetuation of 'unique' beliefs, and issues with health care utilization	If FSU immigrants experience appropriate acculturation, this will lead to less risky behaviours, more robust social support networks, reduction in 'unique' beliefs, and proper health care utilization
Engagement in more risky behaviours, fewer social support networks, holding 'unique' beliefs, and lack of health care utilization exacerbate the experience of cumulative stress, which, in turn, causes issues with physical and mental health	Engagement in less risky behaviours, more robust social support networks, fewer 'unique' beliefs, and better health care utilization will result in less cumulative stress, which, in turn, will improve physical and mental health

Discussion and Conclusion. This paper addresses an important yet understudied aspect of medical sociology: the health paradox among immigrants from the former Soviet Union. Given that this group is growing in the U.S. and other countries, it is crucial to provide a better theoretical understanding of this group's life outcomes. Whereas many foreign-born individuals tend to enjoy better health than native-born, it does not appear to be the case for FSU immigrants. Thus, to untangle the health paradox related to this group, I propose a new theoretical model.

Drawing on empirical literature and theoretical perspectives, I argue that acculturation is a crucial process affecting the health of the FSU group through various mechanisms related to behaviours, beliefs, networks, and institutional domains. Proper acculturation should be understood as a multidimensional and multidirectional process that can help create unique conditions to improve the FSU group's health outcomes. Given that acculturation is a complex phenomenon [3, p. 112–113], future research should incorporate it and develop this measure using robust theoretical and empirical tools. The proposed model can be tested using various statistical techniques (e.g., structural equation modelling, different mediation regression analyses etc.).

This paper also has important theoretical implications regarding the parsimonious argument of SES as a fundamental cause of health across time and space. Although SES often proves to be the cause of health and illness for the native-born populations, it does not appear to be a strong predictor of FSU immigrants' health. It is important to consider other effects of SES, such as its interactive/conditioning influences on health. For example, higher SES may be more likely to have a health-protective effect among FSU immigrants with higher levels of acculturation because the acculturated immigrants have better access to the important SES-related resources such as networks and social capital. On the other hand, if FSU immigrants experience extremely high stress, such as prior exposure to violent conflicts or prosecution in their countries, education or income may not be as protective of their health. These moderation hypotheses should be further tested by examining statistically different interactional effects of the factors mentioned above on health.

Finally, it is important to recognize other critical social-structural variables, including gender, country of origin, ethnicity, and religion, which can interact with the factors from the proposed model in affecting health. For example, women from FSU tend to experience more distress than men [45, p. 47], and, thus, certain adverse conditions related to acculturation may be more detrimental to women's health. In addition, while prior studies mainly discussed FSU immigrants as one block, people from different countries may have distinct immigration experiences. For example, considering Ukraine has been in the state of war, individuals from this country could be particularly sensitive to stress and generational trauma [53], which can linger on and affect them in the country of destination when they immigrate. As such, it is possible that Ukrainian immigrants can experience more cumulative stress, and as a result, worse health compared to individuals from other FSU countries.

In conclusion, this paper contributes to medical sociology, epidemiology, and other social sciences by outlining the important factors shaping the health of FSU immigrants with acculturation as one of the key mechanisms driving their health. Such focus is particularly urgent given recent calls for nuanced theoretical developments of novel and understudied

topics related to health [54]. Future research should incorporate, test, and refine the proposed model to provide a more nuanced understanding of the most critical processes driving FSU immigrants' health and ultimately move towards a parsimonious yet comprehensive explanation of the health of this unique social group.

References

1. Yearbook of Immigration Statistics 2005. (2005). Homeland Security. URL: https://www.dhs.gov/immigration-statistics/yearbook/2005

2. European Immigrants in the United States (2018). Migrant Policy Institute. URL: https://www.migrationpolicy.org/article/european-immigrants-united-states-2016

3. Dubowitz, T., Bates, L.M., Acevedo-Garcia, D. (2010). The Latino health paradox: Looking at the intersection of sociology and health. In C.E. Bird, P. Conrad, A.M. Fremont, S. Timmermans (Eds.), *Handbook of Medical Sociology* (pp. 106-123). Nashville: Vanderbilt University Press.

4. Cunningham, S., Ruben, J., Narayan, K. (2008). The health of foreign-born people in the United States: A review. *Health & Place*, 14 (4), 623-635. https://doi.org/10.1016/j.healthplace.2007.12.002

5. Markides, K., Eschbach, K. (2005). Ageing, migration, and mortality: current status of research on the Hispanic paradox. *The Journals of Gerontology. Series B: Psychological Sciences and Social Sciences*, 60 (2), 68-75. https://doi.org/10.1093/geronb/60.Special_Issue_2.S68

6. Antecol, H., Bedard, K. (2006). Unhealthy assimilation: why do immigrants converge to American health status levels? *Demography*, 43 (2), 337-360. https://doi.org/10.1353/dem.2006.0011

7. Singh, G., Siahpush, M. (2002). Ethnic-immigrant differentials in health behaviours, morbidity, and cause-specific mortality in the United States: an analysis of two national databases. *Human Biology*, 74 (1), 83-109. https://doi.org/10.1353/hub.2002.0011

8. Hayes-Bautista, D.E. (2002). The Latino Health Research Agenda for the Twenty-First Century. In M. Suarez-Orozco, M. Páez (Eds.), *Latinos: Remaking America* (pp. 215-35). Berkeley: University of California Press.

9. DeJonckheere, M., Vaughn, L., Jacquez, F. (2017). Latino immigrant youth living in a nontraditional migration city: A social-ecological examination of the complexities of stress and resilience. *Urban Education*, 52 (3), 399-426. https://doi.org/10.1177/0042085914549360

10. Robila, M. (2007). Eastern European immigrants in the United States: A socio-demographic profile. *The Social Science Journal*, 44 (1), 113-125. https://doi.org/10.1016/j.soscij.2006.12.025

11. Cockerham, W., Hinote, B., Cockerham, G., Abbott, P. (2006). Health lifestyles and political ideology in Belarus, Russia, and Ukraine. *Social Science & Medicine*, 62 (7), 1799-1809. https://doi.org/10.1016/j.socscimed.2005.08.024

12. Van Son, C., Stasyuk, O. (2014). Older immigrants from the former Soviet Union and their use of complementary and alternative medicine. *Geriatric Nursing*, 35 (2), 45-48. https://doi.org/10.1016/j.gerinurse.2014.02.019

13. Lipson, J., Weinstein, H., Gladstone, E., Sarnoff, R. (2003). Bosnian and Soviet refugees' experiences with health care. *Western Journal of Nursing Research*, 25 (7), 854-871. https://doi.org/10.1177/0193945903256714

14. Ledeneva, A., Ledeneva, A. (1998). Russia's economy of favours: Blat, networking and informal exchange. Cambridge: Cambridge University Press.

15. Mehler, P., Scott, J., Pines, I., Gifford, N., Biggerstaff, S, Hiatt, W. (2001). Russian immigrant cardiovascular risk assessment. *Journal of Health Care for the Poor and Underserved*, 12 (2), 224-235. https://doi.org/10.1353/hpu.2010.0822

16. Miller, A., Wilbur, J., Chandler, P., Sorokin, O. (2003). Cardiovascular disease risk factors and menopausal status in midlife women from the former Soviet Union. *Women & Health*, 38 (3), 19-36. https://doi.org/10.1300/J013v38n03_03

17. Shultz, J., Corbett, C., Allen, C. (2009). Slavic women's understanding of diabetes dietary self-management and reported dietary behaviors. *Journal of Immigrant and Minority Health*, 11 (5), 400-405. https://doi.org/10.1007/s10903-008-9177-8

18. Hosler, A., Melnik, T., Spence, M. (2004). Diabetes and its related risk factors among Russian-speaking immigrants in New York State. *Ethnicity & Disease*, 14 (3), 372-377.

19. Fridman, V., Vandalovsky, E., Bergmann, S. (2006). Cardiac risk factors, medicine usage, and hospital course in immigrants from the former Soviet Union. *Journal of Health Care for the Poor and Underserved*, 17 (2), 290-301. https://doi.org/10.1353/hpu.2006.0060

20. Mehta, N., Elo, I. (2012). Migrant selection and the health of US immigrants from the former Soviet Union. *Demography*, 49 (2), 425-447. https://doi.org/10.1007/s13524-012-0099-7

21. Hofmann, E. (2012). The burden of culture? Health outcomes among immigrants from the former Soviet Union in the United States. *Journal of Immigrant and Minority Health*, 14 (2), 315-322. https://doi.org/10.1007/s10903-010-9436-3

22. Janevic, T., Savitz, D., Janevic, M. (2011). Maternal education and adverse birth outcomes among immigrant women to the United States from Eastern Europe: a test of the healthy migrant hypothesis. *Social Science & Medicine*, 73 (3), 429-435. https://doi.org/10.1016/j.socscimed.2011.05.041

23. Link, B., Phelan, J. (1995). Social Conditions as Fundamental Causes of Disease. *Journal of Health and Social Behavior*, 35, 80-94. https://doi.org/10.2307/2626958

24. Phelan, J., Link, B. (2005). Controlling disease and creating disparities: a fundamental cause perspective. *The Journals of Gerontology. Series B: Psychological Sciences and Social Sciences*, 60 (2), 27-33. https://doi.org/10.1093/geronb/60.Special_Issue_2.S27

25. Michalikova, N., Yang, P. (2016). Socioeconomic adaptation of post-1991 Eastern European immigrants in the USA. *Journal of International Migration and Integration*, 17 (1), 1-34. https://doi.org/10.1007/s12134-014-0381-1

26. Krishnakumar, P., Indumathi, T. (2014). Pull and Push Factors of Migration. *Global Management Review*, 8 (4), 8-13. URL: https://web.b.ebscohost.com/abstract?direct=true&profile=ehost&scope=site&authtype=crawler&jrnl=09739947&AN=103541289&h=S5SMCdIfTQ%2fvQ9Bc%2bMqmkhFLkzf227lxJS7SsPRmUPHp%2bwoSLt9CnjIniZshCch52pn0tJJ5hmNr87HVC2CboQ%3d%3d&crl=c&resultNs=AdminWebAuth&resultLocal=ErrCrlNotAuth&crlhashurl=login.aspx%3fdirect%3dtrue%26profile%3dehost%26scope%3dsite%26authtype%3dcrawler%26jrnl%3d09739947%26AN%3d103541289

27. Jasso, G., Massey, D., Rosenzweig, M., Smith, J. (2004). Immigrant health, selectivity and acculturation. In N. Anderson, R. Bulatao, B. Cohen (Eds.), *Critical perspectives on racial and ethnic differences in health in late life* (pp. 227-266). Washington: National Academy Press.

28. Wright, M., Levy, M., Citrin, J. (2016). Public attitudes toward immigration policy across the legal/illegal divide: The role of categorical and attribute-based decision-making. *Political Behavior*, 38 (1), 229-253. http://dx.doi.org/10.1007/s11109-015-9311-y

29. Karlsen, S., Nazroo, J., Stephenson, R. (2002). Ethnicity, environment and health: putting ethnic inequalities in health in their place. *Social Science & Medicine*, 55 (9), 1647-1661. https://doi.org/10.1016/S0277-9536(01)00297-0

30. Vinokurov, A., Trickett, E. (2015). Ethnic clusters in public housing and independent living of elderly immigrants from the former Soviet Union. *Journal of Cross-Cultural Gerontology*, 30 (4), 353-376. https://doi.org/10.1007/s10823-015-9271-z

31. Leão, T.S., Sundquist, J., Johansson, S.E., Sundquist, K. (2009). The influence of age at migration and length of residence on self-rated health among Swedish immigrants: a cross-sectional study. *Ethnicity & Health*, 14 (1), 93-105. https://doi.org/10.1080/13557850802345973

32. Nicholson, L., Miller, A., Schwertz, D., Sorokin, O. (2013). Gender differences in acculturation, stress, and salivary cortisol response among former Soviet immigrants. *Journal of Immigrant and Minority Health*, 15 (3), 540-552. https://doi.org/10.1007/s10903-012-9752-x

33. Foster, R., Goldstein, M. (2007). Chernobyl disaster sequelae in recent immigrants to the United States from the former Soviet Union (FSU). *Journal of Immigrant and Minority Health*, 9 (2), 115-124. https://doi.org/10.1007/s10903-006-9024-8

34. Cockerham, W. (1997). The social determinants of the decline of life expectancy in Russia and Eastern Europe: a lifestyle explanation. *Journal of Health and Social Behavior*, 38 (2), 117-130. https://doi.org/10.2307/2955420

35. Guarino, H., Moore, S., Marsch, L., Florio, S. (2012). The social production of substance abuse and HIV/HCV risk: an exploratory study of opioid-using immigrants from the former Soviet Union living in New York City. *Substance Abuse Treatment, Prevention, and Policy*, 7 (1), 1-14. https://doi.org/10.1186/1747-597X-7-2

36. Grabbe, L. (2000). Understanding patients from the former Soviet Union. *International Family Medicine*, 32 (3), 201-206.

37. Jasinskaja-Lahti, I., Liebkind, K. (2007). A structural model of acculturation and well-being among immigrants from the former USSR in Finland. *European Psychologist*, 12 (2), 80-92. https://doi.org/10.1027/1016-9040.12.2.80

38. Birman, D., Simon, C., Chan, W., Tran, N. (2014). A life domains perspective on acculturation and psychological adjustment: A study of refugees from the former Soviet Union. *American Journal of Community Psychology*, 53 (1-2), 60-72. https://doi.org/10.1007/s10464-013-9614-2

39. Ivanov, L., Buck, K. (2002). Health care utilization patterns of Russian-speaking immigrant women across age groups. *Journal of Immigrant Health*, 4 (1), 17-27. https://doi.org/10.1023/A:1013055110631

40. Salimbene, S. (2000). What Language Does Your Patient Hurt In?: A Practical Guide to Culturally Competent Patient Care. Diversity Resources.

41. Blomstedt, Y., Johansson, S.E., Sundquist, J. (2007). Mental health of immigrants from the former Soviet Bloc: a future problem for primary health care in the enlarged European Union? A cross-sectional study. *BMC Public Health*, 7 (1), 1-12. https://doi.org/10.1186/1471-2458-7-27

42. Persidsky, I., Kelly, J. (1992). Educational perspectives for elderly migrants: A case of Soviet refugees. *International Review of Education*, 38 (4), 417-425. https://doi.org/10.1007/BF01102327

43. Portes, A., Fernández-Kelly, P., Light, D. (2012). Life on the edge: immigrants confront the American health system. *Ethnic and Racial Studies*, 35 (1), 3-22. https://doi.org/10.1080/01419870.2011.594173

44. Bíró, A., Branyiczki, R. (2020). Transition shocks during adulthood and health a few decades later in post-socialist Central and Eastern Europe. *BMC Public Health*, 20, 1-14. https://doi.org/10.1186/s12889-020-08839-7

45. Aroian, K., Norris, A., Chiang, L. (2003). Gender differences in psychological distress among immigrants from the former Soviet Union. *Sex Roles*, 48 (1), 39-51. https://doi.org/10.1023/A:1022392528490

46. Enriquez, L.E., Hernandez, M.M., Ro, A. (2018). Deconstructing immigrant illegality: a mixed-methods investigation of stress and health among undocumented college students. *Race and Social Problems*, 10 (3), 193-208. https://doi.org/10.1007/s12552-018-9242-4

47. Pearlin, L.I., Menaghan, E.G., Lieberman, M.A., Mullan, J.T. (1981). The stress process. *Journal of Health & Social Behavior*, 22 (4), 337-356. https://doi.org/10.2307/2136676

48. Kim-Goh, M. (2006). Correlates of depression among the Soviet Jewish immigrant elderly. *Journal of Human Behavior in the Social Environment*, 13 (2), 35-47. https://doi.org/10.1300/J137v13n02_03

49. Miller, A., Gross, R. (2004). Health and depression in women from the former Soviet Union living in the United States and Israel. *Journal of Immigrant Health*, 6 (4), 187-196. https://doi.org/10.1023/B:JOIH.0000045256.45988.6a

50. Kostareva, U., Albright, C., Berens, E-M., Levin-Zamir, D., Aringazina, A., Lopatina, M., Ivanov, L.L., Sentell, T.L. (2020). International perspective on health literacy and health equity: Factors that influence the former Soviet Union immigrants. *International Journal of Environmental Research & Public Health*, 17 (6), 2155. https://doi.org/10.3390/ijerph17062155

51. Andersen, R.M. (1995). Revisiting the behavioural model and access to medical care: does it matter? *Journal of Health and Social Behavior*, 36 (1), 1-10. https://doi.org/10.2307/2137284

52. Brouwer, A., Mosack, K., Wendorf, A., Sokolova, L. (2013). Patterns of missing data in ethnic minority health research: A survey project with Russian-speaking immigrant women with hypertension. *Research and Theory for Nursing Practice*, 27 (4), 276-295. https://doi.org/10.1891/1541-6577.27.4.276

53. Cancio, R., Kuptsevych-Timmer, A., Omori, M. (2020). Perpetual War with the Brother Nation: An Analysis of Ukrainian Veterans, Cultural Identity and Historical Trauma. *Journal of War & Culture Studies*, 13 (3), 219-236. https://doi.org/10.1080/17526272.2018.1558536

54. Novisky, M.A., Nowotny, K.M., Jackson, D.B., Testa, A., Vaughn, M.G. (2021). Incarceration as a Fundamental Social Cause of Health Inequalities: Jails, Prisons and Vulnerability to COVID-19. *The British Journal of Criminology*, azab023. https://doi.org/10.1093/bjc/azab023

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