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 **TOPIC: PREJUDICE BASED ON RACE**

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 For about thousands of years ago, prejudice based on race has been occurring all over the world. This was mostly between the Caucasians and other races, making the Caucasians and others have the mentality of superiority complex. So the question here is what is RACISM?? This is the feeling or act of feeling one race is superior over other races or a particular race.Studies of race and health frequently invoke racism, prejudice, and discrimination as possible reasons for high levels of morbidity and mortality among black and among other racial and ethnic minorities. Definitions of these terms vary, and no definitions are universally accepted. For our purposes, we use these terms somewhat interchangeably as indicating negative attitudes toward or biased treatment of one group by another.

Various types of racism have been described which may be considered the same as prejudice institutional, involving a set of environmental conditions, such as housing market conditions, that favors one group over another; and cultural, referring to shared beliefs about the superiority of one group over another. Racism also often involves control by one group over resources that another group wants or needs.Discrimination refers to unequal treatment based on group membership. What actual perceptions, attitudes, or behaviors these constructs refer to depends on the context—the nature and timing of events, their frequency, severity, and duration, whether they are acute or chronic—and on how they are perceived and interpreted, whether intent is attributed, and how they may later be distorted in memory.

Prejudice, discrimination, and racism could affect health in several ways. First, discrimination could determine a group's living conditions and life chances, affecting such areas as education, employment, and housing. As we note above, low socioeconomic status is one of the most important predictors of adverse changes in health status, though the specific mechanisms by which low status compromises health have yet to be adequately elucidated Similarly, all the mechanisms by which discrimination limits economic and social opportunities still need to be fully accounted for but that it has historically had an effect on minority socioeconomic status is unquestioned.

Early literature on black health, especially mental health, reflects a clear consensus that racism and discrimination have adverse effects That some degree of discrimination continues is clear: for example, audit studies continue to document discrimination in housing and employment. However, there have been comparatively few attempts to explore empirically the health effects of such discrimination among blacks, whether on children, adolescents, or adults (. There have been even fewer empirical studies of any kind on other racial and ethnic groups ). Researchers have continued to note that discrimination is an important factor in understanding black health status, and some suggest that it may account for particular patterns of association even proposed that racial discrimination does not just add to stress; it is an actual pathogen. Nevertheless, these constructs and arguments have received limited empirical attention especially as they relate to the life course and aging.

 Correlational studies have also commonly examined self-reported overall health. More than 70 percent of the studies report poorer health among those who report discrimination. The studies have shown somewhat more variable relationships of discrimination to more specific health indicators. Blood pressure, an important health status measure, has sometimes been positively associated with discrimination, but sometimes has had no association or even a negative association. Cigarette smoking and alcohol use have also been linked to discrimination. Some studies attempt to show that perceptions of discrimination, net of socioeconomic factors, account for racially related health differences.

Systematic investigation of the role of discrimination in health over the life course is rare . One longitudinal panel study did find that reports of discrimination that were related to poorer health in the first year were still linked, 13 years later, to poorer mental health, though by that time they were related, somewhat surprisingly, to better self-reported physical health). Another study that used reports of the experience of chronic discrimination found that these were related to subclinical carotid artery disease for blacks.

These correlational and experimental studies suggest that the subjective experience of bias and unequal treatment could affect particular health outcomes. However, the evidence is uneven and inconclusive, as almost every individual study has substantial inadequacies. Across the variety of studies, the definition and measurement of the factors of prejudice, racism, discrimination, and resulting unequal treatment are still relatively crude. Another problem is uncertain delineation of physiological pathways that serve as conduits for the effects of such factors on health. In addition, the conduits undoubtedly are affected by a host of contextual factors, such as socioeconomic status, individual host resistance factors, and coping styles and responses, as well as varying by age and possibly period and cohort.

Research into the effects of prejudice and discrimination on health differences requires some systematization. Such constructs as prejudice, discrimination, and racism have shifting definitions across studies and are often poorly operationalized. The confusion from continual redefinition makes it difficult for studies to build on one another. Measurement is also a problem, particularly the determination of discrimination from self-reports, which is the usual practice in non experimental studies. Response biases are possible in such data and may not be independent of response biases in self-reported health status Biases could even affect longitudinal studies, when prior experiences are reinterpreted in the light of subsequent events, though some closed-cohort longitudinal studies suggest this is not a critical issue.

Stressful events and experiences have been reliably linked to heath outcomes, as we discuss in the next chapter. However, what roots stress may have in prejudice and discrimination require better delineation. There is a need to distinguish among traumatic events and between macro- and microstressors and the relationships may be complicated. Discriminatory experiences may combine with other life stressors that affect health. But stress resulting from discrimination may be less easy to deal with through normal coping responses than stress from other sources, and different groups may have generally different ways of dealing with stress. For instance, active and passive coping responses work as well for blacks in response to normal life stressors (low income, negative life events, deaths of relatives and friends, etc.) as for other groups, but blacks are reported to have relatively few effective coping responses to poor treatment due to racial prejudice

The effects of discrimination on the experience of stress and health outcomes may involve lags and host resistance factors and may change over the life course, influenced by personality and other life experiences, such as resource acquisition, exposure, and support processes. Effects related to aging have to be seen in the context of period and cohort variation. Experiences of discrimination may be tied to particular periods or significant historical events (such as the 1960s civil rights movement). And birth cohorts each have their own history, possibly reacting to events differently because of the stage in the life course at which the events are experienced. A framework that combines aging, period, and cohort factors is therefore needed to understand how early experiences may lead to a cascade of subsequent health-relevant events and how experiences may have different effects over the life course. Such a framework is also needed to put scientific observations in context, since these observations necessarily pertain to particular periods and may be of limited relevance to individuals late in the life course. Models for the complex processes involved in stress reactions to the experience of discrimination also require development

Other racial and ethnic groups, such as American Indians and Alaska Natives, have been subject to prejudice over long periods. Immigrants have also been discriminated against, though as they assimilate and new immigrants enter, the targets shift. Arab Americans and Muslims are the latest to feel targeted. Yet indicators for the health of older adults in these groups are more favorable than indicators for blacks—and indicators actually deteriorate for immigrants as they assimilate and prejudice presumably declines. Does prejudice have effects on health in these groups, but are the effects counterbalanced by other factors, such as immigrant selectivity or better socioeconomic status? Or is prejudice against these groups weaker or less pervasive, of a different quality, or for some reason less consequential for health than among blacks? The answers could have implications not only for these racial and ethnic groups, but also for understanding the mechanisms that link prejudice and health for any group.