HEALTHCARE DELIVERY TO SOVIET IMMIGRANTS

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Abstract

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Providing health care services for the refugee and immigrant population is often a difficult task. In today’s world it is necessary for providers to learn better ways of delivering services that reduce the effects of a rapid culture change on the health of individuals. Providers must ensure respect for the values and norms the individual brings from his or her old culture. The process of adjustment in recent immigrants is the base for improvement of well-being of society in general and services to a refugee or immigrant in particular. This paper examines potential dilemmas for provision of medical and mental health services to Soviet immigrants as addressed in the literature and in the experience of the author, both as a former refugee and as a health care provider. As the necessity for quality service increases with the growing diversity of the American society, the adjustment issues of new members of society are going to have a significant impact on the ways health care services are being delivered in the United States.
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Introduction

Many refugees have undergone painful and traumatic experiences prior to leaving their country of origin. The purpose of this paper is to present the potential dilemmas that occur with provision of health care services to immigrants from the former Soviet Union and suggestions to health care providers on how to improve the delivery of health care services. When providers have an understanding of who those individuals are, where they came from, what kind of system they were used to, what the differences are between the delivery of services in their homeland and in the U.S., they would be able to provide higher quality of care. Castex (1992) emphasized that the smoother resettlement in the host society may depend as much on what has happened before the date of arrival, as it does on the actions of the service provider and the situation in a host society.

I was born in Lithuania, one of the fifteen republics of the former USSR. Growing up in that culture and later working as a nurse in a large hospital in the capital of Lithuania Vilnius, I was able to acquire first hand experience and knowledge of health care provision. When I arrived in Spokane with my husband and our oldest daughter in 1990, there were only two families in the city from the former Soviet Union. Currently, it is estimated that there are about 25,000 people from that part of the world residing in the Inland Northwest. This paper will include examples from my own experience as a former Soviet refugee, as well as the materials I obtained from the various research articles regarding this topic.

Aroian, Spitzer, and Bell (1996) studied family stress and support among former Soviet immigrants and found that refugees experience many losses, such as the loss of homeland traditions, family, friends, and use of native language. Leaving the homeland has meant leaving behind lifelong relationships and, possibly, never seeing friends or family members again.
The Immigration and Naturalization Service defines a refugee as “any person who is outside his or her country of nationality, who is unable or unwilling to return to that country because of persecution or well-founded fear of persecution. Persecution or the fear thereof may be based on the alien’s race, religion, nationality, membership group, or political opinion” (Castex, 1992).

Baker (1989) examined and analyzed adaptation and ethnicity of Eastern European immigrants. He stated that “the subjects left their native countries because of oppressive political conditions, and blamed the communist government for the terrible economic conditions” (Baker, 1989). In addition to political and economic barriers, many people in the former Union of the Soviet Socialist Republics (USSR) experienced persecution for their religious beliefs. Even though there were several churches and synagogues open in the country, teachers, college professors and other educators could not worship freely without the possibility of losing their jobs. This was an unwritten policy of the government contradicting the Constitution of the USSR, which guaranteed the freedom of religion.

Until 1990, the standard process for immigrating from the Soviet Union to North America was to travel to Vienna, Austria and after that to Rome, Italy. All arrangements for refugees in those two cities were made by the workers of International Center for Assistance to Refugees, including basic needs such as food and shelter. After undergoing several interviews with the Immigration officers from the United States (U.S.) or Canada, refugees were either granted or denied entry to their country of destination.

People who decided to leave their country were undertaking a risky and dangerous path. The application process was very unpleasant and bureaucratic. When a person or family applied for an exit visa they usually entered a state of limbo lasting for months or even years before they
were allowed to leave. To initiate immigration a person had to obtain permission from the workplace, which meant that co-workers learned of the person’s intentions to leave the country. Consequently they often looked upon the immigrant as a traitor. In addition to that, there were no guarantees for a positive outcome. I personally knew several people who were denied permission to leave the Soviet Union without any reason or explanation prior to 1989.

An unprecedented relaxation in policy occurred in 1991, when refugees in the USSR were allowed to complete paperwork and enter the U.S., flying directly from the Soviet Union. The new procedure was an exception to the law requiring that the individuals and families apply for refugee status only after they had left their country of origin. In an aftermath study by Castex (1992) on the dynamic of migration, Senator Alan Simpson stated, “It’s very difficult to be a real refugee when you’re in your native country” (p.143). The senator’s concern was that because of this alteration in the process Soviet refugees should have been considered economic rather than political refugees. The main difference is that in order to receive a political refugee status and, consequently, permission to enter the U.S. one had to have strictly political not economic reasons.

Perhaps the most difficult step to take for the future refugees was the requirement to give up their Soviet citizenship. From my own experience and that of others being stripped of one’s citizenship adds an enormous degree of vulnerability and stress. The psychological effect is profound. Thoughts of not being protected by the government, while at the same time feeling guilty for leaving the country were particularly intrusive. People leaving the Soviet Union as refugees had to pay a considerable amount of money – seven times of an average monthly salary per person – for the exit visas added to the stress as well.
Stages of Refugee Transition and Culture Shock

Arrival in the United States brings with it inevitable mixtures of exceeded and unfulfilled expectations, bewilderment, confusion, possibilities and demands. Usually, the word “shock” is not combined with the phrase “normal process.” Henner, Weller, and Shor (1997) were successful in uniting the two concepts by stating that an immigrant’s adaptation to a new society, namely “culture shock,” is a normal process of physical and psychological adjustment to an abrupt transition from one culture to another. The term “culture shock” first appeared in the work of Oberg (1956) who studied immigrant adaptation.

According to Gavagan and Brodyaga (1998), the time following the decision to leave a homeland for refugees can be divided into five stages. Initially, in the impact/preparatory stage, the family reacts by coming together, considering resources and developing a plan. The second, migration stage, represents the period of moving to the country of destination. Once the refugees arrive to their new country, they enter the third, overcompensation stage, where all their energy and resources are mobilized to enable them to live in a strange or unknown environment. At this stage opportunities and possibilities in the new environment are viewed optimistically. Then, after the “honeymoon period”, refugees often find themselves in a fourth, decompensation stage as the challenges of life in the new surroundings become obvious. Finally, refugees may resolve personal issues, and a period of accommodating to the host country’s norms and expectations may follow.

Researchers who studied the process of immigrant adaptation concluded that the most important factors in adaptation into the mainstream culture of the new country are obtaining employment and learning the country’s dominant language (Bach, 1980; Berry & Uichol, 1987). Other factors which play a significant role in this process are the size of the refugee population in
a given area, cultural similarities or differences with the main stream culture, strength of religious ties within the immigrant population, the level of general acceptance towards immigrants, the rate of assimilation to the mainstream culture of their children, and the length of time spent in the host country (Baker, 1989).

Health Care System in the Former USSR

Leaving the homeland has meant for the refugee leaving behind the familiar environment of health care. In order to effectively provide medical treatment in the U.S. to Soviet refugees, it is important for health care workers to be aware of the delivery of medical services in the former USSR.

Soviet medicine in general comprised an archetype of socialized health care, based on the principle of universal and free access to all levels of care as a fundamental human right (Davis, 1989). Primary care was provided by a network of local polyclinics staffed by internists and a basic array of specialists, supplemented by women’s health centers for gynecological care, and pediatric polyclinics for children from birth through age 15. All services, including home visits for acute illness and emergency facilities, were easy to access and free of charge (Remennick & Shtarkshall, 1997).

This sounds wonderful, however the quality of services was poor. It was one thing to write a prescription, but another thing to have that prescription filled. Not all drugs were readily available for the patient even with prescription. The equipment in polyclinics, as well as hospitals was outdated. For instance, X-ray machines were only available in a few major medical centers. One time my husband needed a dental X-ray which was not available in the local polyclinic, therefore he had to go a large medical center with the X-ray equipment in another part of town.
Internists or general practitioners, the primary level, often served their small neighborhood for years, which ensured familiarity with the patients and a certain continuity of care. Women's health centers combined a variety of services in one center dealing with gynecological diseases, prenatal care, and contraception. The majority of Soviet primary care physicians, and over 90% of gynecologists, were women. Male doctors were concentrated in the more prestigious and better paid secondary level of care (Ministry of Health of the Russian Federation, 1992).

The secondary level of care refers to the health care providers working in the hospitals or clinics where various surgical procedures were performed. Health care providers in the former Soviet Union were paid a salary rather than fee for service as usually exist in the U.S. Salaries of doctors and nurses in the former USSR regardless of the level were small and varied little. The reason secondary level providers were better off was that they were offered under the table money and gifts which was a common practice in Soviet medicine. This kind of overt behavior was typical in all sectors of the Soviet economy, and was in fact the only mechanism ensuring at least minimal efficiency (Barr & Field, 1996). Most people viewed giving a “bribe” to a doctor as a necessity to receiving better care.

The bribery, which existed throughout the entire system, was more prevalent in the secondary level because of the nature of services provided. For instance, if one had a sore throat or an upper respiratory tract infection, the prescription for antibiotics was written regardless of whether the bribe was given or not. Yet when a major surgical procedure and hospitalization was needed, the “gift” was customarily in exchange for extra attention.

In line with the general relationship between the Soviet State and its citizens, the medical system had a paternalistic attitude toward patients whose healthcare choices were very limited.
The implicit message was: “It is our duty to take care of your health and you should comply with our recommendations.” Consequently, patients perceived health as a function of proper medical supervision. Physicians were held accountable for their patients, not only professionally, but also administratively, which reinforced the paternalism of the provider - patient relationship (Remennick and Shtarkshall, 1997). However, paternalism was limited to the illness model which predominantly meant treating patients only when the disease was obvious, leaving little attention to primary prevention.

Health services in the former USSR were funded almost entirely by general government revenues (World Bank, 1993). Private individuals’ expenditures financed only 3.3% of health services and were incurred primarily when public sector practitioners saw patients in state run facilities after official office hours. Approximately 87% of health care spending was devoted to treatment facilities. Hospitals alone accounted for two thirds of disbursements. Research and education accounted for about 3.3% of expenditures; public health 2.7%; pharmaceutical subsidies 3.9%, and other expenditures 4.7% (World Bank Study, 1993).

The health status of people living in the former USSR was poor and has become worse since the fall of the Soviet Union in 1991. Two statistics often used to assess the standard of living and of health care are life expectancy and infant mortality. The former Soviet Union stood well below the West European countries and the United States. Life expectancy at birth fell between 1990 and 1994, from 63.8 years to 57.6 years for men and from 74.0 years to 71.0 years for women (Mehler, Scott, Pines & Gifford, 2001). Infant mortality in the former Soviet Union in 1991 was 20 per 1000 live births, as opposed to 10 per 1000 live births in the U.S. (World Bank Study, 1993).
Leon, Chenet, & Shkolnikov (1997) demonstrated that large fluctuations of mortality occurred in the former USSR in the 1980’s and 1990’s. There was a decrease in the overall mortality rate between 1984 and 1987, but an increase in that rate between 1987 and 1994. According to Leon et al.(1997), the decline in mortality from 1984 to 1987 could be attributed, at least partly, to President’s Gorbachev’s anti-alcohol campaign that began in 1985. According to the World Health Statistics Annual (WHO, 2000), the standardized death rate in the former Soviet Union is 1,142 per 100,000. This is 57% higher than in the U.S..

After the collapse of the Soviet Union in 1992, the situation in the county became even grimmer. The already imperfect and vulnerable health care system was put at the crossroads of newly developed capitalism. Many residents who felt somewhat protected during the Soviet rule by the system, found themselves wondering if health care could be obtained at all under a new political system. Corruption and bribery flourishing in other areas of the life of the Soviet people did not bypass the health care industry. Citizens that did not have means to pay for services were denied access or totally neglected.

One of the major issues that became obvious with the demise of the Soviet Union was the unavailability of inexpensive medications. Due to the closing of pharmaceutical factories, the various newly independent countries, which comprised the former USSR, had to rely on imported medications. The imported drugs were costly and, unfortunately, those in need were rarely able to pay for them. In many ways the system remained the same, but with the arrival of capitalism people were required to pay for certain procedures and medications. The prices were equivalent to those in the developed countries, while the average salary of a Soviet citizen was approximately 26 times less than those in the developed Western World (Barents Information Service, 2001).
Health Care in the U.S.

The health care in the U.S. differs greatly from that of the former Soviet Union. After the arrival to the U.S., refugees enter the American healthcare system, however, there is not any single “American health care system” (Williams & Torrens, 1999). The population served can be divided into four groups: 1) regularly employed middle income families with continuous programs of health insurance coverage, 2) poor unemployed or underemployed families without continuous health insurance coverage, 3) active duty military personnel and their dependants, and 4) veterans of US military service. The first group is financed by personal, non-governmental funds, whether paid directly by consumers or through private health insurance plans. The other three groups are financed either by the local or state government or by federal funds (Williams & Torrens, 1999).

The reality is that most refugees, at least initially, fall into the second category. The Welfare Reform of 1996 profoundly affected eligibility for immigrants to receive medical benefits. The period of time of receiving Medicaid benefits was shortened to eight months. After that period of time it is expected that immigrants would obtain employment and medical coverage would continue through their workplace medical insurance coverage.

In the beginning, most refugees are able to find only temporary, seasonal or part-time jobs. As a rule, their employers do not offer health care coverage to these types of workers, which leads to no coverage at all. This could be partly attributed to the fact that people find their previous job training to be non-transferable to a new labor market (Baker, 1989). In other cases immigrants’ limited English hindered the possibility of finding professional jobs. For instance, in Spokane many Soviet men work for construction companies which lay people off during the winter months. Women predominantly work in janitorial positions and fast food industry.
One of the main aspects that distinguishes the U.S. health care system from other
developed nations is the lack of universal access. About 14% or 34 million people in the civilian
non-institutionalized population lack healthcare coverage of any type, because they lack access
to the system (Williams & Torrens, 1999). The U.S. health care system receives 14% of the
gross national product (Chang, Price & Pfoutz, 2001). Preventive tests are available on request,
granted one has access to the system. For all major disease categories, morbidity and mortality
of the US population is significantly lower than in the former Soviet Union, and the average life
expectancy is about 10 years higher (Central Bureau of Statistics, 1995).

Both curative and preventive procedures are voluntary and based on the informed consent
of the patient. The physician bears legal and ethical responsibility for healthcare, but the patient
is expected to initiate medical contacts, if needed and to make autonomous decisions during the
course of treatment. In this multi-option system, outcomes depend on the patient receiving
appropriate information and making correct choices (Remennick and Shtarkshall, 1997).

The United States population and, consequently, the health care system highly values
personal autonomy, which reflects respect for the dignity and feelings of all people and one’s
ability to choose from various options. The emphasis in U.S. health care is placed on the
patients’ decision making, when options are given. People are also considered to be responsible
for maintaining a healthy life style and for primary prevention (Fowler, 1998). In contrast,
people from the former Soviet Union expect physicians to be more direct in disease prevention.
For instance, it would not be unusual for a physician to bluntly tell a patient to quit smoking,
whereas in the U.S. a more suggestive approach is dominant, such as providing literature about
detrimental effects of smoking or sharing with a patient the consequences of long-term smoking.
Barriers to Medical Care Experienced by Soviet Immigrants

Kohn (1995) in "Dismantling sociocultural barriers to care" described four types of barriers from the patient’s prospective. First, U.S. medicine is an unfamiliar culture to immigrants. Many of them are uncomfortable with a system that offers diagnosis and a choice of treatments to an individual who is then expected to make decisions and follow-through on treatments connected to the option chosen.

In the U.S. it is generally assumed that a patient will arrive for care at an appointed hour and if they do not, another assumption is made that they are unmotivated or disrespectful. For instance, an elderly Russian woman did not show up for a doctor’s appointment. When asked for the reason she replied: “The doctor is always so busy that I decided to let him rest a little.” From her standpoint, she was doing the doctor a favor by allowing him to relax between seeing patients. More than that, in a way she was willing to forego her chance to attend to her medical needs so the doctor could have a break.

A patient is expected to understand the nature of the illness and course of treatment. Such expectations are foreign to many cultural groups and create barriers to care. “They [newcomers from the former USSR] expect the expert to tell them what to do,” said Laura Rodgers, an assistant professor at Oregon Health Sciences University, when she spoke at a Portland forum about health care for Soviet immigrants in 1998. “They think you are the physician; you should know best”. People who are not familiar with the U.S. health care system often perceive having to make a decision for themselves as a sign of the provider’s negligence or incompetence.

A second barrier to medical care for immigrants is an inability to speak and understand the language and therefore the nuances of the culture. Frequently in immigrant populations,
children serve as an interpreter when a designated or qualified interpreter is not available. Related to the language barrier, misinterpretation may occur because of nonverbal communication styles such as body language, eye contact, silence, and physical closeness (Kohn, 1995). Fortunately, the State of Washington is one of the most progressive in the nation in terms of assistance to refugees. The Medical Assistance Administration provides funds for interpretive services, which means that visits to health care providers can be accompanied by interpreters.

On a personal note, from 1994 to 1997 my husband ran an interpreting business providing translation services in Spokane. Being one of the very first people to settle in this area and having graduated from Eastern Washington University in 1992, my husband was often contacted by the members of the Russian speaking community, as well as Social Service agencies in Spokane to provide interpretive services. These agencies included the Department of Social and Health Services, courts of law, hospitals, physician and dentist offices. As more and more people arrived from the former Soviet Union to Spokane, the need for translation services increased significantly. What had begun as an occasional volunteer activity, had evolved into a full time job. The demand for interpretive services still exists. Currently, the language services in Spokane are provided by Merino Interpretive Services.

A third barrier is the foreign customs or traditions, which may not be understood or respected by the provider. A person’s health care practices and beliefs, age, gender, family roles and customs may differ from that of the mainstream culture. A lack of knowledge of cultural practices and beliefs by the health care provider may prevent a new patient from seeking needed services. Patients from many cultural groups including recent Soviet immigrants, often rely on traditional remedies for cures and relief from symptoms. In addition, refugees may have physical signs related to traditional health care practices such as cupping (application of heated
cups to the skin) that can be mistaken for signs of abuse. For example, application of heated glass cups was widely practiced in the former Soviet Union. Providers should know about and be sensitive to the cultural variations of these groups during the delivery of services (Gavagan & Brodyaga, 1998).

The fourth issue is about trust in the system in general and a provider in particular. Some Soviet immigrants, especially in the decompensation stage, feel that Soviet health care was more holistic and providers were more personal (Remenick and Shtarkshall, 1997). In my conversation with a middle-aged woman who has resided in Spokane for 8 years she said, “Yes, there [in the USSR] they really cared about our health… There were not so many medicines and instruments there, but there were open hearts, and eyes, and hands of the doctor…it was much more humane”. Another woman who arrived to the U. S. from Ukraine 10 years ago admitted that she is somewhat distrustful of male gynecologists for she feels that one has to be a woman to completely understand the issues of womanhood. This attitude is understandable because most of the primary level gynecologists in the former Soviet Union were female.

Health Care Issues Among Refugees

Recent Soviet immigrants are more likely than resident populations to have special medical problems, including infectious diseases, parasites, and mental health problems resulting from extreme stress (Kohn, 1995). Preventive medicine in the former Soviet Union was poorly organized. Ironically, Soviet healthcare traditions strongly emphasized the secondary prevention approach (like early detection of diseases) (Remennick & Shtarkshall, 1997). Less attention in the Soviet public health discourse was paid to primary prevention via the adoption of a healthier lifestyle. Lifestyle habits prevalent in the former Soviet Union, including smoking, alcoholism, poor nutrition and little preventive healthcare or attention to a healthier life style allow one better
understanding of the health status of this population (Mehler et al.,2001). According to the 1997 Heart and Stroke Statistical Report from the American Heart Association, residents of the former USSR had the highest death rate from cardiovascular disease compared with all other major countries in the world.

Mehler et al., (2001) assessed the risk of cardiovascular disease in Soviet immigrants in the Denver area. The mean age of participants was 63 years and 64% of the patients were female. Two hundred and four participants were successfully screened using a risk assessment questionnaire adapted from the San Luis Valley Diabetes Study. Laboratory data which included serum glucose, creatinine, total cholesterol, high-density lipoprotein (HDL), low-density lipoprotein (LDL), and triglyceride levels revealed that almost half of all participants had two or more cardiac risk factors. The overall prevalence of hypertension in this cohort was 56%. In the U. S., 25% of the adult population has hypertension, defined as a systolic blood pressure ≥140-mm Hg and/or diastolic blood pressure ≥90 mm Hg and/or the use of antihypertensive medication. The studied group also had a significantly higher prevalence of hyperlipidemia (p<0.04) than the U.S. counterparts.

Healthcare providers must be aware of these risk factors in Soviet immigrant populations. Screening and laboratory tests should be offered to these groups when appropriate and clinically indicated. Physicians and mid-level providers should encourage these patients to adopt a healthier lifestyle. Providers should also emphasize the importance of compliance with medications and treatments during follow-up care. If possible, a more direct and imperative approach should be taken when treating this population. The former Soviet immigrants are not a strictly homogeneous group to which one standard approach can always be applied.
Women’s health and prenatal care are important aspects of immigrant health. Among Soviet women, frequent prenatal visits, as recommended by the American College of Obstetrics and Gynecology (ACOG), are viewed as unnecessary. Unless serious complications arise, visits to the obstetrician’s office are fairly rare (Remennick and Shtarkshall, 1997). Providers of women’s healthcare should make sure that women from these populations completely understand the risk they assume for not showing up for their scheduled appointments. An interpreter should be used in explaining in details all the risks of neglecting the recommended appointment schedule.

Another health issue concerns vaccinations. Soviet immigrants’ immunization status usually needs to be updated. Children most commonly have some diphtheria, pertussis, and tetanus/oral polio vaccine coverage, but often documentation is lacking. They also often need vaccination for measles, mumps, and rubella, as well as Haemophilus influenzae type b and hepatitis B (Gavagan & Brodyaga, 1998). The recommended protocol for persons who have lapsed immunization status is to follow the Centers for Disease Control and Prevention recommended childhood immunization schedule (Burns et al., 2000).

Refugees are occasionally seen as “somatizers” who express underlying psychological problems in terms of physical complaints (Gavagan & Brodyaga, 1998). The tendency to somatize is especially common in Soviet elderly (Gavagan and Brodyaga, 1998). Cultural sanctions or stigma in former Soviet Unien prevent the self-acknowledgment of a mental disorder (Aroian et al., 1996). It is more culturally appropriate to express illness in terms of physical symptoms rather than psychodynamic constructions of stress that are more common in the U.S. culture (Aroian et al., 1996). Compliance with antidepressants and in more serious disorders with antipsychotic agents may be low. From a young age people in that part of the
world are taught to be emotionally strong and deal with psychological problems themselves or with the help of the close family members.

In some cases soviet immigrants could be perceived as aggressive and manipulative during health care encounter. These are learned behaviors that were adopted in order to receive care in the former Soviet Union. This may be why upon their arrival in the U.S. they often request excessive testing and evaluation (Mehler et al., 2001).

**Bridging the Gaps**

Many primary care providers encounter refugees and immigrants in their clinical practices. Specific screening recommendations should depend on the refugee’s health status as well as age, gender, and lifestyle habits. Physical examination and the collection of a patient’s medical history with questions about disabilities, substance abuse and mental health issues is the key factor in determining what screening tests are required. According to Gavagan & Brodyaga (1998) the following tests should be performed routinely in screening refugee patients: complete blood cell count, hepatitis B screening, HIV, stool analysis for ova and parasites, and an annual PPD (Purified Protein Derivative). When symptoms suggest, the blood and urine glucose test should be obtained for diagnosis of diabetes mellitus. There was an instance in my husband’s practice as an interpreter, where a newly arrived man from the former USSR had a blood glucose of over 700 mg/dl. He stated that for the last three years his condition was left untreated due to the lack of medicine. Naturally, he was put on insulin immediately and currently is doing quite well.

It is crucial that communication barriers between health care providers and immigrants are removed. The most concrete step one can take to increase access for non-English speaking groups is to use certified interpreters, translate forms, patient education materials, and signs
(Kohn, 1995). Other possibilities include hiring bilingual staff, offer language classes for staff, record a message in Russian on the answering services, or establish a shared language bank for community providers. Also, cultural sensitivity training should be required for all staff working with diverse populations, because it reduces misunderstanding that may occur through nonverbal communications (Kohn, 1995).

Healthcare providers ought to reach out to immigrant community members as well. The best way to engage community members is through direct services, partnership with community organizations, developing links with refugee communities such as churches, social service agencies, and community based organizations to create programs aimed at improving the health and well being of residents. Clinics that serve a large refugee population should increase the diversity of their board and staff at all levels. Finally, efforts should be made to make a facility welcoming. The physical setting should convey an attitude of “you are welcome here” or “this is where you belong.” At minimal expense a lobby or waiting area can include visual signs in Russian such as where the reception and appointment desks are. Also providers should offer handouts for most common illnesses in Russian, as well as English.

**Summary**

For many health care professionals the collapse of the Soviet system has moved from television news into their offices. The possibility that a medical service agency will treat an immigrant is growing. Health care providers dealing with the effects of immigration may have little experience regarding the refugee population in general or the Soviet refugee client in particular.

No model of delivery of care is perfect. As ethnic diversity of the United States grows, health care agencies will want to position themselves to meet the unique needs of diverse ethnic
groups. At the present time due to shrinking sources of funding and subsequent changes in health care policy, resources are becoming even more scarce.

The political voice of immigrants is weak. Inability to speak and understand English plays a major role. Also, newcomers can not vote until they become U.S. citizens, which takes at least five years from the arrival date. Most immigrants do not possess financial resources to hire advocates or lobbyists on their behalf. Therefore, they must rely either on coalition forming through church or social groups or seek outside advocacy from the health care system in the U.S.

By demonstrating an active interest in learning cultural concepts, people increase their respect and sensitivity for diversity, minimize their potential for violating cultural norms, and improve health care and working relationships among individuals from similar or dissimilar cultures. Therefore, health care providers must become the voice for those who otherwise are literally voiceless.
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